CE TEST QUESTIONS

AJN0320

Brain Death: History, Updates, and Implications for Nurses

GENERAL PURPOSE:
To provide information about the history of the development of brain death criteria, including recent controversies and criteria updates.

LEARNING OBJECTIVES/OUTCOMES:
After completing this continuing education activity, you should be able to

- explain the history of brain death, including some important controversies and position statements that have guided health care professionals in understanding this concept.
- discuss the applicable nursing considerations when caring for patients declared brain dead and their families.

1. **The 1968 Harvard Ad Hoc Committee proposed that death could be defined when a brain no longer functions and cannot regain function in a patient who exhibits**
   a. complete unresponsiveness to stimuli.
   b. cessation of circulatory function.
   c. diminished elicitable reflexes.

2. **Electroencephalography (EEG) can confirm that brain damage is irreversible provided that 2 conditions have been ruled out, one of which is**
   a. hyporeflexia.
   b. hypothermia.
   c. cerebral hypoxia.

3. **The Uniform Determination of Death Act defined death as occurring in the presence of one or both of 2 criteria, one of which is classified as**
   a. hemodynamic criteria.
   b. cardiopulmonary criteria.
   c. multiorgan failure criteria.

4. **Which of the following states allows for religious exemptions to the declaration of brain death if family members object?**
   a. New Hampshire
   b. New Mexico
   c. New Jersey

5. **Confusion can arise when the physical appearance of a patient who has been declared dead by neurologic clinical criteria is identical to that of a patient who is**
   a. comatose.
   b. hypoxic.
   c. acidotic.

6. **Bernat argued that, while some human tissues and organs can be kept alive outside the body of a deceased person and transplanted to a living person, the survival of these components doesn't**
   a. rule out intermittent responsiveness.
   b. guarantee that the donor will survive.
   c. alter the fact that the donor "as a whole" is dead.

7. **Shewmon pointed out that, in rare cases, even when all diagnostic criteria for brain death are met, patients who receive ongoing physiological support**
   a. would most certainly perish without such support.
   b. may continue important integrative functions, such as digestion.
   c. may undergo rapid deterioration of the gross structure of the brain.

8. **The 2008 white paper from the President's Council on Bioethics on "Controversies in the Determination of Death" argued that the preservation of some bodily functions via mechanical ventilation in patients declared dead by neurologic criteria**
   a. enables them to act upon their environment.
   b. can, in some cases, signify self-consciousness.
   c. isn't sufficient to define these patients as living.

9. **In 2019, the American Academy of Neurology released a position statement that encouraged the development of institutional policies across U.S. medical facilities that reflect uniformity in which of the following areas?**
   a. the use of EEG to confirm the irreversibility of brain damage
   b. the appointment of specialized committees to resolve ethically complex dilemmas
   c. the training and credentialing for all physicians involved in brain death declarations

10. **A 2016 data analysis of policies pertaining to brain death determination in use at the majority of U.S. hospitals between June 26, 2012, and July 1, 2015, found significant variability among the policies in all 5 categories studied, one of which was**
    a. risk management consultation.
    b. prerequisites for clinical testing.
    c. age-related differences in pediatric patients.

11. **When brain death is suspected, a clinical assessment is performed, which typically involves testing to establish**
    a. the absence of brain stem reflexes.
    b. the presence of any form of sedation.
    c. a lack of fluctuation in any vital signs.

12. **A study by Tawil and colleagues found that, compared with family members who did not observe brain death evaluation, those who did had significantly higher postevaluation scores on scales measuring**
    a. their ability to cope with the loss of their loved one.
    b. their appreciation for the staff's diligence.
    c. their understanding of brain death.

13. **If family members choose to observe brain death testing, nurses should arrange for which of the following to be present to reduce any confusion and distress?**
    a. a specialist from donor services
    b. a behavioral health counselor
    c. a spiritual support person

14. **As cited by Bosek, which of the following religious traditions accepts cardiopulmonary death but may not accept death by neurologic criteria?**
    a. Sikhism
    b. Orthodox Judaism
    c. Seventh-Day Adventist

15. **The 2012 "Guidelines for the Determination of Brain Death in Infants and Children" recommends**
    a. 2 neurologic examinations and 2 apnea tests.
    b. examinations of neonates after 48 hours of observation.
    c. examinations of older children after 24 hours of observation.

16. **If a patient declared brain dead has viable organs or tissue, who should initiate organ donation conversations?**
    a. a member of the spiritual support staff
    b. the nursing or medical staff caring for the patient
    c. trained personnel from an organ procurement organization ▼