Brain Death
Legal Duties to Accommodate Religious Objections

To the Editor:
I read with great interest the recent article by Luce\(^1\) in CHEST (April 2015). Luce provides an informed and useful summary of the ethical and legal issues that arise in the growing number of disputes over the determination of death by neurologic criteria (DDNC) or “brain death.” I write to clarify three points in this legal landscape.

First, Luce\(^1\) states that New York allows families to reject the concept of determining death entirely by neurologic criteria. This is incorrect. Yes, in 1986, New York considered legislation that would have permitted families to reject DDNC. This legislation would have carved out a religious “exception,” such as New Jersey later did in 1991. But the New York legislation failed. Instead, the New York Department of Health promulgated regulations mandating hospitals to provide only “reasonable accommodation” of religious and moral objections. In contrast to Luce’s characterization, asserting a moral or religious objection to DDNC in New York does not affect the individual’s status as dead (as it does in New Jersey). Instead, it changes only the hospital’s “treatment” duties after DDNC.\(^2\) The New York regulations require a definite and limited accommodation, not an indefinite one such as in New Jersey. Indeed, the New York regulations have been interpreted to require hospitals to continue physiologic support for only 24 to 72 h after DDNC.\(^3\)

Second, Luce\(^1\) omits mention of Illinois as the third state that mandates hospitals to reasonably accommodate religious objections. Like similar laws in California and New York, Illinois requires that every hospital “adopt policies and procedures to allow health care professionals, in documenting a patient’s time of death at the hospital, to take into account the patient’s religious beliefs concerning the patient’s time of death.”\(^4\)

Third, Luce\(^1\) cogently argues against adopting a New Jersey-type “exception” law that prohibits physicians from applying DDNC to religious objectors. But it is far easier to defend “reasonable accommodation” laws such as those in California, Illinois, and New York. Hospitals in these states have not reported that compliance is burdensome. Indeed, the burden of extending such a mandate to other states would be minimal. The duration of accommodation would be limited to just a few hours or days. And these disputes would be rare given the relatively small US population with religious objections (Japanese Shinto, Orthodox Jews, Buddhists, Muslims, and Native Americans).\(^5\) Furthermore, most US hospitals already typically offer such accommodation. Consequently, extending a “reasonable accommodation” mandate would simply codify and clarify the prevailing standard of care.

Thaddeus Mason Pope, JD, PhD
Saint Paul, MN

AFFILIATIONS: From Hamline University School of Law.
FINANCIAL/NONFINANCIAL DISCLOSURES: The author has reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.
CORRESPONDENCE TO: Thaddeus Mason Pope, JD, PhD, Hamline University School of Law, 1536 Hewitt Ave, Saint Paul, MN 55104; e-mail: tpope01@hamline.edu
© 2015 AMERICAN COLLEGE OF CHEST PHYSICIANS. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians. See online for more details.
DOI: 10.1378/chest.15-0973

References

The US Uniform Determination of Death Act
Will It Survive a Constitutional Challenge?

To the Editor:
The unusual case of Jahi McMath, written by Luce\(^1\) in a recent issue of CHEST (April 2015), has raised many ethical and legal challenges to the current legal and medical definition of death in the United States. The success of a constitutional challenge to the US Uniform Determination Act...
of Death Act (UDDA) would have a major impact on organ procurement and transplantation practice. Many individuals declared dead by neurologic criteria supply human organs for transplantation practice in the United States. Organ transplantation contributes > $7 billion to health-care costs in the United States annually.\(^2\)

Luce\(^3\) discusses the application of the UDDA to McMath’s case and suggests that the Act would likely survive a constitutional challenge based on freedom of religion grounds. He primarily relies on the case of Employment Division, Department of Human Resources v Smith,\(^3\) in which the US Supreme Court held that Oregon’s denial of unemployment benefits to two Native Americans who used peyote in religious ceremonies did not violate the employees’ First Amendment rights. The key to the decision was that Oregon’s denial of benefits involved a neutral law of general applicability rather than one specifically aimed at curtailing religious freedoms.

Although Luce\(^3\) is correct that the UDDA is also neutral in its application, the legal landscape has changed since the Smith decision in 1990. The case was subject to substantial criticism and resulted in Congress enactment of The Religious Freedom Restoration Act of 1993,\(^4\) which prohibits the government from violating a person’s exercise of religion even if the law involved is of general application. Although the statute only applies to federal law, about one-half of the states have adopted similar legislation, and many others are in the process of doing the same. Accordingly, the prospects for the UDDA definition of death surviving a religious-based constitution challenge is far from guaranteed.

For the neurologic criteria of death of the UDDA to be upheld without providing for a religious exception, states with religious freedom legislation would have to demonstrate that the definition of death furthers a compelling government interest and achieves that interest in the least restrictive manner. Presumably, the interest that the current definition of death upholds is the integrity of the medical profession, since a religious exception would require hospital staff to care for patients who are brain dead. However, whether this interest is sufficiently compelling to justify the limit on religious freedom is unclear and will likely be the subject of future litigation.

**References**


**Response**

To the Editor:

In response to my recent article, “The Uncommon Case of Jahi McMath,”\(^5\) Dr Pope correctly notes that New York regulations do not require that death be determined solely by cardiopulmonary criteria to meet religious objections, as New Jersey law does. Indeed, the guidelines merely require that hospitals establish written procedures for the “reasonable accommodation” of such objections. However, as Olick et al\(^2\) have observed, the New York guidelines offer little, if any, guidance regarding what constitutes reasonable accommodation and, therefore, can be interpreted differently by hospitals across the state. In contrast, reasonable accommodation under California law is specified as a “reasonably brief period...afforded to gather family or next of kin at the patient’s bedside.” Furthermore, California law states that “in determining what is reasonable, a hospital should consider the needs of other patients and prospective patients in urgent need of care.”

Neither the New York regulations nor California law obligate third-party coverage for the patient care provided to accommodate religious objections, as New Jersey law does. Absent such coverage, this care must be paid for by families or, more likely, written off by hospitals. Dr Pope argues that “reasonable accommodation” laws like those in California and New York could be extended to other states and that this extension would
not create undue burdens because the duration of accommodation would be limited and because religious objections would be few. Although I agree that the California law, with its specificity, may be a model for other states, I worry that nonspecific regulations such as New York’s may not only accommodate but also invite religious objections. I also am concerned that such objections may not be restricted to members of the organized religions cited by Dr Pope and that accommodating the objections may be more burdensome than he believes. In this regard, the so-far-uncommon case of Jahi McMath may serve as a cautionary tale.

Mr Yanke and colleagues emphasize the need for caution in describing how the legal landscape has changed since the US Supreme Court decision in Employment Division, Department of Human Resources v. Smith. This decision established that neutral laws of general applicability, a category into which the US Uniform Determination of Death Act (UDDA) falls, need not include religious exceptions that would allow families like Jahi McMath’s to require that death be determined solely by cardio-pulmonary criteria. However, the Court’s recent decision in Burwell v. Hobby Lobby suggests that it may not follow the standard set by Smith in the future, as I noted in my article. Furthermore, as Mr Yanke and colleagues observe, recent state statutes prohibiting the government from violating the exercise of religion through laws of general applicability cast further doubt on the prospects of the UDDA surviving constitutional challenge. Failure of the UDDA to survive a challenge would have an adverse impact on organ donation and subsequent transplant, practices highly valued by American society.

John M. Luce, MD, MSL, FCCP
San Francisco, CA

AFFILIATIONS: From the University of California, San Francisco; and the Division of Pulmonary and Critical Care Medicine, San Francisco General Hospital.

FINANCIAL/NONFINANCIAL DISCLOSURES: The author has reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

CORRESPONDENCE TO: John M. Luce, MD, MSL, FCCP. Division of Pulmonary and Critical Care Medicine, San Francisco General Hospital, 1001 Potrero Ave, Room 5 K1, San Francisco, CA 94110; e-mail: jluce@medsfgh.ucsf.edu

© 2015 AMERICAN COLLEGE OF CHEST PHYSICIANS. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians. See online for more details.

DOI: 10.1378/chest.15-1101

References