

## **ARTICLE XIV**

### **DEATH**

#### **14.1 Pronouncement of Death**

Pronouncement of death of a patient in the Hospital is the responsibility of the attending physician or his Physician designee. Such judgment shall not be made by a member of the Nursing Staff. In every instance, the attending physicians will be notified as soon as possible. All consulting physicians will be notified at the discretion of the attending physician. The attending physician or his physician designee will make the diagnosis of death in person whenever possible. If the patient has been under medical care and the physician is familiar with the medical history, the physician can make the final diagnosis of death by telephone based on the reporting of relevant signs by a Registered Nurse. The registered nurse reporting these relevant signs to the Physician must be the Administrative Clinical Coordinator, Directors of Patient Care Services, Clinical Manager, nursing team leader, or primary care registered nurse. The registered nurse reporting and a second registered nurse must witness the signs. These signs include:

- (a) Absence of pulse;
- (b) Absence of blood pressure;
- (c) Absence of heart beat;
- (d) Dilated and unresponsive pupils;
- (e) Absence of respiration (spontaneous).

#### **14.2 Do Not Resuscitate Policy**

When a patient is determined to have a medical condition from which there is no likelihood of recovery, the primary physician after consulting with the family may make the decision not to resuscitate the patient if breathing and/or heartbeat are absent. This means no cardio-pulmonary resuscitation or other means of restoring respirations or heartbeat will be carried out. All patients will be resuscitated unless a "DNR", DNR-CC (Comfort Care), or DNR-CC Arrest order is written by the attending physician. A "DNR" order must be written in compliance with appropriate hospital policy. (Refer to Patient Care Services Policy #206 – Do Not Resuscitate (DNR) and Suspension of DNR Orders) The writing of a "DNR" order does not diminish the level of care of a patient. It may be appropriate for a "DNR" patient to be in a special care unit if his or her condition warrants special care

#### **14.3 Autopsies and Disposition of Bodies**

- (a) The remains of any deceased patient, including a fetal death or a neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician, the event adequately documented within a reasonable period of time by the attending physician or another designated Medical Staff Appointee and only with the consent of the parent, legal guardian or other responsible person. Death

certificates are the responsibility of the attending physician and must be completed within forty-eight (48) hours of death or birth in the case of fetal death.

- (b) All Medical Staff Appointees shall be actively involved in obtaining autopsies when warranted. It shall be the duty of all Medical Staff Appointees to secure consent to meaningful autopsies whenever possible. An autopsy may be performed only with proper consent from a responsible relative or legal guardian in accordance with state law and Hospital policy. All autopsies shall be performed by the Hospital designee referenced in Atrium Patient Care Services Policy #141. The attending Practitioner shall be notified when an autopsy is being performed on a patient.
- (c) The Medical Staff recognizes the autopsy as a valuable medical procedure and resource for purposes of assessing the quality of patient care; evaluating clinical diagnostic accuracy; determining the effectiveness and impact of therapeutic regimens; discovering and defining new and/or changing diseases; increasing the understanding of biological processes of disease; augmenting clinical and basic research; providing accurate public health and vital statistical information and education as it relates to disease; and obtaining medico legal factual information.

Under Ohio law, it is the responsibility of the attending Practitioner to report the case to the Coroner's office. The registered nurse shall notify the Coroner when so requested by the attending Practitioner. The Coroner must be notified in the following circumstances:

**313.12 Notice to coroner of violent, suspicious, unusual or sudden death.**

When any person dies as a result of criminal or other violent means, by casualty, by suicide, or in any suspicious or unusual manner, when any person, including a child under two years of age, dies suddenly when in apparent good health, or when any mentally retarded person or developmentally disabled person dies regardless of the circumstances, the physician called in attendance, (or any member of an ambulance service, emergency squad, or law enforcement agency) who obtains knowledge thereof arising from the person's duties, shall immediately notify the office of the coroner of the known facts concerning the time, place, manner, and circumstances of the death, and any other information that is required pursuant to sections [313.01](#) to [313.22](#) of the Revised Code. In such cases, if a request is made for cremation, the funeral director called in attendance shall immediately notify the coroner.

- (d) All Emergency Room deaths of patients not previously under the care of a physician;
- (e) Short Hospitalization (unless death is known within "reasonable medical certainty")
- (f) All Operating Room deaths or Recovery Room deaths

It is suggested that autopsies should be encouraged and requested in the following circumstances:

- (1) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending Practitioner.
- (2) Cases in which the cause of death is not known with certainty on clinical grounds.
- (3) Cases in which autopsy may help to allay concerns of and provide reassurance to the family and/or the public regarding the death.
- (4) Unexpected or unexplained deaths occurring, during or following any dental, medical or surgical diagnostic procedures and/or therapies.
- (5) Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards. The prosecutor should be made aware of the clinical trial protocol through the permit, chart or family.
- (6) Deaths that are subject to, but waived by, a forensic medical jurisdiction (such as deaths in which the patient sustained or apparently sustained an injury while hospitalized).
- (7) All obstetric deaths.
- (8) Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.
- (9) Deaths known or suspected to have resulted from environmental or occupational hazards. Forensic or possible forensic cases are to be reported to the Coroner's office.
- (10) Unexpected or unexplained deaths of admitted patients that are apparently natural and not subject to forensic medical jurisdiction.
- (11) Unexpected deaths occurring while treatment otherwise appears to be progressing successfully.
- (12) Deaths resulting from high risk infections and contagious diseases.

## 14.4 Guidelines for Determination of Brain Death

### (a) Policy

- (1) This section is aimed at providing guidelines for the determination of brain death in accordance with currently accepted medical standards.
- (2) The Medical Staff has defined brain death in compliance with Ohio Law that defines “death” as follows:

An individual is dead if the individual has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards. If the respiratory and circulatory functions of a person are being artificially sustained, under accepted medical standards a determination that death has occurred is made by a physician by observing and conducting a test to determine that the irreversible cessation of all functions of the brain has occurred.

- (3) Immunity from damages is granted to Physicians under Ohio law who make determinations of death, as follows:

A physician who makes a determination of death in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the physician’s acts or the acts of others based on that determination. Any person who acts in good faith in reliance on a determination of death made by a physician in accordance with this section and accepted medical standards is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for the person’s actions.

### (b) Definition of Brain Death

Irreversible cessation of all functions of the entire brain, cerebral and brain stem, in the presence of artificial means of cardiopulmonary support.

### (c) Criteria

The following criteria are to be followed in situations where a determination of brain death is indicated. The criteria do not relate to those situations in which a physician is able to determine that death has occurred by the usual signs of

irreversible cessation of spontaneous respiratory and circulatory function. The guidelines are directed toward those situations in which deep coma is present and circulation and respirations continue because of mechanical support. A diagnosis of death requires that both cessation of function and irreversibility be demonstrated as follows:

(1) Cessation of Brain Functions

Cessation of brain function will be established when both cerebral and brain stem functions are absent.

(a) Cessation of Cerebral Function

- (i) A deep coma, with complete unreceptivity and unresponsivity to the most intensely painful stimuli, must be present.

(b) Cessation of Brain Stem Function

- (i) Absence of all brain stem reflexes

- (1) Pupils dilated or midposition and fixed to light;
- (2) Absent blinking;
- (3) Absent corneal reflexes;
- (4) Absent swallowing, yawning, vocalizations, and gag reflex;
- (5) Absent oculocephalic reflexes; and
- (6) Absent oculovestibular reflexes.

- (ii) No spontaneous movement (peripheral nervous system activity and spinal cord reflexes may persist after death).

- (iii) Absence of respiratory function

- (1) Loss of spontaneous respiration;
- (2) Test for apnea (no spontaneous respiration with  $pCO_2 \geq 60$  mm of Hg)

(c) Electroencephalographic Silence

An EEG may be required based on medical circumstances.

(2) Irreversibility Determination

- (a) The irreversibility of the cessation of brain functions will be established when all of the following are present:
  - (i) Cause of coma is established and sufficient to account for the loss of brain functions.
  - (ii) The possibility of recovery of any brain function is excluded.
    - (1) The brain of an infant or young child (under five years of age) may recover substantial brain functions even after exhibiting unresponsiveness to neurological examinations for longer periods than adults. Thus, particular care must be exercised in diagnosing brain death in such patients. A consultation from a pediatrician to determine brain death in children should be obtained in all such cases.
    - (2) No drug toxicity; no sedative, anesthetic, neuromuscular blocking agents.
    - (3) No hypothermia below 32.2 degrees C (90 degrees F).
    - (4) No shock.
  - (iii) Persistent cessation of all brain function for a period of at least twelve (12) hours.

(3) Other laboratory tests which may be used in conjunction with EEG if considered appropriate.

- (a) Brain stem auditory evoked response.
- (b) Cerebral vessel angiography.

(4) Laboratory Diagnostic Test

Confirmation of death by use of laboratory diagnostic testing is not required. However, confirmation of clinical findings by EEG. is desirable when objective documentation is needed to substantiate clinical findings. Inclusion of any appropriate laboratory test, or extension of the observation period, as appropriate, is at the discretion of the attending Practitioner.

(d) Documentation and Procedures

- (1) If the above criteria are met and there is no evidence of continuing brain activity, the patient may be declared dead. Determination of brain death

should be documented by the physician in the Physician Progress Notes. A physician order must be provided for the removal of life support.

- (2) Brain death declaration is the formal pronouncement of death and the time documented for this declaration is to be used for all legal matters, including the death certificate, issued by the Hospital.
- (3) In cases where the Coroner has jurisdiction, the Coroner's permission is not required for the brain death determination process or termination of medical therapy. However, in all such cases where the Coroner has jurisdiction, the Coroner's office shall be immediately notified of the death and the Coroner's authorization must be obtained prior to the removal of organs.
- (4) When organs are to be removed from brain dead patients, a declaration of brain death must be made prior to their removal. Removal of organs must be authorized by the next of kin. Life support measures will be continued until the organs have been removed. The physician or physicians determining or certifying death shall not participate in the surgical procedure for organ procurement.
- (5) All Hospital rules, policies, and procedures concerning matters related to any deceased patient (i.e., permission for autopsy, Coroner's jurisdiction, etc.) apply equally to brain dead patients after a declaration of brain death has been made and all medical therapy or life-support devices have been discontinued.

(e) References

- (1) Ohio Revised Code Section 2108.40
- (2) Ohio Revised Code Section 313.12
- (3) Guidelines for the Determination of Death: Report of the Medical Consultants on the Diagnosis of Death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. JAMA. 1981 Nov13;246(19):2184-6

Adopted by the Medical Staff on 10/17/90

Approved by the Board of Trustees on 12/13/90

Revision to Section 14.4 approved by the Board of Trustees on 10/24/91

Revision to Section 14.1 approved by the Board of Trustees on 12/19/91

Revisions to Section 14.1 approved by the Board of Trustees on 9/22/94

Revisions to Section 14.3(c) approved by the Board of Trustees on 4/25/96

Revision to Section 14.4(c)(1-c) and 14.4(e) approved by the Board of Trustees on 7/23/98.

Revisions to Article 14 adopted by Medical Staff on 9/30/99

Approved by Board of Trustees on 10/28/99

Revisions to Sections 14.4(c)2,(a)(ii-1) and 14.4(d)-(1) approved by the Board of Trustees on 9/28/00

Revisions to Sections 14.1 and 14.3 approved by the MEC on 5/7/02 and Board on 9/26/02

Revision to Section 14.2 approved by MEC 4/1/03 and Board of Trustees 4/24/03

Revision to Section 14.3; addition of (h) reviewed Bylaws Cmte 6/17/04

Revision to Section 14.3(h) adopted by MEC 7/6/04 and approved by MRH Board 7/29/04

Approved by Bylaws Cmte. 10/17/13

Approved by MEC 11/12/13

Approved by AMC Board 12/5/13