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CASE AND COMMENTARY
Performing Procedures on the Newly Deceased, Commentary 2
Commentary by Gregory Larkin, MD

Case
Scott Lynch is a third-year emergency medicine resident in a large urban teaching hospital. Dr. Lynch has 2 fourth-year medical students under his supervision. Lydia Santos and Carl Mason have a few days remaining in their month-long clerkship, and the ER has supplied rich opportunities to observe and participate in treating patients with acute illness and injury as well as those who use the ER for primary care.

Dr. Lynch, a conscientious clinician and teacher, is pleased with Lydia and Carl's performance during their rotation. He has been increasingly including them in hands-on treatment whenever he judged it prudent. Each has gained a good knowledge base and is acquiring skills in suturing lacerations, wound debridement, and assisting in advanced CPR codes.

On the students' last day in the ER rotation, Mrs. Milos is brought in by ambulance from a local skilled nursing facility. Mrs. Milos, a 76-year-old woman with a history of two previous MIs, complained of shortness of breath, so the nursing home staff called the ambulance. On the way to the hospital, Mrs. Milos suffered cardiac arrest. The ambulance crew continued chest compressions and administered shock and pharmacologic treatment. Mrs. Milos was intubated when the EMTs wheeled her into the ER.

At about the same time, Mrs. Milos's son arrives by car and comes into the emergency room asking to see his mother. He is kept away from the resuscitation attempts and wais for news about his mother outside the treatment area.

Despite all attempts to resuscitate Mrs. Milos, Dr. Lynch calls off the code approximately 20 minutes after her arrival in the ER. Within moments of calling off the code, he says to Lydia, "On the chance that there's some pericardial blood, I want you to do a pericardiocentesis. It's something you need to know how to do." Lydia prepares to follow Dr. Lynch's instructions.

Commentary 2
However well intended, Dr. Scott Lynch's attempts to educate the medical students under his tutelage runs afoul of current norms of ethical medical behavior. Performing procedures on the newly dead can materially undermine societal trust in

the healing arts and violate the surviving interests of newly deceased patients and their families. It is important for caregivers to respect the dignity of patients—both living and newly deceased. Teaching procedural skills, however laudable, must not interfere with family grief, visitation, and in some cases, the need to collect forensic evidence. The preponderance of data in the western medical literature suggest that consent from family members prior to practicing procedures on newly dead patients is mandatory.[1-5] This is further supported by two studies demonstrating the feasibility of obtaining consent for postmortem procedures from family members.[6, 7]

However, while dogmatically requiring consent is all well and good, there are practical and ethical challenges with this approach as well. One well designed study by Olsen et al showed only a minority of patients would allow doctors to practice cricothyrotomy on newly deceased patients in the Emergency Department.[8] In addition to being pragmatically challenging, attempting consent from distraught family members may exacerbate the grieving process and undermine trust in the profession as much if not more than doing procedures without consent[9, 10] An intermediate view between the extremes of mandating consent and foregoing consent altogether is that of teaching procedures so long as family members are not available; if they are available, consent should be attempted. However pragmatic, the inconsistency of this approach is problematic as well.

Both the professions and the general public are split on this issue. While consent is advocated, most studies suggest that practicing procedures on the newly dead is perceived to be an acceptable practice among the general public.[11, 12] In addition to widespread public support, a study of Emergency Medical Training Programs revealed that nearly half (47 percent) use the recently deceased for teaching purposes.[13] Another recent study shows that more than 1 of every 4 teachers in emergency medicine admitted to using recently deceased patients to teach procedural skills without consent.[14] Teaching procedures such as central line placement, chest tube insertion, cricothyrotomy, venus cutdown, and thoroacotomy and pericardiocentesis are all better practiced on newly deceased bodies than living patients whose well-being is materially threatened if these procedures are not done competently. The ethical principles of non-maleficence (avoiding harm to a living patient) and beneficence (providing benefits to future patients) are both satisfied when teaching procedures on the newly dead are done with dignity and care. While the recently bereft family may be concerned about the practice, most medical procedures pale in comparison to what is actually done to a body when it is sent to a funeral home. And, unlike being sent to a funeral home or having resuscitation continued for the sole purpose of education, there is never any financial cost to the patient or the family when the procedures are done on the newly deceased.

In the current case scenario, Dr. Lynch would not have been faulted for continuing the flogging of Mrs. Milos (the patient) if he felt there was a potential benefit for performing a pericardiocentesis toward the end of the resuscitation attempt. Practically speaking, he could have easily extended the resuscitation attempt and used that window to teach procedures to the medical students without fear of

retribution; however, whether such artificial extension of resuscitation attempts is ethical must also be questioned. Certainly, medically appropriate procedures should be attempted on all patients who may benefit, including dying patients, but they must be documented in the medical records and appropriately billed—hence, the conundrum of having resuscitation attempts artificially prolonged and generating inflated costs versus the ethics of performing procedures on newly deceased patients in order to insure beneficent and competent care to future patients.

Indeed, technologic advances may someday make this discussion moot, but until realistic alternatives to training on real patients are widely available, the use of mannequins, virtual reality, and patient simulators, must take a back seat to practicing on cadavers and consenting patients. Perhaps more concerning than the alleged dilemma of teaching procedures using the newly dead is the altogether acceptable practice of teaching procedures on living patients using newly minted doctors and students, often without explicit disclosures of training status or express patient consent. One recent study demonstrated that senior resident physicians were patently unwilling to have other resident physicians as their doctors, belying a more serious inconsistency, if not flagrant hypocrisy, in medical education today.[15]

In conclusion, before worrying about the rights of the deceased, we should preoccupy ourselves with the rights of the living and make every effort to disclose the status of every non-physician, student, and resident trainee involved in the care of unsuspecting patients. Given the ubiquity of moonlighting residents, unsupervised mid-level providers, and anonymous interns and students running amok in hospitals, practicing procedures on the newly dead is a minor and non-egregious concern.

References

1. Goldblatt AD. Don't ask, don't tell; practicing minimally invasive resuscitative techniques on the newly dead. *Ann Emerg Med*. 1995;25(1):86-90.
2. Moore GP. Ethics seminars: the practice of medical procedures on newly dead patients—is consent warranted? *Acad Emerg Med*.2001;8:389-92.
3. Berger JT, Rosner F, Cassell EJ. Ethics of practicing medical procedures on newly dead and nearly dead patients. *J Gen Intern Med*. 2002;17(10):774-778.
4. Manifold CA, Storrow A, Rodgers K. Patient and family attitudes regarding the practice of procedures on the newly deceased. *Acad Emerg Med*. 1999;6(2):110-115.
5. Kerns AF. Better to lay it out on the table rather than do it behind the curtain: hospitals needs to obtain consent before using newly deceased patients to teach resuscitation procedures. *J Contemp Health Law Policy*. 1997;13(2):581-612.
6. McNamara RM, Monti S, Kelly JJ. Requesting consent for an invasive procedure in newly deceased adults. *JAMA*. 1995;273(4):310-312.

7. Benfield DG, Flaksman RJ, Lin TH, et al. Teaching intubation skills using newly deceased infants. *JAMA*. 1991;265(18):2360-2363.
8. Olsen J, Spilger S, Windisch T. Feasibility of obtaining family consent for teaching cricothyrotomy on the newly dead in the emergency department. *Ann Emerg Med*. 1995;25(5):660-665.
9. Iserson KV. Law versus life: the ethical imperative to practice and teach using the newly dead emergency department patient. *Ann Emerg Med*. 1995;25(1):91-4.
10. Orlowski JP, Kanoti GA, Mehlman MJ. The ethics of using newly dead patients for teaching and practicing intubation techniques. *N Engl J Med*. 1988;319(7):439-441.
11. Oman KS, Armstrong JD II, Stoner M. Perspectives on practicing procedures on the newly dead. *Acad Emerg Med*. 2002;9(8):786-790.
12. Tachakra S, Ho S, Lynch M, Newson R. Should doctors practice resuscitation skills on the newly deceased patients? A survey of public opinion. *J R Soc Med*. 1998;91(11):576-578.
13. Fourre MW. The performance of procedures on the recently deceased. *Acad Emerg Med*. 2002;9(6):595-598.
14. Denny CJ, Kollek D. Practicing procedures on the recently dead. *J Emerg Med*. 1999;17(6):949-952.
15. Larkin GL, Kantor W, Zielinski J. Doing unto others? Emergency medicine residents' willingness to be treated by moonlighting residents and non-physician clinicians in the Emergency Department. *Accad Emerg Med*. 2001;8(4):886-892.

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