

Performing Procedures on the Newly Deceased

Two physicians offer commentary on the ethical issues that arise from medical students performing an invasive procedure on the newly dead as part of their medical training.

Commentary by Leonard Morse, MD, and Gregory Larkin, MD

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 waits 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 1

by Leonard Morse, MD

Dr. Lynch appears to have fulfilled his teaching obligations to Lydia Santos and Carl Mason very responsibly, and, undoubtedly, they have had an excellent learning experience as senior medical students during their one-month ED rotation. However, performing pericardiocentesis (or any other invasive learning procedure) without consent, after halting resuscitative efforts and the pronouncement of death is unethical. The question of performing procedures on the newly deceased was referred to the Council on Ethical and Judicial Affairs (CEJA) about 3 years ago by the House of Delegates of the AMA in response to a resolution introduced by the AMA Medical Student Section. In June 2001, CEJA Opinion 8.181, "Performing Procedures on the Newly Deceased," was adopted as AMA ethical policy by the House of Delegates. It calls for obtaining consent from the patient upon hospitalization or seeking permission by an

advance directive or from the patient's guardian before performing a procedure after death. The Opinion states, "When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must not perform procedures for training purposes on the newly deceased patient."

Appreciating that "preserving, expanding (research), and teaching the body of knowledge" distinguishes medicine as a profession, patients should be educated to understand that hands-on learning experiences are essential, with the most junior learning under the guidance of those more senior. Informed consent should be obtained at the time of hospitalization from the patient or surrogate, so that, in the event of death, a medical student, resident, or fellow might expand his or her skill by performing a procedure under supervision. Opinion 8.181 clearly states that "the teaching of life-saving skills should be the culmination of a structured training sequence rather than relying on random opportunities," and that such "training should be performed under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties." The Opinion also recommends that any procedures undertaken on the newly deceased be recorded in the medical record.

Developing skills as a physician draws fundamental human emotions into the pursuit of learning. Most physicians remember performing their first venipuncture. Acquiring skills and new knowledge in medicine is a life-long experience. Opinion 8.181 should prompt hospitals to seek from all patients, upon admission, permission for authority to approve or reject the performing, after death and under supervision, of procedures to improve the skills of trainees in order that they may better serve their future patients. Permission to acquire skills in this manner is recognized as a very special privilege.

Leonard Morse, MD, a retired internist, is currently the Chief Medical Officer of the Greater New Bedford Community Health Center, New Bedford, MA, and professor of Clinical and Family Medicine, and Community Health at the University of Massachusetts Medical School. He became chair of the AMA's Council on Ethical and Judicial Affairs in June 2002.

Commentary 2

by Gregory Larkin, MD

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, venous cutdown, and thoracotomy 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;25:86-90.
[View Article](#) [Google Scholar](#)
2. Moore GP. Ethics seminars: the practice of medical procedures on newly dead patients—is consent warranted? *Acad Emerg Med.* 2001;8:389-92.
[PubMed](#) [Google Scholar](#)
3. Berger JT, Rosner F, Cassell EJ. Ethics of practicing medical procedures on newly dead and nearly dead patients. *J Gen Intern Med.* 2002;17:774-8.
[View Article](#) [PubMed](#) [Google Scholar](#)
4. Manifold CA, Storrow A, Rodgers K. Patient and family attitudes regarding the practice of procedures on the newly deceased. *Acad Emerg Med.* 1999;6:110-5.
[View Article](#) [PubMed](#) [Google Scholar](#)
5. Kerns AF. Better to lay it out on the table rather than do it behind the curtain: hospitals need to obtain consent before using newly deceased patients to teach resuscitation procedures. *J Contemp Health Law Policy.* 1997;13:581-612.

[PubMed](#) [Google Scholar](#)

6. McNamara RM, Monti S, Kelly JJ. Requesting consent for an invasive procedure in newly deceased adults. *JAMA*. 1995;273:310-2.
[View Article](#) [PubMed](#) [Google Scholar](#)
7. Benfield DG, Flaksman RJ, Lin TH, et al. Teaching intubation skills using newly deceased infants. *JAMA*. 1991; 265:2360-3.
[View Article](#) [PubMed](#) [Google Scholar](#)
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;25:660-5.
[View Article](#) [PubMed](#) [Google Scholar](#)
9. Iserson KV. Law versus life: the ethical imperative to practice and teach using the newly dead emergency department patient. *Ann Emerg Med*. 1995;25:91-4.
[View Article](#) [PubMed](#) [Google Scholar](#)
10. Orłowski JP, Kanoti GA, Mehlman MJ. The ethics of using newly dead patients for teaching and practicing intubation techniques. *N Engl J Med*. 1988;319:439-441.
[View Article](#) [PubMed](#) [Google Scholar](#)
11. Oman KS, Armstrong JD II, Stoner M. Perspectives on practicing procedures on the newly dead. *Acad Emerg Med*. 2002;9:786-90.
[View Article](#) [PubMed](#) [Google Scholar](#)
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;9:576-8.
[Google Scholar](#)
13. Fourre MW. The performance of procedures on the recently deceased. *Acad Emerg Med*. 2002;9:595-8.
[View Article](#) [PubMed](#) [Google Scholar](#)
14. Denny CJ, Kollek D. Practicing procedures on the recently dead. *J Emerg Med*. 1999;17:949-52.
[View Article](#) [PubMed](#) [Google Scholar](#)
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. *Acad Emerg Med*. 2001;8(4):886-892.
[View Article](#) [Google Scholar](#)

Gregory Larkin, MD, is a professor of Surgery, Director of Academic Development at UT Southwestern and Director of the Violence Intervention Prevention Center. He is also a member of the Society for Academic Emergency Medicine's Ethics Committee and a member of the American College of Emergency Physicians Ethics Committee. He is one of the authors of the ACEP Code of Ethics.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

© 2003 American Medical Association. All Rights Reserved.