Letter to the Editor

To the Editor:

In the recent article by Lewis et al. entitled "Determination of Death by Neurologic Criteria in the United States: The Case for Revising the Uniform Determination of Death Act,"[1] the authors make an excellent case for the need to revise the United States' Uniform Determination of Death Act to help reduce and avoid increasingly common conflicts and concerns about the determination of death after neurologic criteria. We find the authors' arguments and suggested revisions compelling and on point. Toward the end of the article, the authors acknowledge that there will continue to be family member objections to the determination of death by neurologic criteria in individual patient cases, and that there needs to be clear guidelines to help healthcare providers navigate these conflicts (e.g. what the time of death will be recorded as, what (if any) treatments should be continued after a determination of brain death and for how long, etc.). As practicing clinical ethicists in the hospital setting, we would welcome and affirm the need for such consensus guidelines.

However, we caution against too great an emphasis on the use of legislation and guidelines to resolve disputes around brain death involving specific patients and families. Legislation and guidelines are helpful, but they cannot do it all. Instead, amidst these irreducibly human conflicts involving people with varied thoughts, feelings, and beliefs, there needs to be an equally human response involving skilled communicators who can understand, respond, and seek to resolve the specific conflict as it occurs in the clinical setting. These expert communicators would certainly be better equipped with clearer legislation and guidelines, but they also need to be equipped with a sense of humility and the abilities to hear from and listen to the various stakeholders, empower various voices in the discussion, understand the concerns that are often behind the anger and the frustration, and exhibit the wisdom and prudence to see solutions take shape amidst discussions with those involved. Merely reading hospital policy or national practice guidelines to a grieving and angry family member who is refusing to accept a diagnosis of death by neurologic criteria will not be successful. Instead, compassionate, clear, and thoughtful communication that is tailored to the specific situation at hand is necessary.

Thus, we urge twin efforts to think both (1) systemically through the improvement of legislation and practice guidelines surrounding the determination of death after neurologic criteria, and also (2) locally through consideration of those individuals in any given hospital or health system who possess the expert communication skills to help navigate and resolve conflicts around brain death. Well-trained clinical ethicists are one group of people who may possess these skills in any given healthcare organization, but they are not the only ones. And just as it is important to have hospital policies collected, organized, and accessible, it is also essential to identify those individuals who possess the requisite skills to help effectively navigate these conflicts, to affirm their skillset, and to put them to use when these conflicts inevitably arise.

Sincerely,
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References

1. A. Lewis, R. J. Bonnie, T. Pope, L. G. Epstein, D. M. Greer, M. P. Kirschen, M. Rubin, and J. A. Russell, "Determination of Death by Neurologic Criteria in the United States: The Case for Revising the Uniform Determination of Death Act," *Journal of Law, Medicine & Ethics* 47, no. 4 suppl (2019): 9-24.

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