

9.2.3 Performing Procedures on the Newly Deceased

Medical training sometimes involves practicing procedures on newly deceased patients, in particular, critical medical skills for which adequate educational alternatives are not available. Such training must balance protecting the interests of newly deceased patients, their families, society, and the profession with the need to educate health care providers.

Physicians should work to develop clear institutional policies for performing procedures on newly deceased patients for training purposes. Before medical trainees practice any procedure on a newly deceased patient, the supervising physician has an ethical responsibility to ensure that:

- (a) The interests of all parties are respected and the risks and benefits of permitting the procedure have been carefully considered, including:
 - (i) the rights of deceased patients and their families;
 - (ii) benefits to trainees and society;
 - (iii) risks to trainees, staff, the institution, and the profession.
- (b) The procedure is carried out:
 - (i) as part of an appropriately structured training sequence
 - (ii) in a manner and an environment that is respectful of the values of all involved parties.
- (c) Permitting trainees to perform the procedure is in keeping with the previously expressed preferences of the deceased individual regarding handling of the body or procedures performed after death.
- (d) Permission for a trainee to perform the procedure is obtained from the decedent's family if the individual's preferences are not known. Procedures should never be performed for training purposes if the decedent's wishes are not known and permission is not available from an appropriate surrogate.
- (e) The procedure is entered in the medical record.

AMA Principles of Medical Ethics: I, V

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 5-A-01 Performing procedures on the newly deceased for training purposes

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-A-01

Subject: Performing Procedures on the Newly Deceased for Training Purposes

Presented by: Herbert Rakatansky, MD, Chair

Presented to: Reference Committee on Amendments to Constitution and Bylaws
(William J. Mangold, Jr., MD, Chair)

1

2 Resolution 1 (I-00), “Requesting Consent for Invasive Procedures on the Newly Deceased
3 Patient,” introduced by the Medical Student Section, instructed the AMA to address the ethical
4 concerns associated with using recently deceased individuals for training and other educational
5 purposes. The resolution was forwarded to the Council on Ethical and Judicial Affairs.

6

7 Introduction

8

9 The newly deceased often are used in the teaching of life-saving procedures. These include
10 endotracheal intubation, placement of central venous catheters, surgical venous cutdown,
11 thoracotomy, pericardiocentesis, cricothyroidotomy, liver biopsy, and intraosseous needle
12 placement. According to a 1992 survey, nearly 40% of U.S. training programs in critical care
13 used newly deceased patients.¹

14

15 This report explores whether it is necessary to obtain informed consent before training procedures
16 can be performed on the newly dead. To answer this query, two apparently conflicting
17 considerations need to be weighed: the importance of protecting the integrity of the newly
18 deceased with respect to the family, society, and the profession, and the need to educate health
19 care providers.² It may be instructive to draw comparisons from ethical guidelines on organ
20 donation. In cadaveric organ donation, body parts are used to benefit third parties and families
21 often are involved in the informed consent process.

22

23 Is informed consent required to preserve the integrity of the newly deceased?

24

25 Central to the debate over the use of newly deceased patients for training purposes is the concept
26 of autonomy. While the issue of a deceased person’s claim to autonomy is less clear, concerns
27 over respecting the wishes of the family, being responsive to the sentiments of the health care
28 team and trainees, and maintaining the integrity of the educational endeavor all must be
29 addressed. On a broader level, this guideline attempts to balance the importance of having a
30 constant source of properly trained physicians, with the imperative of individuals and society
31 trusting physicians with their care.

32

33 *Existing ethical guidelines*

34

35 The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and
36 Behavioral Research addressed the issue of using cadavers for teaching purposes. In its report

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 entitled “Research Involving Comatose and Cadavers,”³ it stated that “those conducting the
2 research are expected to make a reasonable effort to obtain specific consent from next of kin
3 when the research is ‘beyond the normal scope of teaching and research’.” Some have interpreted
4 these words to suggest that the Commission condones the performance of minimally invasive
5 procedures, such as intubation, on the newly dead without the consent of next of kin.⁴

6
7 More recently, the American Heart Association (AHA) considered the ethics of practicing
8 intubation skills on the newly dead as part of comprehensive guidelines for cardiopulmonary
9 resuscitation and emergency cardiac care. It has stated that the practice is ethically justifiable,
10 adding that “the sensibilities of family and staff should be compassionately respected and consent
11 obtained whenever practical.”⁵

12
13 *Addressing concerns related to obtaining consent*

14
15 The principal argument put forward by those who consider it unnecessary to obtain informed
16 consent to perform procedures on the newly dead focuses on necessity and the benefit gained.
17 The argument relating to medical necessity relies not only on the ongoing need for newly trained
18 physicians, but also on the idea that alternative models for teaching, such as mannequins, animals,
19 or video, are inadequate. While alternative models are useful in teaching a number of procedures,
20 studies have shown that using animal models or mannequins were unsuitable to teaching certain
21 procedures.^{6, 7, 8} Given that some important medical procedures have no adequate alternative
22 models for teaching other than actual patients, it is further argued that the value of performing
23 procedures on newly deceased patients resides in the benefit society derives from having well-
24 trained medical providers.^{9, 10, 11}

25
26 In contrast, a strict requirement to obtain consent from an individual patient before undertaking
27 any medical procedures stems from respect for patient autonomy. This perspective prohibits the
28 use of individuals merely as a means to an end, even if that end is beneficial.^{12, 13} While
29 arguments for autonomy may apply easily to live patients, it is less clear how they apply to
30 cadavers. Those who argue that consent is not necessary prior to the performance of procedures
31 on dead bodies emphasize that the right of privacy, which includes decision making over one’s
32 body, cannot be exercised after death.¹⁴ In other words, it is argued that dead persons have no
33 claim to autonomy.¹⁵ In support of this view, courts generally have held that no individual rights
34 survive death.

35
36 Some have justified performing procedures on the newly dead before obtaining explicit consent
37 through the notion of presumed consent.¹⁶ This doctrine generally applies to circumstances in the
38 emergency department where patients often arrive unconscious and are provided with treatment
39 that is expected to save their lives. In the case of practicing procedures, the doctrine would be
40 expanded: it would be presumed that a patient consents to all that follows from admission,
41 including the possible use of the cadaver for training, unless a preference has been stated
42 otherwise. Such an extension is problematic, however, since patients who receive life-saving
43 treatment without their consent benefit from the procedures, whereas dead patients who are used
44 for training purposes do not.¹⁷ The doctrine of presumed consent also has been examined in the
45 context of organ donation. The Council, in Opinion 2.155 on “Mandated Choice and Presumed
46 Consent for Cadaveric Organ Donation,” found that a policy of presumed consent, even one that
47 allows an “opt-out” mechanism, raises serious ethical concerns in the absence of effective means
48 to document and honor refusals.¹⁸

49
50 Whether or not patients have autonomy interests that survive death, there is still the question of
51 what interests the family has in controlling what happens to the body. Courts have recognized the

1 interest of next-of-kin to claim the body for burial services,¹⁹ from which a protection against
2 mutilation has been derived. In addition, under model legislation provided by the Uniform
3 Anatomical Gift Act (Sec. 2), next-of-kin are given the choice to make a gift of a deceased
4 person's organs or tissue.²⁰ Thus it appears that the family of a deceased patient has a legally
5 recognized interest in how the remains of the body are to be treated.

6
7 Advocates for the use of cadavers without consent raise the practical concern that, if families
8 were asked to consent to the use of newly deceased patients for training purposes, most would
9 refuse, which would result in a decrease of the number of training opportunities. There is little
10 support for this view in the medical literature.

11
12 Studies specific to gaining consent for performing procedures on the newly deceased demonstrate
13 that consent can be obtained from a majority of families,^{6,7} particularly when requests are made in
14 a sensitive manner and are framed in terms of the importance of enabling physicians to save other
15 lives.²¹ In two clinically-based studies, two populations of 44 families were asked for their
16 consent to allow physicians to perform endotracheal intubation on their deceased infant or wire-
17 guided retrograde tracheal intubation, which involves a small incision in the neck, on their
18 deceased adult relative. The researchers found that 32 families (73%) granted consent for
19 intubation of their newly deceased infant for training purposes,⁷ and that 26 families (59%)
20 granted consent for wire-guided retrograde intubation.⁶ The majority of individuals surveyed in
21 later studies would agree to subject themselves or a relative to training procedures after death, and
22 only a minority of respondents would allow such procedures without prior permission.^{22,23} This
23 suggests that most families of deceased patients want to help in the educational endeavor and that
24 trust in individual physicians is central to families who consent to such procedures. Likewise,
25 greater trust in the profession can be instilled in the public if consent is gained before such
26 procedures take place.

27
28 Closely linked to securing this trust is the finding that feelings of apprehension and discomfort
29 among medical trainees and staff are intensified when the newly deceased are used in clinical
30 training without consent.^{6,7,24} One study reported feelings of hesitation and uneasiness among
31 medical trainees who had performed intubation procedures on newly deceased infants. Some of
32 the trainees indicated that they were more comfortable with the procedures once they knew
33 consent from the parents had been granted.⁷ Furthermore, a subsequent study indicated that a
34 majority of the nursing staff and student nurses surveyed had discussed their personal feelings
35 about using the newly deceased for educational purposes with colleagues.²⁴ Thus, requesting
36 consent from the family to perform such procedures is important to respecting sensitivities not
37 only of the family, but also of the medical team.²⁵ Moreover, carrying out procedures on the
38 newly deceased without consent may have an undesirable effect on impressionable trainees:
39 weakening rather than strengthening their appreciation of the ethical requirement for holding the
40 interests of individual patients above social needs or desires for personal training. Although
41 physicians would rather not approach the family to gain consent for potentially objectionable
42 procedures at an inopportune time, this discomfort does not seem to override the benefits of
43 gaining consent.²⁶

44
45 We also observe that there are risks, which may be substantial, associated with performing
46 procedures on newly deceased individuals without consent. One is the risk of damaging trust in
47 the medical profession should such practices become public knowledge. There are recent
48 examples of the damage done by revelations of uses of dead bodies without consent.²⁷ Moreover,
49 performing procedures on a newly deceased individual without obtaining consent could
50 contravene state laws on the handling of corpses. Such actions also may result in undue
51 emotional distress to the family of the deceased, a potentially actionable offense.²⁶

1
2 *Guidelines for the ethical use of the newly deceased for training purposes*

3
4 An ethically sound policy on the performance of procedures on the newly deceased must ensure
5 that the interests of all parties involved (i.e. patients, families, health care providers, trainees and
6 society) are respected.²⁸ This can be achieved if a few preliminary considerations are addressed
7 before medical trainees perform procedures on the newly deceased. For instance, the teaching of
8 life-saving skills should be the culmination of a structured training sequence, rather than rely on
9 random opportunities.²⁹ Use should be limited to those procedures that are best learned using
10 anatomic structures that are life-like in softness and pliability. Training should be performed
11 under close supervision, in a manner and environment that respects the wishes and values of all
12 involved parties.

13
14 Finally, an ethical policy on performing procedures on newly deceased patients must respect the
15 fundamental principle of autonomy, which medicine has embraced and expanded over the past
16 several decades. If patients have had an opportunity to express preferences regarding what is to be
17 done with their bodies after death, such preferences must be respected.³⁰ In the absence of
18 expressed preferences, families should be consulted, as is the norm for organ donations and
19 autopsies. Training procedures on newly deceased patients should not be undertaken without
20 reasonable efforts to obtain informed consent, as would be done for other medical decisions.
21 When efforts to obtain consent within a reasonable time frame fail, training supervisors must
22 forego the training opportunity. In the case that consent has been granted, any procedures
23 performed on a newly deceased individual should be limited to those practices to which consent
24 has been granted.

25
26 Physicians should explain to families the educational needs that are served by the use of newly
27 deceased patients. When discussing the benefits of educating future health care providers with
28 the family, some researchers have found that framing the request as an attempt to elicit the
29 substituted judgement of the dead person makes consent more likely.³¹ For example, asking
30 whether the patient had discussed the choice to be treated at an educational institution or whether
31 the patient was generous and interested in helping others. Requesting consent in this manner
32 respects both the wishes of the family and the memory of the deceased.

33
34 Conclusion

35
36 Performing procedures on the newly deceased without attempting to gain consent from the family
37 or relying on the application of presumed consent in this context “runs counter to an evolving
38 norm of our society and threatens to erode further the trust of the community in the medical
39 profession.”³² Although there are some situations that may justify a waiver of informed consent,³³
40 or an extension of presumed consent, such doctrines cannot be relied upon in the use of newly
41 deceased for training purposes. The benefits of neglecting consent in this case do not outweigh
42 the impositions placed on patient autonomy, trainee and staff comfort, and family interests, as
43 well as risks to trust in the medical profession and potential legal liabilities.

44
45 Recommendations

46
47 The Council recommends that the following be adopted and the remainder of the report be filed:

48
49
50 Physicians should work to develop institutional policies that address the practice of performing
51 procedures on the newly deceased for purposes of training. Any such policy should ensure that

1 the interests of all the parties involved are respected under established and clear ethical
2 guidelines. Such policies should consider rights of patients and their families, benefits to trainees
3 and society, as well as potential harm to the ethical sensitivities of trainees, and risks to staff, the
4 institution, and the profession associated with performing procedures on the newly deceased
5 without consent. The following considerations should be addressed before medical trainees
6 perform procedures on the newly deceased:
7

- 8 1) The teaching of life-saving skills should be the culmination of a structured
9 training sequence, rather than relying on random opportunities. Training should
10 be performed under close supervision, in a manner and environment that takes
11 into account the wishes and values of all involved parties.
12
- 13 2) Physicians should inquire whether the deceased individual had expressed
14 preferences regarding handling the body or procedures performed after death. In
15 the absence of previously expressed preferences, physicians should request
16 permission from the family before performing such procedures. When
17 reasonable efforts to discover previously expressed preferences of the deceased
18 or to find someone with authority to grant permission for the procedure have
19 failed, physicians must not perform procedures for training purposes on the
20 newly deceased patient.

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