CATHOLIC MEDICAL ASSOCIATION

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

July 13, 2023

To: Uniform Law Commissioner

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

Re: Revised Uniform Determination of Death Act

Since your receipt of our letter to ULC Commissioners in early February (attached), our organization has continued to closely monitor deliberations regarding potential UDDA revisions. In anticipation of your Annual Meeting later this month, this second letter is submitted to further reinforce the significant concerns we and many other medical groups share.

The diagnosis of death by neurologic criteria (DNC) remains a paramount concern, particularly in a clinical setting of a patient with continued cardiac function. The diagnostic accuracy of bedside and ancillary testing that confidently determines DNC remains very limited, an observation that is noted by the American Academy of Neurology. As is true in all of medicine, if the diagnosis is not clearly established, decisions for intervention cannot be made in the patient's best interest.

It is also critically important that the patient's family and/or surrogates be fully informed before any DNC-related procedures are implemented. Informed consent must be obtained before testing for brain death is initiated, and those providing such consent must be offered as much time and information as is needed to do so. They must also be advised of their right to refuse such testing. Similar protections are warranted for the physicians and other clinicians working with these patients. These professionals must be allowed to opt out of DNC determinations and any means of pressure on them to participate must be prohibited.

550 Pinetown Rd., Ste. 205 • Ft. Washington, PA 19034-2607 • Ph. (484) 270-8002 • Fax (866) 714-0242 • cathmed.org • info@cathmed.org

In Section 3 of the current draft of possible revisions, the options of "permanent" *versus* "irreversible" with regards to the determination of death are presented to the Commissioners. It is necessary that "irreversible" be utilized in any revisions. "Permanent" is a dangerous term, implying that nothing will be done. That is the antithesis of medicine. "Irreversible" cessation of circulatory and respiratory function is necessary for an incontrovertible determination of death. Given the lack of sensitivity and specificity of brain death testing, DNC should not be included at all.

Thank you for your attention and consideration of these important facts that must be part of your deliberation. We look forward to a well-reasoned process by the ULC, resulting in a UDDA that recognizes the limitations of current medical science and protects the dignity of our patients and their loved ones.

Sincerely,

Craig L. Treptow, M.D.
President

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)

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

---

[1]Eelco 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)

[2]Nair-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

[3]Seifi 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