

**To: New Jersey Law Revision Commission**  
**From: Marna L. Brown**  
**Re: Uniform Determination of Death Act**  
**Date: July 9, 2012**

## MEMORANDUM

In the summer of 1980, the National Conference of Commissioners on Uniform State Laws (“NCCUSL”) (now known as the Uniform Law Commission) approved and recommended for enactment in all states the *Uniform Determination of Death Act* (“UDDA”). This uniform law provides “comprehensive bases for determining death in all situations” and is based on evolving statutory language that began with a 1970 Kansas statute. According to NCCUSL, the uniform law was influenced by a Model Definition of Death Act drafted by the Law and Medicine Committee of the American Bar Association (“ABA”) in 1975, and a Model Determination of Death statute created by the American Medical Association (“AMA”) in 1979.

According to other sources, including the United States Government (see the website <http://bioethics.gov/cms/history>), the UDDA was proposed as a result of the report of the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1981, but the date of the UDDA promulgation makes this assertion unclear. What is clear is that in the 1970s and early 1980s, the standards for determining death became the subject of lively debate for two reasons: first, because of the advent of organ donation for transplant; and second because of the advancement of technology which could prolong a person’s respiratory and circulatory functions despite the permanent or irreversible cessation of that person’s neurological functions.<sup>1</sup>

Under common law, a person was deemed “dead” upon cessation of all vital functions, traditionally demonstrated by an absence of spontaneous respiratory and cardiac functions. According to the UDDA Prefatory Comment, the uniform law addresses the potential disparity between the common law standard of death and the definition of death that has evolved as a result of modern advances in healthcare.

The UDDA simply provides that<sup>2</sup>:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

---

<sup>1</sup>See James L. Bermat, *Are Donors After Circulatory Death Really Dead, and Does it Matter? Yes and Yes*, CHEST, Official Publication of the American College of Chest Physicians, 138(1):13-16 (2010). (author states that the UDDA was based on a 1981 Presidential Commission); Steven Laureys, *Death, Unconsciousness and the Brain*, Nature Reviews/Neuroscience, Vol. 6, p. 901, Box 1 (November 2005) (“Although the neurocentric definition of death originated before the advent of multiorgan transplantation . . . the demand for donors has been a major driving factor in the popularization and legalization of brain death.”); Stuart J. Youngner and Robert M. Arnold, *Philosophical Debates About the Definition of Death: Who Cares?*, Journal of Medicine and Philosophy, Vol. 26, No. 5, pp. 527-537, 533 (2001).

<sup>2</sup> The act also contains the customary uniform law language which states that the act is to be applied and construed to make uniform the law with respect to the subject of the act among the states enacting it.

The Prefatory Note states that the “overwhelming majority of cases will continue to be determined according to part (1). When artificial means of support preclude a determination under part (1), the Act recognizes that death can be determined by the alternative procedures.” The UDDA purposely does not discuss the medical criteria for determining the death, the time of death, or the liability of persons who make death determinations.<sup>3</sup>

The UDDA, which has not been altered since its promulgation in 1980, has been enacted in 38 jurisdictions. Sources note that all 50 states and the District of Columbia have recognized whole brain death as the governing definition of death.<sup>4</sup> See also *Controversies in the Determination of Death*, A White Paper by the President’s Council on Bioethics, December 2008, for a thorough discussion of the definition of death.

## **ANALYSIS OF NEW JERSEY LAW**

Although not having formally adopted the UDDA, New Jersey’s own law has evolved on this subject.

The definition of death was tangentially discussed in *In re Quinlan*, 70 N.J. 10 *cert. den. sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the seminal New Jersey Supreme Court case involving whether to grant a father’s request to discontinue extraordinary medical procedures sustaining the life of his 22-year old, comatose daughter, Karen Ann Quinlan. Having determined that Karen was *not* “brain dead”-- although she had lost all of her cognitive function -- the Court discussed the changing definition of death with the advance of medical technology, stating:

The determination of the fact and time of death in past years of medical science was keyed to the action of the heart and blood circulation, in turn dependent upon pulmonary activity, and hence cessation of these functions spelled out the reality of death. Developments in medical technology have obfuscated the use of the traditional definition of death.

The Court referred, with approval, to the 1968 report of the Ad Hoc Committee of the Harvard Medical School in describing those standards for determining brain death,

---

<sup>3</sup> As for time of death, the Prefatory Comment states that in those instances where time of death affects legal rights, although the act gives the bases for determining death, time of death is a fact to be determined in each case, and may be resolved, if necessary, upon expert testimony in a court proceeding. There is some controversy on the topic of time of death because when death occurs is directly tied to the definition of “irreversible” for purposes of applying the legal standard. See Stuart J. Youngner and Robert M. Arnold, *Philosophical Debates About the Definitions of Death: Who Cares?*, *Journal of Medicine and Philosophy*, Vol. 26, No. 5, (2001) at p. 531 (“All laws, clinical criteria and philosophic theories about death insist that the essential functions (whatever they are) must be *irreversibly* lost for death to be declared. But nowhere is irreversible defined.”) As for the liability of persons who make death determinations, the Prefatory Comment summarily states that “[t]here is no need to deal with these issues in the text of this Act”.

<sup>4</sup>See Melissa Goldstein, J.D., Rapid Public Health Policy Response Project of the GW School of Public Health and Health Services, The George Washington University Medical Center, *Diagnosing Death: Why does it remain “well settled and persistently unresolved?”* (December 2008); Paul W. Armstrong & Robert S. Olick, *Innovative Legislative Initiatives: The New Jersey Declaration of Death and Advance Directives for Health Care Acts*, 16 *Seton Hall Legis. J.* 177 (1992).

including “absence of response to pain or other stimuli, pupillary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as ‘flat’ or isoelectric electro-encephalograms and the like, with all tests repeated ‘at least 24 hours later with no change’”. The Court further noted that:

In such circumstances, where all of such criteria have been met as showing ‘brain death’, the [Ad Hoc] Committee recommends with regard to the respirator [citing from *A Definition of Irreversible Coma*, 205 J.A.M.A. 337-339 (1968)]: ‘The patient’s condition can be determined only by a physician. When the patient is hopelessly damaged as defined above, the family and all colleagues who have participated in major decisions concerning the patient, and all nurses involved, should be so informed. Death is to be declared and then the respirator turned off. . .(pp. 18-19; p. 28).

In 1988, however, in *Strachan v. J.F.K. Memorial Hospital*, 109 N.J. 523, 533 (1988), the New Jersey Supreme Court directly addressed the issue of how to define death. At about 4:30 p.m. on Friday, April 25, 1980, twenty-year old Jeffrey Strachan shot himself in the head in an apparent suicide attempt. At 5:25 p.m. that day, he was declared brain dead by an emergency room physician and placed on a respirator. That evening, a neurosurgeon at the hospital and one of the attending physicians confirmed Jeffrey was brain dead and informed his parents that nothing could be done to restore brain function. Because the hospital was actively involved in an organ transplant program, the neurosurgeon asked the family if they would be willing to donate any of their son’s organs.

Uncertain of what to do, the parents asked if they could consider the request overnight, during which time their son was continued on life support so that his organs would remain in a condition for harvesting. The next morning, the parents informed the doctors that they did not wish to donate their son’s organs and wanted his life support to be terminated. However, the hospital had no established protocol for responding to such a request. For the next three days, the son was continued on life support while the hospital staff bounced the decision of how to proceed from one person to the next.

First the parents were told by a nurse that the hospital administrator needed to order the release of their son’s body. Then another neurosurgeon examined their son, confirming, once again, that he was brain dead. The nursing director and the assistant to the hospital administrator contacted the hospital administrator who consulted with the hospital’s general counsel. Counsel then directed that the hospital obtain a signed written consent of the parents for removal of the respirator (which released the hospital and the attending physician from all liability with regard to discontinuance of the life support systems); he further recommended that the hospital conduct two additional EEGs, twenty-four hours apart, “to get a clear understanding of what the boy’s condition is”, and perhaps seek a court order as an alternative to a medical decision to turn off the respirator. Counsel even suggested the convening of a Prognosis Committee to assist the physicians with their decision to pronounce the patient dead.

Only after obtaining the parents' written consent, and the results of the EEGs (which again confirmed that their son was brain dead) did yet another neurosurgeon make an entry for Monday, April 28, 1980 indicating: "patient officially brain dead and by hospital regulations we may discontinue respiration c [with] family's permission." (No court order was sought, nor committee convened.) Thus, at 4:05 p.m. on the Monday following the son's first admission to the emergency room, the respirator was disconnected, the death certificate signed, and the body of Jeffrey Strachan given to his family for burial.

In the case brought by the parents against the hospital administrator and the hospital<sup>5</sup>, one of the issues raised was whether the hospital acted reasonably in honoring the family's request to turn over their son's body. The Court upheld the Appellate Division's conclusion that the family had a quasi property right in the body of their dead son, but disagreed with the conclusion that the son was not legally dead until 4:10 p.m. on the Monday after he'd shot himself, i.e., the time when the respirator was turned off and the death certificate signed. Since "[p]laintiffs' right of recovery, then, depends on when Jeffrey's death occurred," (see p. 531), the Court carefully examined how death should be determined in this instance.

The Court first concluded that "[t]he evidence is overwhelming that Jeffrey was deemed brain dead considerably earlier than Monday at 4:10 p.m. when Dr. Santoro pronounced him dead and executed a death certificate. Thus, the question comes down to whether our legal definition of death should include brain death". (p. 532). Acknowledging that traditionally death had been defined as the "irreversible cessation of cardiopulmonary function" (citing to *In re Quinlan*, 70 N.J. 10, 26-27, *cert. den. sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976)), the Court also recognized that this definition had been challenged over time as not reflecting advances in medical technology. The Court explained the dilemma faced as a result of modern medical advances, as follows:

For organs to be preserved for transplant, the donor's cardiopulmonary system must continue functioning until the organs can be removed. Under the traditional definition of death, such a donor would be considered as still alive because the heart continues to beat and the lungs continue to perform the respiratory function. In a very real sense, then, a break from the traditional definition of death is a necessary condition to the existence of transplant programs, for otherwise the organ-removal process might be deemed to have 'killed' the donor. (p. 532).

The Court then referred to the UDDA (which at that time, had been adopted by thirteen states and the District of Columbia), and to the many states that had adopted new definitions of death which incorporated "brain death", noting that these new definitions of death were in response to the above concerns. The Court also noted that the Appellate Division had adopted a definition equating death with brain death in the criminal context. The Court ultimately held that the UDDA provided an appropriate legal definition of death, further supported by the Court's earlier reference in *Quinlan* to "brain death" as an "accepted and prevailing medical standard for death", and thus found that defendants had

---

<sup>5</sup> The claims against the physicians and the transplant program and its coordinator were dismissed prior to trial.

negligently held the body of Jeffrey Strachan so as to prevent his proper burial.

***The New Jersey Declaration of Death Act.***

In 1991, New Jersey enacted the New Jersey Declaration of Death Act, N.J.S. 26:6A-1, *et seq.* (“NJDDA”), which sets forth the standards for determining death in New Jersey. The NJDDA was originally drafted and proposed, along with the Advance Directives for Health Care Act, by the New Jersey Bioethics Commission<sup>6</sup> and both acts were signed into law by Governor James Florio within a few months of each other.

The Bioethics Commission mandate was to provide “a comprehensive and scholarly examination of the impact of advancing technology on health care decisions” in order to enable government and professionals in the fields of medicine, health care, law and science to better understand the issues, the responsibilities of all concerned and the options available. The Commission was also directed to make recommendations on health policy to the legislature, the Governor and the citizenry of New Jersey.

Comprised of 27 appointed members (including representatives of the executive and legislative branches of state government, of statewide professional and health care associations, and of New Jersey’s professional and public communities), the Bioethics Commission, over the course of approximately two years, held six public hearings and more than twenty open meetings on the proposed NJDDA and Advance Directives for Health Care Act. Both legislative houses also held extensive, open committee hearings and deliberations on the two bills before they were passed with bipartisan support.

The NJDDA provides that an individual, who has sustained irreversible cessation of all circulatory and respiratory functions, as demonstrated in accordance with currently accepted medical standards, shall be declared dead. It also provides that subject to the standards and procedures established in accordance with the NJDDA, an individual whose circulatory and respiratory functions can be maintained solely by artificial means, and who has sustained irreversible cessation of all brain function, including the brain stem, also shall be declared dead. The NJDDA has additional features:

**Licensed physician makes determination.** With regard to a determination of death based on irreversible cessation of brain function, New Jersey’s law requires the declaration of death to be made by a licensed physician professionally qualified by specialty or expertise, in accordance with currently accepted medical standards and additional requirements, including but not limited to appropriate confirmatory tests.

**Regulations must be adopted and updated.** The Department of Health, jointly with the Board of Medical Examiners, must adopt and periodically revise regulations

---

<sup>6</sup> The Bioethics Commission (also called the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care) was established in November of 1985 as a permanent legislative commission, although it has since been eliminated by statute because of inactivity. See N.J.S. 52:9Y-1 through 52:9Y-6, inclusive, repealed by P.L. 2007, c. 39, §1.

which set forth the requirements for physicians authorized to declare death upon the basis of neurological criteria as well as accepted medical standards to govern such declarations.

**Procedure to avoid conflicts over organ donation.** To avoid any potential conflicts of interest, the statute provides that if the individual to be declared dead on the basis of neurological criteria is or may be an organ donor, the physician who declares that person's death may not be the organ transplant surgeon, the attending physician of the organ recipient or otherwise subject to a potentially significant conflict of interest relating to procedures for organ procurement.

**Criteria for time of death determination.** When the declaration is based on neurological criteria, provision is made for determining the time of death.

**“Religious or Conscience exception” to the definition of death.** The exception provides that if the physician has reason to believe on the basis of information in the individual's available medical records or information provided by the family or any other person knowledgeable about the individual's religious beliefs, that the individual's personal religious beliefs would be violated by the declaration of death, then the death of the individual shall not be declared upon the basis of the neurological criteria. In such cases, death is declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria. Only New Jersey and New York<sup>7</sup> recognize such an exception.<sup>8</sup>

**Protection from care provider liability.** The NJDDA protects from criminal or civil liability or discipline for unprofessional conduct a licensed health care practitioner, hospital or health care provider who acts in good faith and in accordance with currently accepted medical standards to execute the provisions of the NJDDA and any rules or regulations issued pursuant thereto.

**Denial of insurance coverage prohibited.** Equally important, the NJDDA also clarifies that no health care practitioner or healthcare provider, and no health service plan, insurer, or governmental authority, shall deny coverage or exclude from the benefits of service any individual solely because of personal religious beliefs regarding the application of neurological criteria for declaring death. And changes in pre-existing criteria for declaration of death effectuated by the legal recognition of modern neurological criteria shall not impair or modify the terms of any existing health insurance policy, life insurance or annuity, or governmental benefits program.

---

<sup>7</sup> 10 N.Y. A.D.C. 400.16(e) (2009) (“Each hospital shall establish and implement a written policy regarding determinations of death in accordance with paragraph (a)(2) of this section. Such policy shall include . . . a procedure for the reasonable accommodation of the individual's religious or moral objection to the determination as expressed by the individual, or by the next of kin or other person closest to the individual.”).

<sup>8</sup> An example of use of the exception is as follows: A 14 year-old boy is in a car accident and declared brain dead, but at the request of his Orthodox Jewish parents, the boy is placed on a ventilator for as long as his heart is able to beat independently. Although the “irreversible cessation of all functions of the entire brain” standard of determining death would fulfill the criterion for a legal determination of the boy's death, the cessation of respiratory function standard is substituted by way of religious exception. See Rachel Delaney, *Defining Death: Why All Fifty States Should Adopt the Uniform Definition of Death Act with a Religious Exception*, Marquette University Law School, 2010.

Although the provisions of the NJDDA have not been altered since the law's original enactment in 1991, rules that have been promulgated pursuant to the NJDDA, have been amended or readopted at the request of the Board of Medical Examiners several times since the act was first enacted, most recently in 2011. Consistent with the intention of the NJDDA, the rules will continue to be modified as accepted medical standards change.<sup>9</sup>

## CONCLUSION

The NJDDA already incorporates the UDDA definition of death while adding other provisions which only enhance application of the UDDA determination of death standard. These additions include clarifying that a licensed physician must make the death determination, that the physician who makes the determination may not be the organ transplant surgeon because of potential conflicts of interest, that a health care provider who acts in good faith and in accordance with the act is protected from liability and that these standards must be monitored periodically and revised as accepted medical standards change. Further, New Jersey case law is consistent with application of the NJDDA standard. Although the "religious or conscience exception" may be considered controversial because New Jersey is only one of two states that have included the exception in their definition of death, there are no reported cases challenging this provision.<sup>10</sup> In sum, it does not appear that any changes to the NJDDA are necessary at this time and nothing further is recommended.

---

<sup>9</sup> Current Section 13:35-6A of the New Jersey Administrative Code sets forth the requirements for physicians authorized to declare death on the basis of neurological criteria, including the physician's qualifications (which are dependent upon the age of the patient upon whom a declaration of brain death is to be made), the physician protocols for pronouncing brain death, the exemption to accommodate personal religious beliefs, and the protections from physician conflict of interest when there is organ donation.

<sup>10</sup> Only one case mentions the exception, *Matter of Moorhouse*, 250 N.J. Super. 307 (App. Div. 1991), and it does so in a footnote in which the Appellate Division states that: "The limited record here only allows us to recognize the existence of these issues, but not to further analyze their impact on this case." (p. 321.)