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Consent Needed to Perform Procedures on the Newly Deceased for Training Purposes

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When medical crisis demands emergency interventions such as intubation, open-chest heart massage, or tracheotomy, skillful performance of these procedures can mean the difference between life and death. How are clinicians-in-training to acquire these necessary skills? Not in the medical crisis itself. Not by practicing the intervention on a patient who does not need it. In some medical training programs, physicians learn difficult procedures on newly deceased patients[1, 2]. Proponents of the practice argue that endotracheal intubation, for example, simply cannot be learned properly by practicing on mannequins, animals, or even cadavers. Moreover, they say, an attempt at intubation that fails due to lack of experience or skill can damage the patient's anatomy in ways that cause future attempts to fail and, hence, could be responsible for loss of lives.

This method of teaching and learning has serious flaws—educational as well as ethical. As an educational approach, learning procedures on the newly deceased is an unsystematic, haphazard practice that depends upon events outside the educators' control rather than on organized curriculum and learner readiness. Ethically, the practice offends many by violating respect for the deceased, a closely held, widely shared cultural value in the US. Sensitive to the repugnance that violating of the body provokes, some medical student and residency programs have allowed students and physicians-in-training to practice certain procedures on newly dead without seeking consent from a spouse or next-of-kin[2]. The main reasons given for not seeking consent are that the benefit to society of well-trained physicians overrides individual patient autonomy (particularly when the patient is no longer living) and that requesting permission from grieving family members causes them unnecessary distress[3]. Conducting the learning experience in this ethical netherworld of "no consent," however, compounds the conflict for students and residents who find themselves torn between demands, on the one hand, to learn as much as they can and, on the other hand, to respect patient and surrogate rights to grant or refuse consent.

The Council on Ethical and Judicial Affairs (CEJA) took up the issue of consent for performing procedures on newly deceased patients in response to a resolution from the AMA's House of Delegates (HOD) in 2000. Speaking in the open forum that preceded the HOD vote on CEJA's recommendation, opponents voiced the fear that a consent requirement would result in inadequately skilled physicians and would

encourage the practice of unnecessary interventions on living patients. Defenders of a consent policy cited studies in which family members, when asked, had consented to allowing procedures to be performed on their recently deceased loved ones. Seventy-three percent of parents with newly deceased infants consented in one study[1], and 59 to 75 percent of those with newly deceased adult relatives consented in others[4, 5].

After thoughtful deliberation, CEJA's recommendation requiring consent was adopted by the HOD at the 2001 annual meeting. The new policy states that "the teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities." And the policy explicitly forbids practicing interventions on newly deceased individuals without consent: "Physicians should inquire whether the deceased individual had expressed preferences regarding handling the body or procedures performed after death." Absent advance directive preferences on the part of the patient, physicians should request permission from the family members, spouse, or a person with authority to grant permission on behalf of the newly deceased. Family members, spouse, or designated surrogates have "quasi-property rights" over the corpse; that is, the right of possession for the purpose of burial and other lawful disposition. If "reasonable efforts" to secure consent from those with quasi-property rights fail, "physicians must not perform procedures for training purposes on the newly deceased patient." The House of Delegates' consensus vote in favor of required consent reflects the medical profession's belief that society's interest in educating physicians does not override its interest in protecting individual patient rights to consent to or refuse medical intervention.

References

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