

TABLE 1] Accommodation Laws by State

State	Law
California ²	"If the patient's legally recognized health care decision-maker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns."
Illinois ³	"Every hospital must 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."
New Jersey ⁴	"Hospitals should establish written procedures for the acknowledgement of the patient's religious beliefs, if the examining physician has reason to believe, on the basis of information in the patient's available medical records, or information provided by a member of the patient's family or any other person knowledgeable about the patient's personal religious beliefs, that such a declaration of death by neurological criteria would violate the personal religious beliefs of the patient. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria."
New York ⁵	"Hospitals must establish written procedures for the reasonable accommodation of the individual's religious or moral objections to use of the brain death standard to determine death when such an objection has been expressed by the patient prior to the loss of decision-making capacity, or by the surrogate decision-maker. Policies may include specific accommodations, such as the continuation of artificial respiration under certain circumstances, as well as guidance on limits to the duration of accommodation."

repercussions of ignoring a family's wishes, such as legal action, negative publicity, or job loss.

Because solving these controversies is a formidable task for individuals or institutions, we recommend the creation of guidelines on management of these complex situations. Additionally, families may request continuation of organ support after brain death because of nonacceptance of death or the desire to await arrival of other family members, so physicians also need guidance to manage these scenarios.

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Bronchial Thermoplasty Misleading Differences in Asthma Exacerbation Rates!



To the Editor:

I read with interest the reply of the AIR2 trial authors entitled "Bronchial thermoplasty: ready for prime time—evidence is there!"¹ One of the major findings in the AIR2 trial reported by Castro et al² was the statistically significant difference in the rate of severe asthma exacerbations per subject per year between the bronchial thermoplasty arm and the sham arm. It is important to observe that the two groups were not matched in their baseline exacerbation rate per subject per year (see Table 1 in the AIR2 trial). Therefore, the difference in the asthma

exacerbation rate could simply be a result of the fact that more patients with frequent baseline exacerbations (ie, frequent exacerbators) were included in the sham arm than in the bronchial thermoplasty arm. It remains unclear why important baseline characteristics such as number of exacerbations per subject per year, ED visits in the previous year, and work absenteeism were not considered in the baseline patient characteristics, while comparison between the two arms with regard to these outcomes was planned for and conducted. If there was an intention to measure these outcomes and compare them between the two groups, the two arms should have been matched in these characteristics as well.

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Identifying Pathogen in Culture-Negative Pneumonia



To the Editor:

In their article in the July 2015 issue of *CHEST*, Andruska et al¹ reported that pathogen-related pneumonia was associated with an increased hospital readmission rate. In the Discussion section, the authors noted that hospitalization readmission could be related, in that setting, to inappropriate antibiotic therapy.

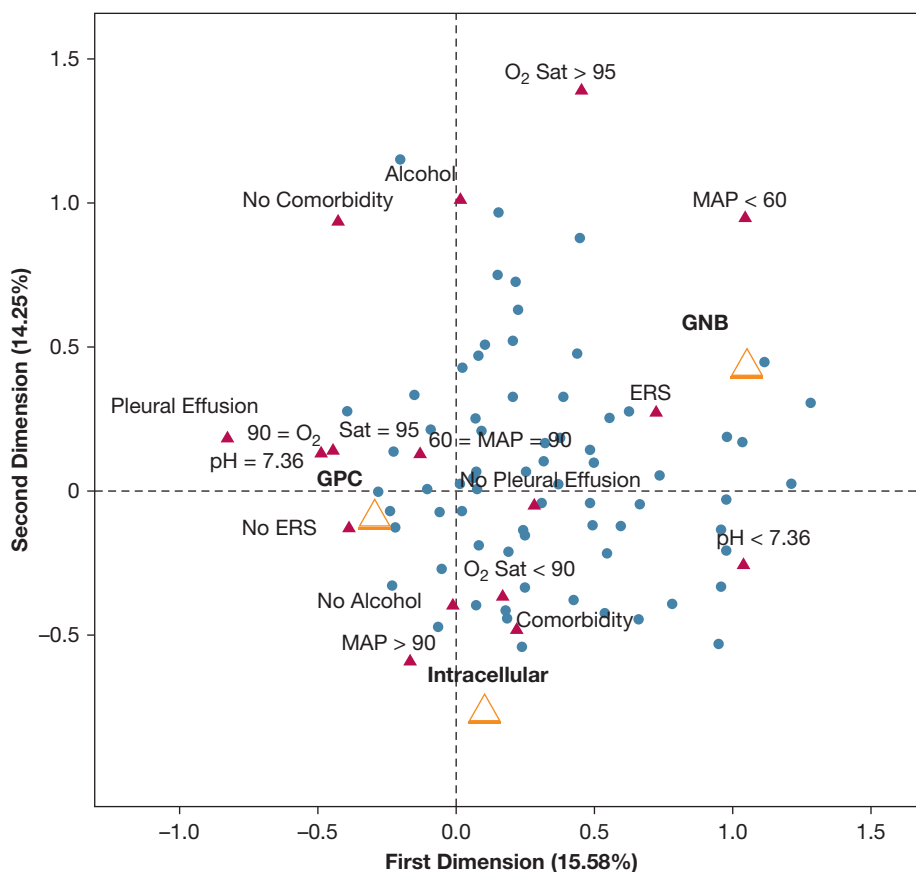


Figure 1 – Multiple correspondence analysis between admission parameters to microbiologic diagnosis. Each point corresponds with one patient with nondocumented pneumonia. ERS = extra-pulmonary symptoms; GNB = gram negative pneumonia; GPC = gram positive pneumonia; MAP = mean arterial pressure; O₂ Sat = oxygen saturation.