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Brain Death—An Opposing Viewpoint

Paul A. Byrne, MD; Sean O'Reilly, MD, FRCP; Paul M. Quay, SJ, PhD

• Recent and proposed legislation to establish "brain-related" criteria of death has uniformly confounded irreversible cessation of total brain function with the death of the human person. Much of the confusion comes from widespread misunderstanding of how the word "death" is used and what it means. Cessation of total brain function, whether irreversible or not, is not necessarily linked to total destruction of the brain or to the death of the person. Further, to take vital organs or to otherwise treat people as though they were dead already on the basis of these recent criteria is morally unacceptable to most Orthodox Jews and Christians.

(JAMA 242:1985-1990, 1979)

IN a 1977 article in *THE JOURNAL*, Veith et al¹ argued in support of defining death by statute. They favored, in particular, a statute modeled on the American Bar Association's (ABA's) proposed definition of death: "For all legal purposes, a

Capron-Kass models, we do not discuss these latter explicitly, though Veith et al regard them, along with the ABA's proposal, as satisfactory. For similar reasons, we do not take up explicitly the Uniform Brain Death Act, proposed in August 1978 by the National Conference of Commissioners on Uniform State Laws.)

As many others before them have done, Veith et al discuss medical feasibility and write at length concerning legal advantages.¹ What seems to be novel in their article are their arguments that "pronouncements of death on brain-related criteria are in accord with secular philosophy and principles of the three major Western religions."

The present article is written to show that the ABA's definition of death and, indeed, all 19 or so statutes that have undertaken to define and establish at law "brain-related" criteria of death are based on scientifically invalid assumptions and are also opposed to the three major religious traditions of this country.

Understanding 'Death'

When speaking of "definitions of death," a sharp distinction must be made between two quite different modes of definition. On the one hand, "death" is the word we use to name a certain empirically given state of affairs, a state difficult to describe in full generality, yet one with which we are all too familiar as a situation of fact. Someone we have known ceases to breathe, sags wherever not supported; we find no pulse; there is no sign of inner activity or of reaction; all is silent, inert, then cold; the body grows rigid, later becomes flaccid and begins to putrefy, decomposing till only bones remain. Most importantly, from a certain moment on—"the moment of death"—whatever happens, whether it involves putrescence, mummification, incineration, or nuclear vaporization, is entirely describable in terms of disintegration, dissolution, destruction of the unity of the single organism that was formerly present: a human being has, so far as this world can tell, simply ceased to be.

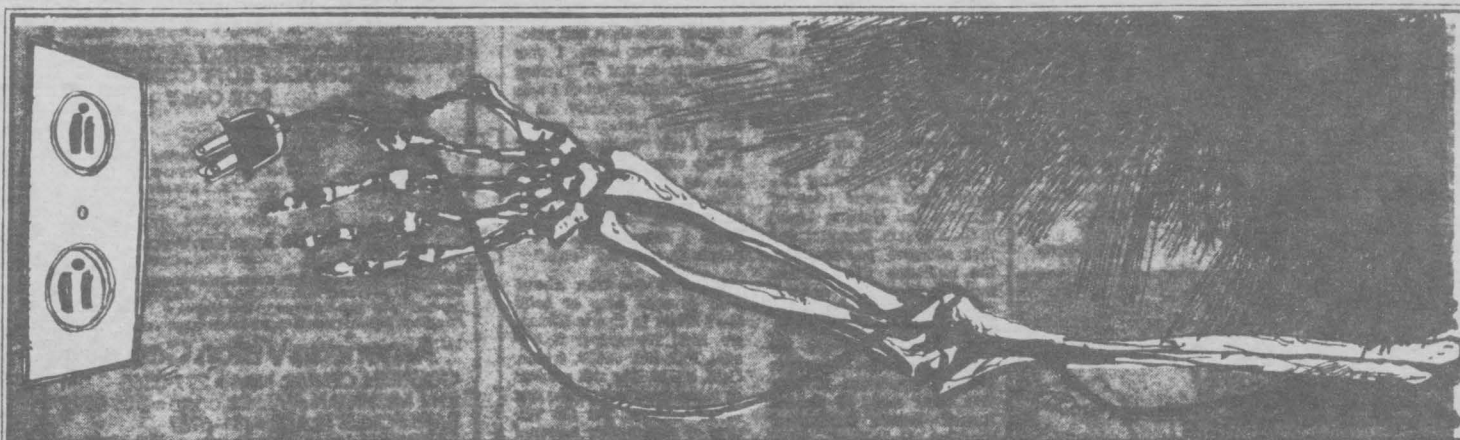
On the other hand, at all times people have attempted, when using the word "death," not merely to refer to the experientially given state we have mentioned but to say what that state is, to explain it where possible, at least to describe it in terms of the concepts found useful for describing the rest of the universe. Such a re-description and, ultimately, explanation of death can be seen as a definition of

For editorial comment
see p 2001.

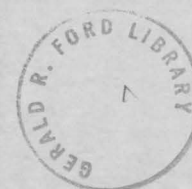
human body with irreversible cessation of total brain function, according to usual and customary standards of medical practice, shall be considered dead." (Since the arguments we shall offer against the ABA proposal apply a fortiori to statutes based on the

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Sun-Times Graphic by John Demme



When do we have right to choose death?

Barbara Varro

In the Broadway play, "Whose Life Is It Anyway?" a woman who has been paralyzed from the neck down in an auto accident begs her doctor to leave her alone so she can die in peace. The woman, a sculptor, does not want to face a life as a quadriplegic who will never again be able to do the work she loves.

The essential question posed in Brian Clark's play is: Do people have the right to choose death rather than accept extraordinary medical measures that might sustain their lives?

THERE ARE NO SIMPLE answers to that question, but it continues to pop up frequently as attention is focused on the issue of patients' rights in regard to medical treatment. That issue becomes extremely complex in the case of terminal illness, raising a host of ethical, moral and legal questions for doctors and hospital administrators.

Health professionals point out that the very advances in medical technology that have made it possible for doctors to sustain more lives today—wonder drugs and electronic life-sustaining machines—are raising new questions in regard to patient care:

- Must doctors do everything in their power to persuade patients (or their families, if the patient is not competent to make a decision) to accept the technology or drugs that may prolong their lives?

- Who should have the final word about whether something such as surgery or chemo-

therapy should be used—the doctor, the patient, his family?

- Can failure to persuade a terminal patient to opt for therapy or surgery that may save his life be construed as helping that person to commit suicide?

- Can discontinuation of apparatus such as a respirator (which essentially breathes for the patient) be interpreted as a kind of euthanasia?

MANY HEALTH PROFESSIONALS view the patient's right to let fate take its course as

the acceptance of the inevitable. "It is a terminal patient's innate right to accept or refuse treatment after his or her doctors have explained the prognosis," says Sister Dorothea Salcius, S. S. C., president of Holy Cross Hospital. "If the patient is Roman Catholic, a hospital chaplain or counselor will explain the moral implications. Patients and their families are told that they are under no moral obligation to accept heroic measures to attempt to save their lives."

Salcius does not believe that failure to use

extraordinary means to prolong the life of someone whose brain activity has ceased should be construed as a hastening of that person's death. "It is letting life take its natural course," she said.

Judith Johns, clinical director of psychiatry at Grant Hospital, does not think that the wish to die a "natural" death without extreme means of intervention can be interpreted as suicide. "I think of suicide as cutting off of a viable life," she says. "The person who believes in the quality of life may feel that his life, which may be irrevocably altered [by a serious accident or terminal illness], is no longer viable."

She believes that a person who chooses not to accept heroic measures to prolong life may be accepting the inevitable. "The issue of patient's right to die is so subjective," she says. "It depends on how an individual looks at death. While some people are terrified of death, others are not so frightened by it."

IT ISN'T HER JOB, JOHNS says, to talk a person out of a decision if that person is mentally competent. But she encourages patients to give their decision a lot of thought, and to talk to their families about it. "I tell them that choosing to die is the most irreversible decision they can make in their lives. There is no turning back."

In the course of her work, Johns has counseled scores of patients who have had to contend with great suffering and pain. "I can em-

The state of right-to-die legislation

Attempts to legislate the patient's right to die continue to cause controversy. While laws concerning the issue have been enacted in 10 states in the last seven years, Illinois has resisted such legislation. Ill. Rep. Bernard E. Epton (R-Chicago) has introduced a "death with dignity" bill several times since 1973. The bill was defeated each time. "My bill to protect a patient's right to die is very simple," Epton said. "It states that a person of sound mind who was suffering from a terminal illness could authorize a doctor to discontinue heroic measures."

EPTON POINTS OUT that his bill was defeated primarily by medical professionals who lobbied against it. Some doctors

protested on the basis that patients already have the right to refuse heroic measures. Others said that the bill didn't provide enough protection for physicians. Nor did it provide for what can be done by family members in the case of terminally ill patients who are unable to decide about having life-sustaining apparatus withdrawn.

Epton believes that the right-to-die issue is a gray area that needs clarification under the law. "It's not true that patient's rights are always honored by doctors and hospitals," he said. "While my bill is primarily concerned with patients' rights, it also protects the doctor from possible

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PBS' 'Suicide' is not the way to go

THE PUBLIC BROADCASTING SERVICE has always had a soft spot for how-to programming, but isn't *How to Kill Yourself* carrying things too far? I'm talking about something called "Choosing Suicide," which will air on Channel 13 June 10 at 8 p.m. You probably remember the incident that prompted the show, which was widely reported in the press a year or so ago.

Jo Roman, a New York artist and social worker, decided to end her life after learning that she had terminal cancer, and she made quite a production of it. She brought her husband (a professor of psychiatry) and friends together in the living room of her spacious West Side apartment, where they sat around quaffing wine and discussing Jo's decision, after which Jo made her

**KAY
CARDELLA**



DAILY NEWS, FRIDAY, JUNE 6, 1980

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ANN LANDERS

The question of death with dignity



DEAR ANN. In the last eight months I have lost my father and sister to cancer. She was the beauty of the town. She was 40 years old. It was June

Anyone who wants more information and a free copy of a living will can obtain one by writing to Concern for Dying, 250 West 57th St., New York, N.Y. 10019. This

Beyond the Quinlan decision

By GEORGE F. WILL

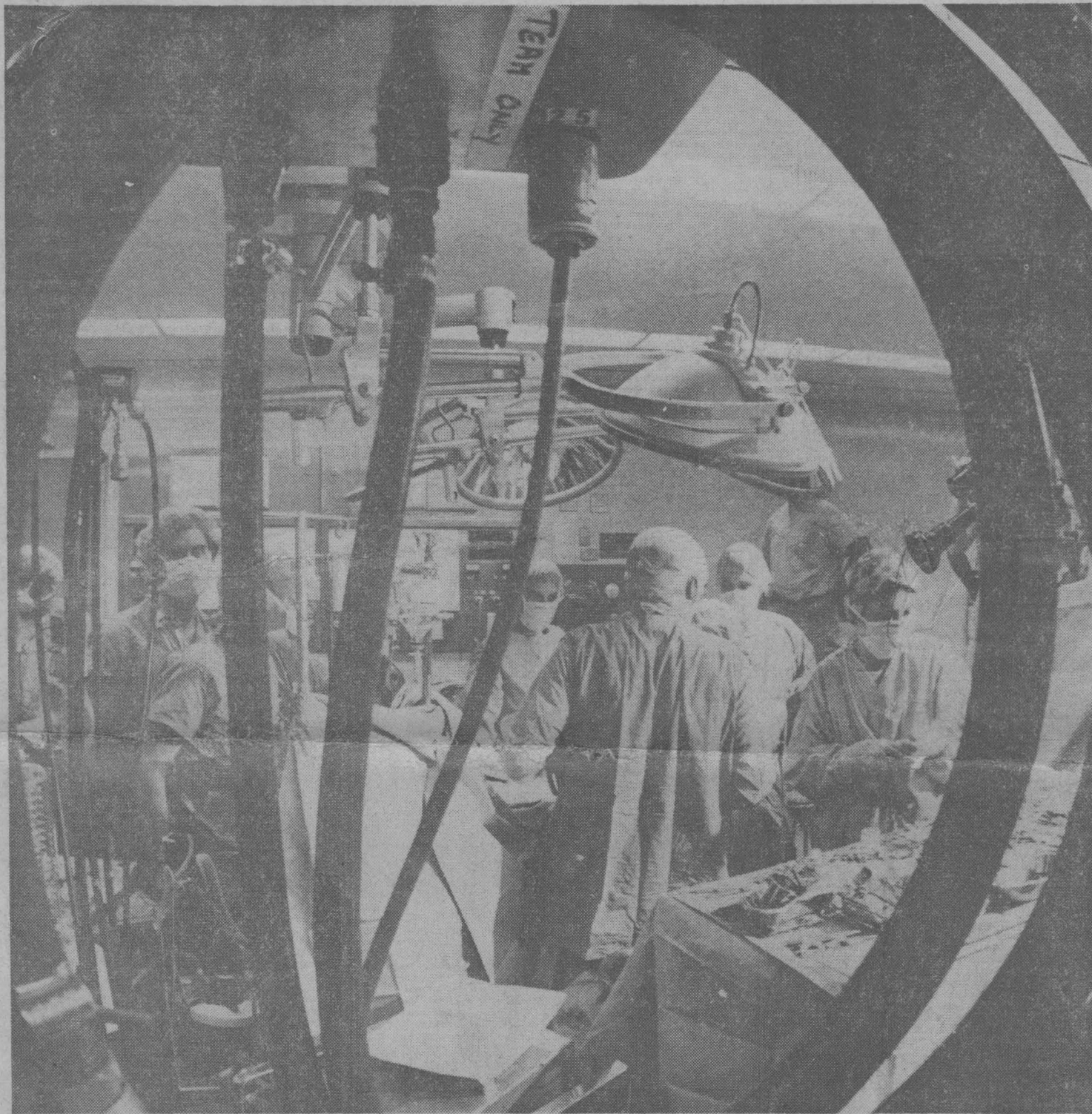
WASHINGTON — When death comes to Karen Quinlan it will not come with the assistance of the State of New Jersey. That is the unexceptionable decision of the

But although the judge would have been correct in his belief that vegetative life is not meaningful, and that Ms. Quinlan's "meaningful life" is over, it would have been a terrible mistake to have allowed

They argue that the aged, the retarded, and others will be in jeopardy. Such people will constantly face danger from shifting standards of what constitutes meaningful life; their right to life will exist only at the sufferance of a standardless society.

Inquirer 10/16/77

The twins decision: One must die so one can live



Special to The Inquirer / ED ECKSTEIN

At Children's Hospital, a surgical team separates the Siamese twins, who were joined at the heart

Parents, doctors, rabbis in dilemma

By Donald C. Drake
Inquirer Medical Writer

It was a very low-key press conference and only half a dozen reporters had come out to hear the doctors tell how they had just separated Siamese twins.

Sitting behind a long table on the stage of a mostly empty auditorium, the doctors explained that one of the girls had died because the twins together had only one-and-a-half hearts. Some questions were asked, and then the conference was over — an anti-climatic ending to one of the most intense dramas ever played out at Philadelphia's world-famous

Children's Hospital.

No one in the audience realized it, but the operation had probably provoked more debate, more soul-searching on the part of the staff and more concern about the law than any other surgery at Children's in recent years.

At issue was one painful fact:

The surgeons knew that in an attempt to save one of the twins they would have to kill the other.

The one-and-a-half hearts were strong enough to support only one child. Thus the doctors knew that one twin would die soon anyway, and that without the surgery this would lead to the death of her sister.

During the weeks preceding surgery:

- Several rabbis and other learned men met four to five hours every night for 11 days discussing the ethical issues. The parents, who are deeply religious Jews, refused to allow surgery without rabbinical support.

- Nurses and doctors at Children's brooded about the certain death of one of the twins. A few refused to participate.

- Dr. C. Everett Koop, the hospital's chief of surgery, was so concerned about being prosecuted for (See TWINS on 14-A)

Donald C. Drake, The Inquirer's medical writer, interviewed nearly all the principals in preparing this reconstruction of the unique separation of Siamese twins last week in Philadelphia. Through Children's Hospital personnel, the twins' parents asked not to be publicly identified.

Yesterday the hospital reported that Baby Girl B, the surviving twin, was in stable but critical condition.

Section 2

Euthanasia: When you can't stand the agony

By Terry Daniels

RECENTLY I READ a newspaper article about a nurse in Baltimore. The headline read: "Nurse on trial for murder called compassionate." It threw me into a panic. She was accused of taking a GORK off a respirator. GORK is a medical acronym in universal use—it means God Only Really Knows. The patient in this case had stopped breathing and had been brought back. He had bladder cancer, cirrhosis of the liver, pneumonia, and heart failure. My reaction to that headline was, "Oh God, somebody got caught."

What I felt was what most nurses I know felt. I know because I asked them. They were truthful, because I'm from the inside of medicine, from the same family, so they shared with me. All have been nurses for five years or more, some for as long as 15 years. Each has worked in at least three hospitals, and everyone agrees it's about the same in all of them. They range in age from 24 to 50, and all have children. Medicine is very important to them, and none considers it just a job.

Clinically, a GORK is a man, woman, or child lying in a bed, unable to do anything for himself; he has no voluntary functions left. There usually is a tube through his nose down which liquid food is poured; he never tastes it. Sometimes he's unable to digest it, and sometimes his stomach gets too full so he vomits it and then has to be suctioned quickly so he doesn't choke on it, or get it into his lungs, which causes pneumonia. He's unable to move purposefully, and his involuntary movements are erratic and seizurelike. If his eyes are open, they stare without blinking. Often they are taped shut so his corneas don't ulcerate. You can talk to him, and he doesn't respond. He doesn't appear to be able to hear. If he has an itch on his nose, he can't scratch it. He's figuratively locked in cement, literally a prisoner in his own body.

THE HUMAN REALITY, the thing I say to myself, is, "That could be me . . . or my child, or my mother, or my father." And then while I pour the food down these tubes, and wash their faces, and turn them over, and clean up their feces, and put pillows between their knees so they don't get bedsores, I talk to them and look at them and ask out loud and sometimes to myself, "Is there anything more I can do?" And then with frustration and pain, "Is there nothing more I can do?"

The tool used in medicine to separate the brain dead from the severely brain damaged (GORKs) is an EEG machine. From the outside you often can't tell; they look the same. You have to have two or three EEG readings, 24 hours apart, to certify brain death, which means you can legally take someone off a respirator and then bury him. I can't explain that any more kindly.

I'm never quite sure, even with a flat EEG, that a person's awareness is gone. I know it means that they are sure

Continued on page 4

there's no consciousness. I'm not. There's just too much that our machines can't measure. They can't measure pain; they can measure only the reaction to pain. And they can't measure caring and intuition and other tools of medicine. They can't measure "will to live," but I've seen it make all the difference in a patient's getting well or dying.

I've worked with people who were severely brain damaged (GORKs), and the space between the brain damaged and brain dead is sometimes as thin as a hair. You can still get spikes on an EEG and feel that someone's not "in there" anymore. And if they are, it's a terrible place to be.

IT'S EASIER FOR me to take care of someone who's brain dead for the 24 to 36 hours between EEGs. Then I can just take care of the body and when I see big craters of bedsores, I don't feel the pain. When saliva is slobbered down his face, I'm not embarrassed for him. When his family sits around the bed and cries, I still have trouble handling their pain. But not as much trouble taking care of him.

It's the GORKs that cause me the most grief. Maybe there is a flicker of consciousness, and this poor guy knows what's happening to him. Maybe he's embarrassed; maybe he can't stand the indignity. Maybe he's in pain, and I don't know he's in pain because he can't tell me he's in pain.

For a period of time, when there's any question of a patient's being able to function again, there's not a good nurse who wouldn't break her neck taking care of him. But when the only thing that a doctor can offer is that possibly he'll return enough to be strapped up in a chair, not to be able to sit up himself, no bladder or bowel control, never to be able to eat by himself or interact with anyone . . . when this is the final hope, a real stretch of what medicine can do for him, then it's almost impossible to do. Not because we don't care, but because we do.

Andrea describes it:

"Did you ever walk into a situation that utterly and absolutely repulses you? I don't mean like blood and guts. Let me explain. This is only one example but not an unusual one.

"IT WAS A WOMAN with brain-stem melanoma (cancer). She wasn't old, only in her 50s. She was lying in bed, hooked to a respirator, her head hanging to the side and her tongue falling through her open mouth. She was drowning in her own secretions. She had black lumps sticking out all over her body. And here she was, on a respirator. She was supposed to have tube feedings, and I couldn't give them to her. I couldn't add to her misery. I couldn't add to what they were doing to her. I couldn't even suction her. She stopped gurgling finally and died. And do you know what I thought the whole time that I was leaving her alone? It reminded me of old people, those poor old people, digging in garbage pails. How degrading. How immoral. This shouldn't be. But it is. And for me, there is much more to the moral issue than pulling a plug."

Is withholding the means to extend life, when we have the knowledge to extend it, passive? If it's actively withheld?

There isn't a nurse I know, and I've been nursing a long time, who wants to be resuscitated if she dies. In fact, many of us have seriously considered wandering into an unpopulated area in the hills somewhere if we are told we're going to die. No hospitals, no doctors, no extraordinary life-support systems. We're almost a club, and we've all decided to have "NO CAC" tattooed across our chests, in case somebody finds us and drags us into an emergency room. CAC means "Cardiac Arrest Code." It means being "brought back," and that's a nightmare for all of us.

OVER THE YEARS, I've asked the best nurses what they think about mercy killing. None of them would be willing to do it on a patient she didn't care about. It's not worth the risk. I've heard good nurses say, "Oh, I could do it. But only for my mother, father, or my child." And then they add, "Or maybe someone I loved."

Unless there's that kind of emotional investment, few people are willing to handle the guilt because a GORK lives immortally . . . in your own brain. A terminal patient's stopped screams stay in your own bone marrow. You can't be sure if you'd do something like that. You're never completely sure.

I've heard a lot of talk about passive as opposed to active euthanasia. When those of us inside medicine talk about it, we find it difficult to figure out what passive euthanasia is. Watching someone starve to death be-

'I've asked the best nurses about mercy killing . . . I've heard good nurses say, "Oh, I could do it. But only for my mother, father, or my child."'

cause you're not giving him food or IVs seems active when you know it takes food to keep him alive. "Keep him comfortable," when he's a terminal patient in excruciating pain, means give him as much medicine as he needs and if it kills him, it kills him. None of this is done easily.

Here's how Tracy feels about this issue:

"It's seldom that you need enough medicine to kill pain and kill the patient too. But that 'seldom' doesn't count if it's you and your patient who are in the position. You only have to walk into one room, to have to suffer over it, because then all the talk about 'seldom' sounds empty."

THEORETICALLY, IT'S NOT euthanasia to give a high dose of pain medicine to alleviate pain, even if it hastens death.

If my patient is screaming and yelling in pain, begging to be put out of his misery, I say to the doctor, "His respirations are shallow, but he desperately needs more pain medicine.

He's tossing and turning. He's in agony." If the doctor says, "Give him morphine; we have to help his pain," both of us know what the other is saying. Both of us know that a side effect of morphine is depressed respirations. But it's still theoretical. Once I pick up the needle and syringe and draw up the morphine, once I inject it into him and 15 minutes later he stops breathing because of what I did, it feels like euthanasia. To everyone else, his death was only a side effect, but to me while I stand there and it's my patient who stopped breathing, it doesn't feel like a side effect. It feels like I killed him.

The author has been a nurse for 13 years. "Terry Daniels" is a pseudonym. The names of the other nurses also have been changed.





A Doctor's Search for the Way to Save Baby Boy Alvarez

The Struggle Doctors Face to Save Newborn Life

First of Two Articles

By B. D. Colen

Washington Post Staff Writer

"What's this?" asked Dr. James Hannan, the director of the intensive care nursery, as he stepped up to the warming table.

His hands were busy behind his back, tying his gown closed, as he looked down at the table and saw Baby Boy Alvarez for the first time. "Oh, Jesus," he said softly.

The 6-pound, 8-ounce baby lay on his back, his chest and grossly distended abdomen rising and falling with each of his sharp, saw-edged cries. His dusky blue-gray color was accentuated because he was not bathed before being rushed to the nursery from the delivery room floors below.

The tan shades already were lowered across the nursery's plate-glass windows, protecting the privacy of the baby and the sensibilities of visitors coming to view other sick infants. For Baby Boy Alvarez did not look right. His clubbed feet were obvious, as were his bowed legs. And there

was something odd about his face. Not something one could immediately describe. Just something odd.

"This leg's shorter than the other," said Dr. Ari Javed, a young member of Hannan's staff.

The ability to sustain life by artificial means also confronts physicians with deciding whether and when not to do so. What follows is the account of one such decision, made in a Washington area hospital this year. The names have been changed to protect the privacy of individuals involved. Everything else is reported as it occurred.

He felt the baby's barrel-shaped abdomen. "I think it's an abdominal mass; it's tense. Can we get a catheter?"

"Get an X-ray! FAST!" Hannan ordered. "Jeees; I wonder if he's got (intestine) in his

chest. You hear anything up there?" he asked Javed, who was removing his stethoscope from his ears.

"Yes," replied the younger man, a pediatrician training under the director to become a neonatologist, a sub-specialist who cares for infants for their first 28 days after birth.

"Is it bowel?"

"I don't know," Javed responded.

"He looks premature on top of it," Hannan observed.

"He's 36 weeks," replied Javed, checking the chart on the infant born about 20 minutes earlier by cesarean section and finding him three weeks short of full term.

Although other staff members drifted over to look at the new arrival, his presence did not long disturb the natural rhythm of the nursery. There were more than a dozen other infants to care for, and to ignore any of the electronic systems monitoring vital signs could mean the difference between survival and death.

See INFANT, A22, Col. 1

Wa Post 4/30/79

The Decision: 'I Don't Want the Baby to Suffer'

This is the account of a decision by physicians in a Washington area hospital who were faced with the question of whether to sustain a life by artificial means. The names have been changed to protect the privacy of the individuals involved. Everything else is reported as it occurred.

Second of two articles

By B. D. Colen

Washington Post Staff Writer

Dr. James Hannan sat down heavily in his desk chair and reached for the phone. It was after 7 p.m. and he had not yet told his wife he wouldn't be home for dinner.

"Hi. I'm going to be late. We've got a just terrible problem here," the director of the hospital's intensive care nursery told his wife. "It's a new baby that came up with multiple anomalies [birth defects] and we're trying to decide . . ." He paused as she asked a question.

"No, no. That baby hasn't even come in yet. This is another kid I've got on a respirator, and he's passing

fetal feces through his penis, and he has no anus, and he has a cardiac defect and an abnormality of the cartilage and big, doughy, masses which are probably ureters" — tubes linking the kidneys to the bladder.

"It's the first baby and the parents are all upset and we had to put him on a respirator on 100 percent oxygen. It began about two hours ago. No," he said, answering a question, "it was an elective cesarian, Don Benjamin was the OB.

"No, go ahead and feed the kids but save me something to eat. I haven't had a thing. Put Jeff on the phone, please.

"Hi, Jeff. Sorry I can't come home to read 'Winnie the Pooh' with you, but I have to stay here. I've got a little baby that's real sick. It's got a lot of problems. It's very, very sick. Your Teddy has a little sickness? Well, I'm sure your Teddy will get better. How'd school go today? Okay, I love you. Sleep tight . . ."

He hung up the phone and redirected his thoughts to the newborn baby in the nursery across the hall.

Hannan, at 39, has seen more desperately ill infants than most pediatricians see in a lifetime. Like only about 600 other doctors across the country — perhaps a dozen of them in the Washington area — he practices in one of medicine's newest specialties: neonatology, or the care of the newborn, a field largely ignored two decades ago.

As director of the intensive care nursery, he supervises the care of roughly one-third of all the babies born in his hospital.

Half of those find their way to the nursery for only a day or two; victims of nothing more than a few degrees of fever or perhaps an inexplicable rash. The rest, however, arrive with life-threatening problems: A birth weight of only a pound-and-a-half; serious lung disease; being born without a portion of the brain.

Baby Boy Alvarez belonged in the latter category.

"Man," sighed Hannan. "What can you say? You feel sorry for another human being, but I don't know what

to do. If the kid has a lethal defect you can be positive the kid's going to die. But you come to that little thread; now how far out on the thread do you go?"

He had already consulted a pediatric surgeon, and a cardiologist was on his way to the hospital. "I keep stringing it out to Dave [the cardiologist], but I know what Dave's going to say. I'm going to get waffles, that's what I'm going to get."

At that point Hannan was working under the assumption that the baby had a major heart defect, and that only the remnants of his fetal circulatory system were keeping him alive.

There are ways, he explained, to keep the fetal system going but they don't always work.

"This business: There's always one more little thing you might try; one more little thing that you might do; one more little exercise. It's the thing people don't understand.

"Talk about heroic care or extraordinary care," said Hannan, referring

See DECISION, A12, Col. 1

Nurse Robaczynski Sad At Leaving Her Profession

By Christopher Hanson
Washington Star Staff Writer

BALTIMORE — A nervous, smiling Mary Rose Robaczynski, no longer facing murder charges in four cases of alleged mercy killings, expressed sadness yesterday that she would never be a nurse again.

After a press conference here yesterday, the former nurse at Maryland General Hospital remained nearly as much an enigma as she did during her long trial on charges of disconnecting the respirator of a comatose patient.

Her attorneys insisted that she answer no questions dealing with the facts of the case or with her views on euthanasia.

Robaczynski's so-called mercy killing trial for unhooking the mechanical respirator of Harry Gessner, a comatose patient at Maryland General Hospital, ended in a mistrial last week.

After nearly 19 hours of deliberation, the jury was hopelessly deadlocked over the key issue: was the patient's brain alive or dead when the nurse pulled the plug? Robaczynski was also charged with the murder by respirator disconnection of three other patients.

All charges were dropped on condition

that Robaczynski agree never again to practice nursing in Maryland or any other state. She has given up her nursing license.

Yesterday she thanked the press for its courtesy, her family and friends for their support, but expressed sadness that she would never be a nurse again.

"It was such a big part of my life," she said, adding that what she will miss most is "just caring for people."

Was her fatal mistake that she cared too much?

"You can never care too much," she replied in a squeaky drawl.

She said she had felt "very proud and good" when a former patient testified that he would have wanted her for his nurse again even if he were on a respirator.

During the trial, co-workers testified that Robaczynski was a strong advocate of euthanasia for hopeless patients in comas, partly because of the emotional and financial burden they imposed on their families.

Witnesses also testified that she was an unusually compassionate nurse, who sent greeting cards to her former patients, and cried with the families of the ones who died.

See NURSE, DC-3



Associated Press

Mary Rose Robaczynski and her attorney George Helinski arrive for a news conference.



Nurse

From DC-1

Meanwhile, the state's attorneys office here is advocating revision of a statutory definition of brain death which, prosecutors believe, prevented them from convincing a jury that Robaczynski was guilty of homicide.

preceding disconnection actually amounted to "spontaneous brain function."

Several jurors interviewed after the trial said, in effect, "If doctors disagree on the matter, how can we be expected to decide?" Swisher echoed this reasoning yesterday.

Nurse won't be tried in mercy killing case

Associated Press

Baltimore, Md.

Murder charges were dropped Thursday against a nurse accused of mercy killings by unplugging the respirators of four comatose patients.

In return, Mary Rose Robaczynski, 24, agreed to give up her nursing license and never practice again.



*Mpls. Tribune
March 30, 1979*

UNIFORM BRAIN DEATH ACT

Drafted by the

**NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS**

and by it

**APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES**

at its

**ANNUAL CONFERENCE
MEETING IN ITS EIGHTY-SEVENTH YEAR
IN NEW YORK, NEW YORK
JULY 28-AUGUST 4, 1978**

WITH PREFATORY NOTE AND COMMENTS



Special Committee On Uniform Brain Death Act

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645 North Michigan Avenue, Suite 510
Chicago, Illinois 60611

UNIFORM BRAIN DEATH ACT

PREFATORY NOTE

Between 1970 and 1978, 19 states enacted legislation recognizing the concept of brain death. This was a new legislative undertaking, for death had always been determined before by common law principles. The common law criterion for death was: "an absence of spontaneous respiratory and cardiac function."

The technology of medical care can now overcome the natural cessation of both breathing and heartbeat. That technology creates a concern among medical practitioners that legal liability might be imposed when life-support systems are withdrawn, even though the case is hopeless and acceptable medical practice sanctions the withdrawal, and though the continuation of artificial means of life support offends even those most morally and emotionally committed to "the preservation of human life." This Act expresses community approval of withdrawing artificial life-support systems when the whole brain has irreversibly ceased to work.

This Act is silent as to acceptable diagnostic tests and medical procedures. It addresses the concept of brain death, not the criteria used to reach the medical conclusion that brain death has occurred. The medical profession should formulate over time the acceptable practices, taking into account new knowledge of brain function and new diagnostic equipment.

The "time" of death is an overriding concern of anyone contemplating the occurrence of brain death. Upon reflection, the Special Committee concluded that, in those instances in which time of death affects legal rights, this Act should simply state the facts constituting brain death and thus provide the basis for whatever inquiry is necessary to fix the time of death.

Some other questions and subjects not addressed by this narrow Act are: living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in cases of pregnant women or of organ donors, and protection accorded the dead body. Those subjects are left to other law.

UNIFORM BRAIN DEATH ACT

1 SECTION 1. [*Brain Death.*] For legal and medical pur-
2 poses, an individual who has sustained irreversible
3 cessation of all functioning of the brain, including the
4 brain stem, is dead. A determination under this section
5 must be made in accordance with reasonable medical
6 standards.

COMMENT

This section legislates the concept of brain death. The Act does not preclude a determination of death under other legal or medical criteria, including the traditional criteria of cessation of respiration and circulation. Other criteria are practical in cases where artificial life-support systems are not utilized. Even those criteria are indicative of brain death.

"Functioning" is a critical word in the Act. It expresses the idea of *purposeful* activity in all parts of the brain, as distinguished from random activity. In a dead brain, some meaningless cellular processes, detectable by sensitive monitoring equipment, could create legal confusion if the word "activity" were substituted for "functioning."

1 SECTION 2. [*Short Title.*] This Act may be cited as the
2 Uniform Brain Death Act.



MEDICAL CENTER
701 Park Avenue South
Minneapolis, Minnesota 55415



March 26, 1979

Mr. Richard Krause
Public Affairs Division
Legislative Department
American Medical Association
535 North Dearborn Street
Chicago, IL 60610



Dear Rick:

Our phone conversation on March 16 revealed many points of agreement, and a few points of disagreement. For purposes of clarity, emphasis, and as a basis for future dialogue, I wish to develop a few of these issues in writing.

Now that the AMA is changing its position on brain death legislation and is moving in the direction, slow but sure, that legislation is needed, it would be extraordinarily helpful to have the AMA join forces with other state and national medical organizations to unite behind one uniform brain death bill. The advantages of such a move are obvious. It would help us a great deal to coordinate our efforts, and uniting behind one statutory proposal would be very persuasive to state legislatures. As you know, the previous position of the AMA in opposition to legislation has seriously hampered state medical organizations and other groups in their efforts to pass bills in this area, and the pro-life movement has achieved maximum mileage out of the AMA's position. Besides facilitating passage of legislation, combined support of various medical organizations would encourage efforts to establish uniform standards and criteria for the medical determination of brain death, and give us an opportunity to educate the medical profession and society to the most important issues.

I would hope, therefore, that you and your staff would reconsider your position on the Uniform Brain Death Act (UBDA). The UBDA is not perfect, but it is just as good as any other bill and, in some ways, better. It is interesting to note that what you regard as one of the weakest points in the bill is what I would consider the strongest feature, i.e. the clear and explicit definition of what we mean by brain death. This is exactly the feature that will win us support from the responsible pro-life movement.

HENNEPIN COUNTY

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Doubt Voiced on Whether Patient Was Alive at Unplugging

Jury Deadlocked, Mistrial Ruled in Nurse's Murder Case

By Christopher Hanson
Washington Star Staff Writer

BALTIMORE — A mistrial was declared yesterday in the euthanasia trial of former nurse Mary Rose Robaczynski, 24, who was charged with first-degree murder for unplugging the respirator of a comatose patient at Maryland General Hospital last year.

Doubt over whether 48-year-old Harry Gessner was dead or alive before Robaczynski pulled the plug caused them to deadlock, jurors confirmed.

The final vote, according to jury forelady Beverly Skotorski, was 10-2

in favor of acquittal. A unanimous vote is required for a verdict.

"There was so much doubt over whether he was alive or dead," said Skotorski. "We thought doctors couldn't agree on that point either. And we didn't have medical background."

THE MISTRIAL was declared by Baltimore Criminal Court Judge Robert Karwacki at 11:20 p.m., after the jury had deliberated about 18 hours Monday evening and yesterday.

In a handwritten note early yesterday evening the jurors told Karwacki that they could not reach a verdict. He called them to the jury room and re-read part of his original instruction

in an effort to break the logjam.

The jury returned to the deliberating room and over the next few hours shouts could be heard from the adjacent court chamber. But the arguments apparently were unproductive and the jury remained deadlocked.

During 10 days of testimony, expert witnesses had clashed on the key issue of the trial — what is death?

Was Harry Gessner's brain dead when the respirator was disconnected? The defense argued that Robaczynski could not have killed Gessner because he already was brain dead. Under a 1972 Maryland law, death is equated with the absence of

"spontaneous brain function." But the term led to dispute among expert witnesses.

In addition to coping with the moral issue of euthanasia, the jury was being asked to evaluate complex medical testimony and apply it to a statute which, according to prosecutors, was untested in a Maryland criminal case.

"It was too much to ask a jury what the statute meant," complained juror Clee Anderson. Foreman Skotorski agreed, as did Assistant State's Attorney Howard B. Gersh, one of the prosecutors.

See NURSE, A-9

Md. Law on Brain Death Was Unclear to Jurors

By Sandra Saperstein
Washington Post Staff Writer

Several of the 12 jurors who found themselves unable to agree whether former nurse Mary Rose Robaczynski had murdered a comatose patient said their confusion over Maryland's legal definition of brain death led to the deadlock.

Baltimore prosecutors met yesterday with 11 of the jurors and came away uncertain whether any jury could understand the existing law.

Robaczynski was accused of murdering patient Harry Gessner by unhooking his respirator, but the defense contended that Gessner was legally dead hours before the disconnection.

A mistrial was declared late Tuesday, when the jurors after 19 hours of deliberation, deadlocked 10 to 2 in favor of acquittal, according to one jury member.

"Everybody agreed that what Mary did was wrong," Assistant State's Attorney Peter Semel said yesterday, after an hour-long talk with the jurors. "But they couldn't decide whether he [Gessner] was dead or alive."

"It was the first case I ever had to try," Semel said, "where I had to prove the victim was alive before he was dead."

To help the prosecutors decide whether to retry the case, Semel said, the jurors were asked to meet when they returned to jury duty on other cases yesterday. Eleven jurors agreed to the meeting, Semel said.

Semel said he and Assistant State's Attorney Howard Gersh will decide "probably next week" whether to retry the 24-year-old Robaczynski on this charge, or on any of three other charges of murdering patients by respirator disconnection.

After the mistrial was declared, jury foreman Beverly Skotarski told reporters, "We couldn't even decide whether he (Gessner) was dead."

Juror Teresa Severe agreed. "The main thing was the law they had defining whether the man was dead or alive," she said. "It was hard to make a decision."

That law is the 1972 Maryland stat-

See DEATH, C13, Col. 2

Robaczynski Jurors Unclear On Maryland Brain Death Law

DEATH, From C1

Professor Alexander Capron, who has

Wa Post 3/22/79



MEDICAL CENTER
701 Park Avenue South
Minneapolis, Minnesota 55415



March 28, 1979

Mr. Joseph Lampe
Executive Director
American Citizens Concerned for Life, Inc.
6127 Excelsior Boulevard
Saint Louis Park, MN 55416

Dear Joe:

Thanks for the article from the Washington Star dated March 21, 1979 concerning the trial of Mary Rose Robaczynski. I was interviewed that same day by Sandy Saperstein of the Washington Post. I didn't know many details of the case, but the reporter questioned me regarding the vagueness of the Maryland brain death statute and the confusing testimony of the medical experts. My comments should have appeared in the March 21 or March 22 edition of the Washington Post.

Among other things, this case emphasizes the confusion that can arise with a poorly worded brain death statute. I would hope that no such confusion would arise with the wording of the Uniform Brain Death Act.

I have also enclosed some recent correspondence which may be of interest to you.

Best regards.

Sincerely,

Ronald E. Cranford, M.D.
Associate Physician in Neurology
Hennepin County Medical Center

REC/mmhf

xc: Mr. Richard Krause
Joseph Boyle
Enclosures

HENNEPIN COUNTY

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In the long run, the introduction of a wide variety of brain death bills sponsored by different medical and legal organizations will be confusing and counter-productive, and will hamper, not facilitate, the passage of brain death legislation in the individual states. As you know, the Ethics Committee and Executive Board of the American Academy of Neurology have already adopted two resolutions, one endorsing the principle of brain death legislation and the other endorsing the specific statutory language of the UBDA, and these two resolutions will be brought to the attention of the general membership of the American Academy of Neurology in April for their approval (enclosure, Editorial, Uniform Brain Death Act, Neurology 29 (3):417-418, 1979). After receiving this endorsement, the UBDA will then be brought to the attention of the other major neurological and neurosurgical organizations, as well as various transplant groups.

Over the last nine years, since the enactment of the first statute by Kansas in 1970, we've gained a great deal of experience on legislation in this area. Some mistakes have been made in enacted legislation in other states, such as amending the definition of death to the Uniform Anatomical Gift Act (Illinois, Virginia, and West Virginia), adopting a permissive statute (Oregon and Georgia), and confusing living wills, brain death, and the persistent vegetative state in the same bill (North Carolina). Hopefully, we can learn from these mistakes, and it seems to me that we are on the threshold of making some very constructive moves in the next few years, especially if we can coordinate our efforts.

You and I did agree, quite strongly I thought, that the formulation and promulgation of uniform brain death criteria and related procedural guidelines by organized medicine would be very beneficial. This would, of course, be completely distinguished from legislation. In this respect, the criteria adopted by the Minnesota Medical Association have demonstrated that the Harvard criteria can and should be updated in a meaningful way, without inappropriately restricting the professional discretion and medical judgment of individual physicians, which is obviously of great concern to your staff.

Such uniform criteria would, first of all, distinguish between essential criteria which must be satisfied in every case versus confirmatory criteria. Essential criteria would include cerebral unresponsivity, apnea, absent brain stem reflexes, and the establishment of irreversibility, common points of agreement between the Harvard and MMA criteria. Confirmatory criteria would include the EEG, radioisotope studies documenting an absence of cerebral blood flow, other cerebral blood flow studies, auditory evoked responses, etc. Most importantly, the essential criteria would emphasize that the basic diagnosis of brain death, as with the traditional cardio-respiratory standard, is clinical, and therefore, in the majority of cases, the diagnosis of brain death can be determined from the clinical examination alone, without the need for confirmatory laboratory studies...although these latter studies could be utilized if the attending physician so decides they would be useful. The MMA criteria exemplifies these points, and their value in the Ellison case stresses these advantages even more so.

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But this brings us to a key issue where you and I disagree. You object to the phrase, "irreversible cessation of all functioning of the brain, including the brain stem," as used in the UBDA. The AMA model bill uses the phrase, "irreversible cessation of brain function." Apparently, you specifically object to the concept of totality, i.e. the use of the words "all" and "including the brain stem." As I tried to explain over the phone, that is the strongest feature of the UBDA, and the one feature that will be persuasive with the pro-life movement. You feel that we have too clearly and explicitly defined what we mean by brain death, and furthermore that this phraseology will somehow limit medical discretion and professional judgment in the actual determination of brain death in individual cases. I disagree. I think you are confusing the concept and the criteria. Essentially every accepted set of criteria that I am aware of have, while not explicitly saying so, listed as their essential criteria the irreversible cessation of all functions of the brain.

Confusion has arisen over the meaning of the term "functions" or "functioning." However, the UBDA was quite specific and precise in defining what we had intended by the term "functioning," and the comment section accompanying the UBDA leaves little room for misinterpretation, in my opinion. Functioning refers to the specific, purposeful activities of the brain, as determined by the clinical examination, in contrast to the random activities or functions of individual cells or groups of cells in the brain, or biochemical, electrical or physiologic actions of the brain. Functions is defined in Dorland's Illustrated Medical Dictionary (25th edition, 1974) as "the special, normal, or proper action of any part or organ." Blakiston's Gould Medical Dictionary (3rd edition, 1972) defines function as "the normal or special action of a part." Further, Webster's Third New International Dictionary (1961) defines function as, "5. One of a group of related actions contributing to a larger action. a. The normal and specific contribution of any bodily part (as a tissue, organ, or system) to the economy of a living organism (a primary function of any gland is secretion)."

Like so many issues in the current brain death debate, the clarification of what we mean by functions is simply one of education, and this is where the AMA could assume a strong leadership role, in cooperation with other organizations.

The primary purpose behind this key phrase, "irreversible cessation of all functioning, including the brain stem" (emphasis added), was to distinguish, as clearly and explicitly as possible, between whole brain death and neocortical death. Some ethicists and physicians are now advocating that neocortical death should be regarded as the death of a human being.* It is, therefore, crucial

*Veatch, Robert M. Death, Dying, and the Biological Revolution. New Haven: Yale University Press, 1976; Fletcher, Joseph: New definitions of death. Prism 2:13-14, 1975; Sweet, William H: Brain death (editorial). New England Journal of Medicine 299:410-412, 24 August 1978.

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that further pieces of legislation in this area should clearly distinguish between these two syndromes. This was the primary objective of this critical phrase in the Uniform Brain Death Act.

However, this phrase, as I understand its meaning, is completely compatible with existing standards for the medical diagnosis of brain death, and will, in no way, unduly restrict the discretion of physicians, nor, in any manner, impede further advances in medical science contributing to the more rapid and accurate diagnosis of brain death.

I understand the apprehension that some physicians feel when first confronted with this type of phrase, and I can understand how such a phrase is subject to misinterpretation. But these fears are based upon an abstract, theoretical concern of how the courts and legislatures might conceivably interpret this term, and are not grounded in any actual reality or specific data. This apprehension, moreover, reflects a suspicion of many physicians towards the motivations of the courts and a lack of understanding of the legal system, unfortunately so prevalent among physicians today. This is another area, of course, where people like yourself, Bruce Nortell, and organizations such as the AMA can be of real value, by educating the physicians to what these terms actually mean and making them recognize that there is no basis, in fact or in law, for their concerns. Further, this is also where established medical criteria would serve a significant educational purpose, by clearly stating the correct meaning, both medically and legally, of these terms. We did this to a certain extent in the MMA criteria, but future criteria should spell out these aspects in even greater detail and more fully develop the idea in the introductory section that functions refers to the clinical aspects of brain activity.

The other major point where we disagree is whether a statute should be mandatory or permissive. The UBDA is mandatory, while the AMA model bill is permissive. The statutory proposals of Capron and Kass and the American Bar Association, as well as the majority of enacted legislation, are all written in such a way that the pronouncement of death is mandatory, not permissive. The comments of Alexander Capron submitted for consideration at the NCCUSL meeting in Arlington, Virginia on March 31, 1978 emphasize that a brain death statute should be definitive, not permissive. Bill Curran and Don Harper Mills both fully agree. So there seems to be little, if any, disagreement among the legal scholars on this point.

I think I understand your reasons for preferring a permissive statute. Your primary objectives in this area, as I understand them, are to ensure legal immunity to physicians from criminal or civil liability, to allow for maximum professional discretion and medical judgment, and to make certain that further advances in medical science will not be hampered. These are, of course, important goals in legislation, but secondary, I would submit,

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to other, slightly more important considerations. The primary purpose of brain death legislation, in my opinion, is to promote societal acceptance of the brain death concept and to educate the public and medical profession to the relevant issues by means of a public dialogue and extensive discussion of the issues. But this gets back to one's philosophy of law, and it may be that you and I differ on our philosophies of law and the purposes of legislation. Even more important than the brain death issue itself is the development of a public policy attempting to resolve current dilemmas brought on by modern medical technology. That's what we're really talking about, isn't it?

In order to achieve an overview on these issues, I guess we need to ask ourselves, what do we really want to accomplish by brain death legislation, and what can be accomplished in other ways, for instance, the formulation of uniform medical criteria? It seems to me that we are trying to create a climate in which the following conditions would prevail: 1) physicians would be knowledgeable and experienced in the medical diagnosis of brain death, so that the chances of any serious mistakes would be minimized, either false-positives or false-negatives; 2) physicians would understand that when there is any reasonable possibility for meaningful recovery of the patient, all appropriate medical support should be used to effect a cure; but if such therapy isn't successful, then it would be morally and legally permissible, as well as medically acceptable, to either withhold or withdraw further medical support; 3) the public will develop trust and confidence in the medical profession with the knowledge and appreciation that physicians would go all out when there was hope of recovery, but that also physicians would not needlessly prolong the pain, suffering, and indignity associated with the dying process when there was no reasonable hope of recovery. Obviously, these previous comments would encompass more than just the brain death concept. Now, the question arises: How do we accomplish these objectives and create an atmosphere in which these attitudes would prevail? Some goals could be achieved through legislation, but more importantly, others could be achieved through the establishment of reasonable standards of medical care, as formulated and promulgated by the medical profession itself. This gets to the heart of the matter regarding a mandatory versus permissive statute.

First, from a purely factual standpoint, a permissive statute simply does not make any sense. The medical profession has been trying to convince society for the last ten years or so that a person is dead when his brain is dead, so what type of mixed message does the public receive when the AMA proposes a permissive statute...saying in effect, well, the patient may be dead when his brain is dead, but that should be left to the discretion of the attending physician. Does that appeal to common sense? Further, the determination of death using the traditional cardiorespiratory standard is mandatory--why should there be any difference using the brain death standard? Or isn't someone just as dead using the brain death standard as with the cardiorespiratory standard?

But problems have arisen, and will continue to arise, with or without definitive legislation. Some of these problems hinge on the distinction between 1) the concept versus specific criteria for brain death; 2) the fact of death versus considerations and procedures related to the actual pronouncement of death and discontinuation of respirator support; and 3) the time when the person dies versus the time when death is pronounced.

In the majority of cases, it is relatively easy, from a strictly medical standpoint, to determine that an individual patient has satisfied the criteria for brain death and that, beyond any reasonable doubt, the brain is dead; therefore, the person is dead. But, during the process of satisfying these criteria, other issues--social, legal, moral--arise. These secondary issues have great impact on the actual pronouncement of death and the corollary decision to discontinue the respirator. The critical question is not whether a physician should pronounce a person dead when his brain is dead; rather, under what circumstances would it be justifiable for a physician to delay the final pronouncement of brain death and the discontinuation of the respirator, and the corollary question which you should be considering, how best can the AMA aid the physician in these matters?

It seems to me that there are five conditions in which it may be morally and legally justifiable to delay the final pronouncement of brain death. These five would include: 1) the fulfillment of all necessary criteria; 2) consideration of the wishes and feelings of the family; 3) legal factors; 4) procedures relating to organ donation; and 5) pregnancy. Let me briefly summarize each of these major points.

The first condition is not actually a delay, but should be included for purposes of completeness. A person is not pronounced dead on the basis of brain death until all criteria have been satisfied, including appropriate confirmatory studies when indicated. But, as noted in the MMA criteria, the time of death is when the brain first ceased to function, and ceased to function irreversibly, or, from the standpoint of the physician, when the physician first noted that all brain functions had ceased, i.e. "the first observation." This would normally be the first complete neurologic examination when the physician has begun to fully appreciate that resuscitation has been unsuccessful in restoring brain function and that brain death is highly suspected. But, even after this initial observation, a further period of evaluation is necessary to establish that the cessation of all brain functions is irreversible. This sequence illustrates the critical distinction between the time of death and the time of the pronouncement of death, and I would hope that your legal counsel would agree with me on this point.

The second circumstance in which it may be justifiable to delay the final pronouncement of brain death is by far the most important, and the one that will give rise to the most problems in the future, i.e. the relation between

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the medical fact of death and the consideration of the wishes and feelings of the family. The general rule which I have followed is this: If the family has any reasonable concerns, objections, or reservations, then the attending physician should make every reasonable attempt to resolve these concerns before the patient is pronounced dead and the respirator discontinued. The physician needs to combine tact, sensitivity, compassion, and understanding in his effort to help the family through the grieving process and the acceptance of the finality of death of their loved one. But this needs to be combined with firmness and unequivocal certainty so that the physician can impress upon the family that their loved one is truly dead, that there is no doubt concerning the irreversibility of the condition, and that further medical efforts will be of no avail. Such certainty is necessary to minimize any unnecessary guilt from the family.

What if the concerns or motivations of the family are not reasonable? Who determines whether the relatives' motivations or intentions are reasonable? It seems to me that the attending physician is in a pivotal position in this regard, since he is primarily concerned about the best interests of the patient (even if it has been determined that the person is dead) and is also concerned about the welfare and well-being of the family. It is not too difficult to envision the many problems and dilemmas that will arise in this area in the future. What should occur if the family objects to the brain death concept for religious reasons? For financial reasons? For personal reasons?

I have been involved with numerous cases in which such difficulties have arisen, but, fortunately, in the majority of cases, such concerns have been satisfied, and the next of kin have been in full agreement that the person was dead, and that the respirator should be discontinued.

I do remember one case in which one family member, for reasons of guilt, refused to allow discontinuation of the respirator. The other family members, a son and daughter, understanding the circumstances surrounding the death of their mother, had no difficulty in accepting her death. However, another son, who had spent little time with his mother and was considered the "black sheep" of the family, strongly objected to the withdrawal of support, and said something to the effect, "I'm not going to kill my mother." What should a physician do when he is faced with an irrational family member, and there seems to be little chance in convincing the relative of the true condition of the patient? Such situations as this will be minimized with the enactment of brain death legislation and the accompanying acceptance and education of the public. But these dilemmas, although significantly lessened by legislation, will continue to arise from time to time. In these cases, if the motivations and intentions of the family members or others are clearly irrational and unjustifiable, several courses of actions are available to physicians. First, the physician should make every reasonable effort to explain to the family the relevant circumstances

in an attempt to persuade them of the proper course of action. In many of these cases, while these attempts are being made, the situation takes care of itself because the patient suffers a cardiac arrest during this time. The physician could elect to disregard the wishes of the family and unilaterally withdraw respirator support, but this, of course, could result in civil (wrongful death suits) or criminal (charges of homicide or manslaughter) liability. It seems to me that even with a brain death statute, the only recourse in some of these cases will be to obtain a court order recognizing the brain death concept and permitting the withdrawal of further support.

The third circumstance, intimately related to the second, is when certain legal considerations become relevant in the determination of death. I need not review all the cases that have occurred in the last few years in this regard. The Ellison case was a typical example of this dilemma, but similar cases have occurred recently in Colorado, Massachusetts, Iowa, Oregon, and Texas (enclosures). It is interesting to note that two of these cases arose in states with enacted legislation, Iowa and Oregon. Iowa's statute is mandatory, while Oregon's is permissive. Seven years passed before the constitutionality of the Kansas statute was subjected to legal scrutiny (Curran WJ: Settling the medicolegal issues concerning brain-death statutes: Matters of legal ethics and judicial precedent. New England Journal of Medicine 299 (1):31-32, July 6, 1978; State of Kansas vs. Shaffer, 574, P. 2d. 205 (Kansas, 1977)).

A fourth circumstance, involving cadaver organ donation, has been fairly well recognized and accepted. In these cases, it seems morally and legally justifiable to allow sufficient time for the family to fully appreciate the finality of death and to make a decision concerning organ donation. Once the family has agreed to the transplantation procedure, the patient is pronounced dead but support is continued to maintain viability of the organs.

Fifth, continued maintenance is justifiable after a person has suffered brain death when that person is a pregnant female. If there is any reasonable possibility of delivering a viable infant, then the mother should be pronounced dead but support continued. In two such cases involving mothers in their fifth month of gestation (enclosures), it was not medically possible to artificially maintain the vital functions of circulation and respiration long enough to deliver a viable fetus.

These, then, are five circumstances in which continued support may be justifiable in a brain dead person, or more appropriately, a brain dead body. But the other question that needs to be asked is, how can one justify the expense and futile support on a brain dead person? This latter issue arose in the Ellison case in Minnesota--who was responsible for the hospital bills on Stacey Ellison, the hospital or public welfare? The Commissioner of Public Welfare was hesitant to pay for any costs after the Ellison child was pronounced brain dead. Total cost of hospitalization was \$32,000. It seems inevitable that the medical profession will be receiving inquiries

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and pressure from insurance carriers and governmental organizations when it is recognized that support is being continued on a dead person. This places the physician and the hospital on the horns of a dilemma. How do we balance full consideration for the wishes and attitudes of the family against the unjustifiable expenses and use of scarce resources used to maintain circulation and respiration in a dead body?

Your preference for a permissive statute reflects, in my opinion, a concern over a satisfactory resolution of some of these dilemmas which I have just discussed. But these dilemmas will not be completely resolved with a brain death statute, although that is clearly a step in the right direction. A permissive statute will only compound these difficulties and worsen the situation, rather than improve it. A mandatory statute would help considerably by stating, as simply yet as clearly as possible, that a person is dead when his brain is dead. In the final analysis, the permissive statute does not really afford the physician any legal protection at all in the more difficult cases, which is, of course, one of your primary concerns. In fact, there are numerous implications--moral, legal, financial--to the brain death issue which haven't even been addressed yet, some of which have been touched upon in this letter.

If legislation won't solve all our problems, what will? Among several possibilities, I would highlight two: education and sound legal advice. And these are two areas where the AMA could serve an important role. We need to educate physicians, to make them aware of potential dilemmas before they arise, to inform them of possible solutions and ways of handling these crises, consistent with the highest standards of medical care. We need to develop position papers, policies, guidelines, established standards--call them what you like--to assist and inform physicians who will soon be confronted with these dilemmas and will be looking to medical organizations for guidance and assistance.

Sound legal advice is actually only one facet of the educational aspect. Physicians, not well versed in legal aspects of medicine, need to rely upon the advice of lawyers who are current and knowledgeable in health care law and yet sensitive and conversant with the dilemmas of modern medicine (Annas GJ: Where are the health lawyers when we need them? (Editorial) Medicolegal News 6 (2):3, 25, Summer 1978). Advocating a permissive brain death statute is not sound legal advice.

You are concerned that a mandatory statute will inhibit professional discretion. On the contrary, a mandatory statute will allow for the greatest possible latitude...in the application of the criteria and procedural aspects, but not in the concept. Either the person is dead, or he isn't. There can be no discretion on that point, in the final analysis. The medical profession cannot have it both ways. Society and the law demands clarity and certainty on the matter of death.

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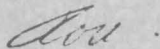
I do strongly feel that many of these issues can be resolved, not by legislation, but by education, which would include the formulation of meaningful guidelines, accompanied by informative, explanatory notes, written and published as a joint effort by the AMA and specialty medical organizations, with the cooperation and advice of skilled lawyers like Bill Curran and Don Harper Mills.

I sincerely hope this letter will encourage further dialogue and cooperation among the medical organizations and their individual members and staff. The American Academy of Neurology is assuming a leadership role in these areas, and I will keep you abreast of our progress.

I further hope I have sufficiently stressed the importance of presenting a unified front and having the AMA assume a meaningful, substantive leadership role. Even if the AMA is unwilling or unable to move quickly enough, it does no harm to be well-informed and aware of what you should be doing.

I would greatly appreciate your opinions on these matters. Best regards.

Sincerely,



Ronald E. Cranford, M.D.
Associate Physician in Neurology
Hennepin County Medical Center

REC/mmhf

Enclosures

xc: Betty Jane Anderson
William Curran, M.D., J.D.
Richard J. Jones, M.D.
Don Harper Mills, M.D., J.D.
Bruce Nortell

MR. RICHARD KRAUSE

March 26, 1979

Page 10

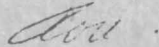
I do strongly feel that many of these issues can be resolved, not by legislation, but by education, which would include the formulation of meaningful guidelines, accompanied by informative, explanatory notes, written and published as a joint effort by the AMA and specialty medical organizations, with the cooperation and advice of skilled lawyers like Bill Curran and Don Harper Mills.

I sincerely hope this letter will encourage further dialogue and cooperation among the medical organizations and their individual members and staff. The American Academy of Neurology is assuming a leadership role in these areas, and I will keep you abreast of our progress.

I further hope I have sufficiently stressed the importance of presenting a unified front and having the AMA assume a meaningful, substantive leadership role. Even if the AMA is unwilling or unable to move quickly enough, it does no harm to be well-informed and aware of what you should be doing.

I would greatly appreciate your opinions on these matters. Best regards.

Sincerely,



Ronald E. Cranford, M.D.
Associate Physician in Neurology
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REC/mmfm

Enclosures

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Don Harper Mills, M.D.
Bruce Nortell



MEDICAL CENTER
701 Park Avenue South
Minneapolis, Minnesota 55415



February 27, 1979

Don Harper Mills, M.D.
Suite 1702 CNA Park Plaza
600 South Commonwealth Avenue
Los Angeles, CA 90005



Dear Don:

I hope to attend the meeting in Las Vegas if my schedule permits, but it doesn't look too promising right now. If I do attend, I would very much like to spend a few minutes with you over lunch, dinner, or at some other convenient time, to discuss our common interests. In the meantime, let me update you on recent developments so that you will have this background information available to you prior to the Las Vegas meeting. Of course, any information shared with you now can be used at your discretion for whatever purposes you deem appropriate. Along that line, I did appreciate your thoughtful reply to my letter from last summer concerning the content of the Uniform Brain Death Act and your support of the UBDA.

*News 1
angle*

First, the general principle of the legalization of the brain death concept by statutory legislation, and specifically the UBDA, have been endorsed by the Ethics Committee (September 1, 1978) and the Executive Board (November 30, 1978) of the American Academy of Neurology, and the Ethics Committee of the American Heart Association (October 26, 1978) (enclosure). These two resolutions will be brought before the general membership of the American Academy of Neurology at the annual meetings in Chicago during the last week of April. After we have received membership endorsement, these same resolutions will be brought to the attention of the other major neurological and neurosurgical organizations, such as the American Neurological Association, the American Association of Neurological Surgeons, and the Congress of Neurological Surgeons, as well as other interested medical and legal organizations, such as transplant groups and the EEG societies. Ultimately, the plan would be to have these organizations and the American Medical Association fully support the enactment of brain death legislation and specifically support the passage of the UBDA, or substantively similar bills, in the individual states.

It would be extraordinarily helpful if you could help convince B. J. Anderson and others at the AMA to endorse the UBDA and to have them recognize that it

HENNEPIN COUNTY

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DON HARPER MILLS, M.D.
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is in the best interests of the medical profession and the AMA to throw our weight behind one uniform brain death bill. There is no reason why the UBDA couldn't enjoy as much success as the Uniform Anatomical Gift Act. I am currently working on a couple articles to discuss the main features of the UBDA, and clarify certain misconceptions about brain death legislation in general and the specific wording and intent of the UBDA. I will send the drafts of these articles to you for your comments when they are near completion.

These attempts at legalizing brain death should be combined with other efforts aimed at educating and informing the medical-legal professions and the public toward the brain death concept and important related issues, such as the value of organ donation and the distinctions between determining death, allowing to die, and euthanasia. As chairman of the AAN Ethics Committee, I hope to achieve some of the measures on a smaller scale within that organization. If successful, I intend to approach the same goals on a broader scale, but I am sure over the next few years other individuals and organizations will be doing the same things with the same goals in mind, so there should be a greater degree of cooperation and communication than is presently manifested on a national scale on these issues.

For example, in addition to supporting passage of brain death legislation, it seems to me that the neurological and neurosurgical organizations should lead the way in developing and promulgating, on a national level, relatively uniform medical criteria for the determination of brain death. The development of criteria would be done for several reasons, most importantly to educate the medical profession to the specific standards so that no serious errors will be made in the diagnosis of brain death, either by falsely diagnosing live persons as dead (such as drug intoxications) or falsely diagnosing dead persons as alive (for example, exclusion of spinal segmental reflexes as a determinant of brain death and a clarification of the distinction between essential and confirmatory criteria). Particularly, I am concerned about educating physicians in the intermediate and smaller size communities as technology and advances in cardiopulmonary resuscitation spread to these areas. Also development of relatively uniform criteria will dispel doubts in the public mind concerning the varying criteria from state to state, from authority to authority, and organization to organization... the old argument about being dead in one state but not another. Further, these criteria would serve to educate the public to the distinction between the concept and criteria for brain death, and would also serve as expert medical testimony before the courts in future cases of brain death subjected to legal challenge. As you well know, even with a brain death law in the individual states, the brain death concept and related issues will still be subjected to legal challenge as society and the courts recognize implications of brain death which will not be completely resolved even after passage of definitive legislation.

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In regard to the adoption of criteria by the medical organizations, I have enclosed relevant information from two brain death cases decided in the Minnesota courts in 1978. As you can see by the testimony in the Ellison case, the formulation of statutory legislation and, more importantly, the medical criteria adopted by the Minnesota Medical Association were of great value in clarifying accepted standards of medical practice in our state and demonstrating to the courts that the physicians involved in the management of Stacey Ellison had used prevailing standards of practice in their determination of the death of that child.

As you probably know, a national Interagency Committee on Brain Death and Irreversible Coma has attempted for the last several years to update the Harvard criteria and develop relatively uniform criteria for brain death on a national level. However, progress has been slow because there are several points upon which we cannot reach a consensus.

One primary source of disagreement within this committee is the issue of essential versus confirmatory criteria, and the precise indications for and appropriate role of confirmatory criteria. Some physicians feel, for example, that the EEG is of such great value in the diagnosis of brain death that it should almost be considered mandatory. These physicians are resistant to any set of criteria which they feel will deemphasize the role of the EEG. We have also spent a great deal of time in this committee discussing specific wording and various technical aspects related to the clinical and laboratory diagnosis of brain death.

Even more interesting and of much more importance in the long run is the developing debate within this committee, as well as among other ethicists and physicians, over the distinction between "total brain death" and "partial brain death." The latter would include such medical syndromes as the persistent vegetative state, or a variant of the persistent vegetative state, neocortical death. Some ethicists, physicians, and others now argue that neocortical death should be sufficient grounds on which to pronounce death, rather than sufficient grounds for allowing to die. William Sweet, neurosurgeon at Massachusetts General Hospital, a member of the original Harvard criteria committee, and a current member of the Interagency Committee, has proposed this hypothesis, both during the deliberations of our Interagency Committee and in his editorial in the New England Journal of Medicine (enclosures). Sweet (and others) now argues that a person with either 1) a dead brain stem or 2) a dead neocortex is "just as dead" as a person with a dead brain. Exactly how serious he is and whether he would be willing to actually pronounce someone dead on this basis I cannot say for sure, since he has not yet replied to my letter. As you recall, the Royal Colleges' criteria made a serious conceptual and substantive error in their otherwise excellent set of criteria developed in Great Britain when they stated: "It is agreed that permanent functional death of the brainstem constitutes brain death..."

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I personally don't feel that this Interagency Committee is going to reach a consensus within the near future; but we can't even agree on that, since some committee members do feel we are close to a consensus. One of the things our Ethics Committee of the AAN will be working on in addition to securing enactment of brain death legislation and supporting the UBDA will be to develop uniform criteria formulated by our committee so that we can at least develop a position paper or a set of criteria which would educate and clarify some of the points directly related to the medical determination of brain death and related procedural guidelines, similar to what we accomplished in Minnesota through the Minnesota Medical Association (enclosure, Minnesota Medicine).

In Minnesota, in addition to formulating brain death legislation and developing criteria and procedural guidelines, the Ad Hoc Committee on Death has developed DNR guidelines, which have not thus far been formally endorsed by the committee or the state medical association. These guidelines (enclosures) have been sent to the chiefs of staff in all hospitals in Minnesota, the Minnesota Society of Hospital Attorneys, the Minnesota Hospital Association, and the Minnesota Nurses Association. After we have received comments from these groups, we will then revise the guidelines as needed and then officially adopt them through the state medical association. I am convinced that guidelines such as these will have to be developed by hospitals and medical organizations within the next few years, not only for brain death and DNR, but also for allowing to die, in cases of terminal diseases and the persistent vegetative state. If the medical profession doesn't lead the way, then the courts will assume an even more aggressive posture than they did in Saikewicz.

I briefly mentioned to you on the phone the interview with McCarthy DeMere which was published in the National Catholic Register on January 7, 14, and 21 along with an accompanying editorial in that newspaper and a letter from DeMere (enclosure). You will not be pleased by his comments. John McCabe, Legislative Director of the National Conference of Commissioners on Uniform State Laws (NCCUSL) headquarters in Chicago, is currently drafting a reply to the National Catholic Register refuting McCarthy's accusations, and we will be sure to send you a copy of that reply as soon as it is finished. McCarthy's charges that advocates of euthanasia had any input into the formulation of the UBDA are untrue.

Further, McCarthy's "distinctions" between the ABA proposal and the UBDA are, for the most part, patently fallacious on the surface. I won't dwell on the fallacies of McCarthy's arguments now...these will be documented in the letter from McCabe to the National Catholic Register. It would almost be funny if it weren't for the fact that McCarthy, because of his ego trip on the "fool-proof" and "genius-proof" ABA definition of death, has made, more than ever, the current definition of death debate into a religious issue around the country. That is a really sad turn of events. To what extent this has occurred I really have no good idea, but I was astounded

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to hear McCabe in Chicago discuss the large numbers of letters that his office and other NCCUSL commissioners around the country have received from members of Catholic parishes. McCarthy's interviews were published in the "Sunday Visitor," a pamphlet sent to the Catholic parishes around the country. McCarthy's views are seriously misleading the members of the pro-life movement and the Catholic community, and apparently many of them are buying what he has to say without any critical analysis on their part or bothering to check on his unsubstantiated charges. The editorial in the National Catholic Register is particularly distressing because of the lack of discrimination on the part of the editors in not recognizing, at least to some degree, the almost comical absurdity of McCarthy's analysis and analogies which at times really do border on being frankly funny. There is a good side to this, however. Because McCarthy has argued for the need for brain death legislation, the National Catholic Register is now on record as supporting this legislation, even if they do prefer the ABA proposal.

I did mention to you on the phone that there are some very responsible people within the pro-life movement who are generally concerned that in the long run the pro-life movement is going to lose credibility and power because of their determined opposition to brain death legislation. Many pro-life people feel, as I do, that the organized pro-life movement is drawing the lines at the wrong places. What they should be attempting to do is to clarify the issues and educate the public on brain death and allowing to die so that a meaningful line can be drawn, medically, morally, and legally, between allowing to die and euthanasia. They are going to hurt their own cause in the long run by opposing, too vigorously, the wrong issues.

In this respect, a book on euthanasia and related issues, Life and Death With Liberty and Justice: A Contribution to the Euthanasia Debate, to be released within the next few months should have significant impact on the attitudes of the pro-life forces towards brain death legislation. The two authors are Germain Grisez, a well-known ethicist who has written one of the definitive books on abortion from a pro-life perspective, Abortion: The Myths, the Realities, and the Arguments, and Joe Boyle, a pro-life ethicist and philosopher at the College of Saint Thomas, here in Saint Paul. One of their chapters deals with brain death, and in general they support the principle of brain death legislation (enclosure) and make such statements (with which I agree) as "a correct definition of death...could relieve some of the pressure for legalizing euthanasia." Hopefully, responsible positions like this will help the pro-life people develop a better overall perspective on these issues.

Further, I have recently met with some people within the pro-life movement who are influential both on a statewide and national basis who share similar concerns as I do, and who, for instance, agree with many of the points

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discussed in Grisez and Boyle's book. They will be attempting within the near future to develop a handbook written from a pro-life perspective on brain death, allowing to die, and euthanasia which will serve to educate members of the pro-life movement on a national level. Such a book as this would be extremely invaluable to clarify these issues and would be very persuasive, I hope, within the pro-life movement.

In this meeting with pro-life leaders, we also discussed some general strategies for attempting to educate the pro-life movement on a national level and to make them aware, for example, of such matters as DeMere's attempt to confuse the issues and muddle the pro-life position because of his ego trip on the ABA proposal. Hopefully, what some of us can do is attempt to contact some people who are high up in the pro-life movement on a national level and make them aware of some of these issues. From my own perspective, I will be attempting to find some nationally influential pro-life neurologists and neurosurgeons. It would be very helpful if people like you could direct us to some nationally prominent pro-life lawyers or doctors if you become aware of them.

Obviously, this sounds like an ambitious undertaking with no guarantee of success, but at least it's worth a try, and we can contact some people to see what type of response we get and determine how much effort would be spent for long range results. Certainly, the least we can do in the immediate future is to try to straighten people out on DeMere's comments so that we can hopefully deemphasize the religious aspects of the brain death debate.

I have been discussing this overall strategy with McCabe in Chicago, and we will hopefully be contacting responsible people, pro-life or not, within the ABA and the NCCUSL so that they will understand exactly where McCarthy's coming from, and hopefully we can educate them on the broader issues as well. Certainly, the long range objective of all of this is not merely the passage of responsible brain death legislation, but much more importantly the development of a reasonable, humane public policy attempting to resolve the dilemmas brought on by advances in medical technology. Looking at these issues from somewhat broader perspectives, I think many of us could envision responsible people within the pro-life movement and members of the medical and legal profession working together in a meaningful way on these issues, not only to secure enactment of good brain death legislation but hopefully with an eye towards resolving the other related issues. Having the opportunity to work with people like yourself gives me great encouragement in this regard.

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Sorry about this terribly long letter, but I did want to make you aware of current developments in this area. I will be calling you before the meeting in Las Vegas after I determine whether I will be able to attend or not.

Sincerely yours,



Ronald E. Cranford, M.D.
Associate Physician in Neurology
Hennepin County Medical Center

REC/mmj

Enclosures

Lisa: A Student's Notebook

by Brian Rees

Saturday

"I need a volunteer. So who wants to work up the kid?" There were only eight of us present, and we each smiled at the improbability of volunteering for anything. But we'd gladly volunteer our neighbor. Bert spoke first, "I tell ya", Dr. Zussman, I think Bob would be happy to do it."

"Actually, Paula's quite interested in hematology," replied Bob. Paula laughed, as did we all. Uncharacteristically, I volunteered. "What do you want me to do?" I asked.

"Well, that beep I got a while ago was about a girl referred from out of town. She'll be over at TMC (Tulane Medical Center) on Monday afternoon, so just go over there, look her over, know the case, and present her at Wednesday afternoon rounds."

These are the waning days of our junior year, only two more weeks left on our last block, Pediatrics. The Saturday morning Hematology/Oncology Seminar with Dr. Zussman had been cancelled the last four weeks in a row, which probably explains why only eight of us, about one-third of the class, were present. We are all fairly tired and not looking for extra work, what with tests approaching and all that. But I feel ignorant about hematology, so I figure I'll work up this little girl, read about her problem, and maybe learn something.

I vaguely understand that for some medicolegal reasons I shouldn't use her real name, so I'll call her Lisa Warren. I'm not sure why, but like so many things in medical school, if you don't know why you're doing something and there's no one knowledgeable available to ask, you just do it, resolve to ask later, and then forget about it until you run into it again. There must be thousands of things like that, tucked neatly away in some hidden recess of my mind.

"Lisa Warren, 4W, TMC, Monday p.m. w/u." I write in my list of things to do, and think of it no more.

Monday

Monday is my first day in the newborn nursery, and we're quite busy. It's already past 5 p.m. by the time I'm able to see Lisa Warren. We students spend almost all our time at the major teaching hospital, Charity Hospital of Louisiana. It's a monstrous inner city hospital, with a couple thousand beds, 19 floors, and an enormous patient population, almost all of whom are indigent.

But TMC is cushy. It's the private university-affiliated hospital where the faculty keep their private patients. No 12-bed wards here. Carpeting, clean walls, functional elevators, piped in music, the whole bit. The school and hospitals are all within a couple of blocks of one another, so I walk across the street to TMC, making sure to take the bubble gum card of Star Wars' Obi Wan Kenobi out of my plastic identification holder. I wear it at Charity, using my penlight as a light sabre to entertain the kids. Official medical ID now in place, I go to the fourth floor, get Lisa's chart without looking at it, and, accompanied by a young nurse who hasn't yet seen the patient and wants to hear what I'll say to her, we knock on the half-open door and walk into her room.

Lisa, a 7-year-old blue-eyed blonde, is sitting up in bed, watching TV and eating supper, as pretty a little girl as I've ever seen and looking the picture of health except for some obvious scleral hemorrhages. Her mother regards us with a mixture of welcome and concern.

"Hi, my name's Brian Rees..." The father steps out of the bathroom and looks surprised. I start again. "Hi. There's nothing to worry about. I'm just here to ask a few questions and take a quick look at your pretty daughter here." They look a bit relieved and everyone seems comfortable. Lisa giggles a bit when I call her pretty. "What is it that brings Lisa to the hospital?"

Her mother quickly outlines the history: Lisa is a healthy girl who was completely fine until about seven to ten days ago when she began bleeding from her gums after brushing her teeth, and got those bloody spots on her eyes. Their local M.D. treated her with antibiotics and aspirin, but to no avail. Then they took her to another doctor who ran some blood tests and referred her to TMC.

I like Mr. and Mrs. Warren. They are not an attractive couple. He is heavy, she is

Mr. Rees, a student at the Tulane University School of Medicine in New Orleans, is the winner of this year's TNP manuscript contest.





MEDICAL CENTER
701 Park Avenue South
Minneapolis, Minnesota 55415



February 15, 1979

Mr. James Sova
Director, Department of Legislative Affairs
Minnesota Medical Association
Suite 900, American National Bank Building
101 East Fifth Street
Saint Paul, MN 55101



Dear Jim:

The model brain death bill approved by the AMA Board of Trustees in January, 1979 is, in my opinion, unacceptable and should not be supported by the Minnesota Medical Association as a possible alternative to the Uniform Brain Death Act. I base my reasoning upon three major defects in the proposed AMA bill.

First and most important, the bill is written in such a way that the determination of death is permissive, rather than mandatory. It has now been well accepted, I think, by knowledgeable physicians and lawyers working in this area that a brain death law should be written in such a way that the determination of death is mandatory, rather than permissive. For example, the Capron and Kass model from the University of Pennsylvania Law Review in 1972, the proposed brain death act of the American Bar Association, and the Uniform Brain Death Act (UBDA) are all written in such a fashion. A permissive law will not, in the long run, help to resolve the difficult cases of brain death in which conflicts arise. This issue of mandatory versus permissive brain death statutes have been extensively explored by the Ad Hoc Committee on Death, and I believe there has always been a strong consensus within our committee on this point. The position of the Ad Hoc Committee on Death and the Minnesota Medical Association is quite clear on this particular issue, and I see no reason to change our position.

Second, in view of the developing controversy regarding neocortical death as another standard for the death of a human being, as proposed by Veatch, Sweet, Fletcher, and others, it is of paramount importance to distinguish between total brain death and lesser degrees of brain damage, such as the persistent vegetative state or neocortical death. The Uniform Brain Death Act has clearly and unequivocally distinguished between these two medical syndromes by using the phrase, "all functioning of the brain, including the brain stem." The proposed AMA bill uses vaguely worded, imprecise

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MR. JAMES SOVA
February 15, 1979
Page 2

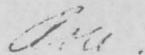
language on this point, i.e. "irreversible cessation of brain function." Such vaguely worded statutes will no longer be tolerated at this stage in the development of brain death legislation. A brain death statute should succinctly but clearly define the brain death concept as the irreversible cessation of all functions (or functioning) of the brain, and anything less than a very clear definition along these lines should not be supported by the medical profession.

Third, it appears that the primary objective of this AMA proposal is to protect the physician from criminal or civil liability. While this may not be a substantive objection to the proposal, such intentions of organized medicine reinforce the suspicions of those opposed to brain death legislation that the proponents of brain death bills are primarily motivated by the desire to protect physicians. Although this is a secondary and acceptable purpose of brain death legislation, it should not achieve the primacy that it has in the AMA bill. Moreover, I question the motivations of the American Medical Association, since it seems clear that their primary, if not exclusive, concern is and has been merely the protection of the physicians in these cases; while I would hope in Minnesota the state medical association and the medical profession are supporting an acceptable brain death bill with due consideration to the broader issues involved.

The AMA proposal would probably be acceptable if it were changed in such a way that 1) it was mandatory, rather than permissive; 2) it would explicitly spell out the concept of brain death; and 3) sections 2-5 were deleted. Of course, if these modifications were made, the bill would appear very similar to the Uniform Brain Death Act.

The MMA Ad Hoc Committee on Death has taken a strong position that, if a brain death bill were to be passed, it should be a substantively good brain death law, and I feel strongly that we should not compromise our principles in this regard for any short-term political gains. I would hope for these reasons that a bill such as the AMA proposal will not be seriously considered as an alternative to the Uniform Brain Death Act.

Sincerely,



Ronald E. Cranford, M.D.
Chairman, Ad Hoc Committee on Death, Minnesota Medical Association
Associate Physician in Neurology, Hennepin County Medical Center

REC/mmhf

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MINNESOTA MEDICAL ASSOCIATION

101 E. FIFTH STREET • ST. PAUL, MINNESOTA 55101 • AREA 612 PHONE 222-6366

HAROLD W. BRUNN, Executive Vice President

MEMORANDUM

February 9, 1979

TO: Ronald Cranford, M.D.
Merle Mark, M.D.
Jule Hannaford
Gregg Orwell

FROM: Jim Sova

RE: AMA MODEL BILL TO PROVIDE FOR A DETERMINATION OF DEATH

Enclosed is a copy of a model bill as approved by the AMA Board of Trustees in January providing for determination of death. We would appreciate your comments and thoughts on this model legislation as a possible alternative to the proposed Uniform Brain Death Act.

We would like to receive your comments at your earliest convenience, as some legislator may possibly introduce this as a substitute for the Uniform Brain Death Act which, as you know, has engendered a great deal of opposition from the pro-life forces.

Thank you for your assistance.

JS:acs
Encls.

cc: David McCuskey

January, 1979

IN THE GENERAL ASSEMBLY
STATE OF _____
An Act
To Provide for Determination of Death

Be it enacted by the People of the State of _____, represented
in the General Assembly:

Section 1. A physician, in the exercise of his professional judgment,
may declare an individual dead in accordance with accepted medical standards.

Such declaration may be based solely on an irreversible cessation of brain
function.

Section 2. A physician who determines death in accordance with section
1 is not liable for damages in any civil action or subject to prosecution in
any criminal proceeding for his acts or the acts of others based on that
determination.

Section 3. Any person who acts in good faith in reliance on a determi-
nation of death by a physician is not liable for damages in any civil action
or subject to prosecution in any criminal proceeding for his act.

Section 4. If any provision of this Act is held by a court to be
invalid, such invalidity shall not affect the remaining provisions of the Act,
and to this end the provisions of this Act are hereby declared to be severable.

Section 5. The Act shall become effective _____ from the date of
enactment.

Rough Draft -- by Joe Boyle

A Suggested Outline for a Right to Lifer's Handbook on Euthanasia

- I Introduction 15 pages
 - A. Definitions
 - B. Areas of right to life concern
 - C. Demographic and socio-economic context

Part I Legal Questions 130 pages

- II Definition of Death
- III Euthanasia -- English Background
- IV Euthanasia -- American Background
- V Justice in distributing life saving resources
- VI Possible Pro-life approaches
 - On death with dignity
 - Constitutional Amendments

Part II Moral/Social Questions 75 pages

- VII On Killing and Letting Die
- VIII On Ordinary and Extraordinary means
- IX Is death a good?
- X The Quality of Life Ethic
- XI The morality of killing
- XII Who's imposing morality?
- XIII Making the pro-life ethic live
 - Hospice concept

"I have been thinking about the euthanasia handbook a bit and I enclose a preliminary outline. First: our task is not primarily a research job. Between Germain's book and the Horan/Mall volume we have all the information we need. The job is to organize the material in a clear and simple way that right to lifers can use and understand. So what we need is a 220 page book that covers all the issues in a non-hysterical way. It should include 1) the state of the question on each issue, 2) the anti-life view and arguments, 3) the pro-life critique and options, and 4) an annotated bibliography of the most important material."

"Second: a possible procedure and timetable might go as follows: 1) develop and present to the board a preliminary outline and rationale, 2) get relevant board members and advisors to develop and improve the outline to the point that all the essentials are included, 3) come to agreement about a detailed outline by the first of the year, 4) assign parts to writers and get drafts by the end of March, 5) send MS to relevant board members and revise by the end of May, 6) to the printers by early June."