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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

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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

Hospitals in the United States are using newly deceased patients, often infants, to teach resuscitation procedures to medical students, interns, and residents without first obtaining consent from the patient’s family.¹ This practice has been addressed in medical journals for almost a decade. Recently, however, a survey indicating the prevalence of this practice has brought the procedure under close scrutiny; new questions have been raised as researchers continue to expand the frontier of medical knowledge.²

While most people agree that, ideally, consent should be obtained prior to allowing deceased patients to be used for teaching purposes, there is strong disagreement about whether or not consent is a necessity, and the appropriateness of continuing the practice.³ A court of law has not yet addressed these issues.⁴

Part I of this Comment examines the practice of using newly deceased patients to teach resuscitation techniques to medical trainees, without first obtaining family consent. Part II evaluates the legal arguments provoked by this practice by comparing and contrasting state statutes and court decisions in related areas of the law. Part III analyzes the public policy arguments surrounding the consent requirement. Part IV proposes

3. Burns et al., supra note 2, at 1652. “Although no crisis in the education of trainees in intubation has occurred, it appears that such a crisis has been averted by the deceptive practice of using newly dead patients to teach intubation without consent. The practice is justified; the deception is not.” Orlowski et al., supra note 2, at 441.
4. See infra Part II; Burns et al., supra note 2, at 1653.
a change in the current practice that would still allow students to obtain
the training they need and ensure the family's right of consent. Part V
concludes that while the practice scientifically is justifiable, it is morally
wrong to deceive patients' families in order to teach resuscitation skills.
By ensuring family consent prior to intubation training, hospitals and
physicians can meet their obligation to train students and their obligation
to respect their patients' families' wishes.

I. THE USE OF NEWLY DEAD PATIENTS IN MEDICAL TRAINING

Both the medical profession and society in general long have accepted
the importance of using human bodies for scientific training and re-
search. As long as there have been doctors, however, society has been
wary of their practice. Teaching and experimentation involving human
corpses has been viewed with a particularly jaundiced eye; therefore,
non-medical people may react emotionally to this controversial intuba-
tion training, yielding reactions ranging from rage to repugnance.

Our society treats the deceased with reverence and is distrustful of any

5. Intubation is defined as "[i]nsertion of a tubular device into a canal, hollow organ,
or cavity; specifically, passage of an oro- or nasotrachael tube for anesthesia or for control

6. See Burns et al., supra note 2, at 1652. See, e.g., LOUIS LASAGNA, THE DOCTORS'
DILEMMAS 96 (1962); Joel Feinberg, The Mistreatment of Dead Bodies, HASTINGS CENTER
REP., Feb. 1985, at 31; Letter from Jeff Stryker to Editor, 320 NEW ENG. J. MED. 396
(1989) (criticizing Orlowski's ethical standards condoning intubation without familial
consent).

7. Burns et al., supra note 2, at 1653-54; Stryker, supra note 6, at 396; LASAGNA,
supra note 6, at 100. Quoting a letter Petrarch wrote to Pope Clement VI, Lasagna writes:
know that your bedside is beleaguered by doctors, and naturally this fills me with
fear. Their opinions are always conflicting, and he who has anything new to say
suffers the shame of limping behind the others. . . . They traffic with our lives.
With them—not as with other trades—it is sufficient to be called a physician to be
believed to the last word, and yet a physician's life harbours more danger than
any other. . . . The physician alone has the right to kill with impunity. Oh, Most
Gentle Father, look upon their band as an army of enemies. Remember the
warning epitaph which that unfortunate man had inscribed on his tombstone: 'I
died of too many physicians.'

LASAGNA, supra note 6, at 100.

8. See Feinberg, supra note 6, at 31.

With a cruel zeal for science, some medical men who are called anatomists have
dissected the bodies of the dead, and have inhumanly pried into the secrets of the
human body in order to learn the nature of the disease and its exact seat and how
it might be cured.

LASAGNA, supra note 6, at 97 (quoting St. Augustine).

9. Orlowski et al., supra note 2, at 439, 441. See also Burns et al., supra note 2, at
1652; Feinberg, supra note 6, at 31-33; Stryker, supra note 6, at 396.
tampering with bodies between the time of death and interment.\textsuperscript{10} Despite this skepticism, "[scientifically] proved advances in care of the critically ill patient are expected, accepted, and perhaps even demanded by society."\textsuperscript{11} Additionally, the quality of the medical profession undoubtedly is directly correlated to the degree of excellence in the training available,\textsuperscript{12} and this training must, at times, involve practicing on an actual human body.\textsuperscript{13} The dilemma for clinical educators, thus, is attempting to balance two often conflicting obligations: educating health care providers in the most comprehensive manner possible, and protecting patients’ physical and psychological integrity.\textsuperscript{14}

The hospital ethics committee at Children’s Hospital in Boston, Massachusetts recently reviewed the hospital’s teaching policies and found the need to formulate a policy regarding the propriety of using newly deceased patients to teach resuscitation procedures.\textsuperscript{15} As a starting point, three doctors, Burns, Reardon, and Truog, were enlisted to conduct a survey of the directors of United States’ hospital training programs “to determine the prevalence of this practice and circumstances under which it is performed.”\textsuperscript{16} The survey, released on December 15, 1994, in the New England Journal of Medicine, indicated that thirty-nine percent of the responding programs used newly deceased patients to teach resuscitation procedures, and of these, “only ten percent required either verbal or written consent from the patients’ families.”\textsuperscript{17}

Although the reporting programs indicated that several medical tech-

\textsuperscript{10} See Lasagna, supra note 6, at 96, 97 (describing religious views on post-mortem dissection and use of corpses). See also Burns et al., supra note 2, at 1653.
\textsuperscript{11} Norman S. Abramson et al., Informed Consent in Resuscitation Research, 246 JAMA 2828, 2828 (1981).
\textsuperscript{12} See Orlowski et al., supra note 2, at 439. See Burns et al., supra note 2, at 1652.
\textsuperscript{13} Lasagna, supra note 6, at 99; Burns et al., supra note 2, at 1652.
\textsuperscript{14} Orlowski et al., supra note 2, at 439.
\textsuperscript{15} Burns et al., supra note 2, at 1652.
\textsuperscript{16} Id. at 1652; See D. Gary Benfield et al., Teaching Intubation Skills Using Newly Deceased Infants, 265 JAMA 2360 (1991) (discussing a 1987 national survey by T. Crawford in which 20% of responding hospitals reported intubating newly dead patients for teaching purposes without informing the family).
\textsuperscript{17} Burns et al., supra note 2, at 1652. In 1992, of 449 questionnaires mailed, 353 hospital training programs across the country responded. Of these, 136 (39 percent) described using newly deceased patients [to teach] resuscitation. [The programs reporting the highest level of such use were] . . . emergency-medicine programs (63 percent) and the neonatal critical care programs (58 percent). Forty percent of programs that used this teaching technique reported using it 10 or more times per year. . . . Only 10 percent (13 of 136) of all the programs . . . required either verbal or written consent from the patients’ families.

Id.
Techniques were practiced, they indicated that tracheal intubation was by far the most frequently performed procedure. Tracheal intubation is a method for providing assistance in breathing by maneuvering an endotracheal tube through the patients' trachea in an effort to open the airway. Once in place, oxygen is forced through the tube and directly into the lungs, preventing aspiration of fluid into the lungs. Intubation is employed most commonly in emergency situations; thus, speed and precision are of the utmost importance. In addition to its prevalence in emergency room settings, intubation is also an integral part of neonatal intensive care unit training, where respiratory complications abound.

II. Legal Implications

The legality of using newly deceased patients for teaching purposes without family consent has not been addressed by a court. The rights at stake and decisions in similar types of cases must be examined in order to predict how a court would rule on this issue. Both criminal and civil laws must be reviewed to determine where liability could rest, and at what consequence.

A. Criminal Implications

At the extreme end of the spectrum, some state laws include statutes imposing criminal sanctions for dissecting a body without authority and for abuse of a corpse. In New York, for example, removal of a dead body that is awaiting burial for the purpose of dissection, without authority...

18. Id. Procedures reported include the placement of central venous catheters (using a large needle to enter a vein for the purpose of threading a catheter into it), surgical venous cutdown (making an incision in the skin to expose an artery or vein), thoracotomy (making an incision in the chest, often through which to massage the heart), pericardioentesis (using a long needle to remove fluid from the sac surrounding the heart), cryochothyrotomy (making an incision in the neck), liver biopsy, and intraosseous needle placement (putting a needle into bone, often for the purpose of removing marrow). Id.


20. Letter from James P. Orlowski, M.D. et al., to Editor, 320 New Eng. J. Med. 396, 397 (1989). Intubation also "isolates the airway, keeps it patent, prevents aspiration, permits suctioning of the trachea, ensures the delivery of a high concentration of oxygen to the lungs, and provides a route for the administration of certain drugs." Id.

21. Orlowski et al., supra note 2, at 439.

22. Benfield et al., supra note 16, at 2360. Of 55 infants studied who died at Children's Medical Center of Akron (Ohio) Neonatal Intensive Care Unit, all but one received respiratory assistance. Id. at 2361.

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ity of law, constitutes a felony. Misdemeanors include dissecting a body without legal right or permission of the deceased, and opening, without authority of law, "a building wherein the dead body of a human being is deposited while awaiting burial... for the purpose of dissection, or from malice or wantonness." There is, however, an exception to criminal sanctions if the person dissecting or performing the autopsy acts in good faith and is unaware of the decedent's opposition to such procedure.

Abuse of a corpse, a misdemeanor of the second degree in Ohio, may be charged when a person "treat[s] a human corpse in a way that he knows would outrage reasonable family sensibilities." Gross abuse of a corpse is a felony of the fourth degree, charged against one who "treat[s] a corpse in a way that would outrage reasonable community sensibilities."

A violation of these laws based on unauthorized dissection or intent to dissect principles would be difficult to prove with regard to intubation training, however, because the requisite cutting or dismembering normally would not be found. While retrograde intubation does involve a minor incision, even this may not meet the degree of dismemberment or disfigurement necessary to qualify as a dissection.

Application of the abuse of a corpse statutes, in the context of unauthorized intubation, would be more likely to result in successful prosecution. Family, as well as community, sensibilities certainly could be outraged when liberties are taken with a body without first consulting the family. In such case, the court would be forced to weigh the shock and outrage of the public and the families, against the societal benefits provided through the training. Ultimately, the court must decide if the hospital or training physician acted knowingly, i.e., even though he knew the act would outrage reasonable family sensibilities. A court undoubtedly could justify holding doctors or hospitals criminally liable for abuse of a

25. Id. at § 4210-a.
26. Id. at § 4218.
27. Id. at § 4210-b.
28. OHIO REV. CODE §§ 2927.01(A) &(C) (Anderson 1996) (emphasis added).
29. Id. at §§ 2927.01(B)-(C)(emphasis added).
30. The definition of dissection: "The act of cutting into pieces an animal or vegetable for the purpose of ascertaining the structure and use of its parts. The anatomical examination of a dead body by cutting into pieces or excising one or more parts or organs." BLACK'S LAW DICTIONARY 472 (6th ed. 1990).
31. See infra note 117.
corpse when unauthorized liberties have been taken knowingly with newly deceased patients.

B. Civil Implications

Civil actions, as well as criminal, are available. Several claims, including statutorily based actions for money damages, have been raised in response to interference with dead bodies. Cases involving organ donation and autopsies are analogous because the body at issue is not a living patient with rights in and of itself, instead a third party must assert a violation of rights claim. Courts have struggled to define what rights to recognize in the families of the deceased, as well as how to formulate suitable remedies.

32. See Everman v. Davis, 561 N.E.2d 547, 550 (Ohio 1989) (holding that a Fourth Amendment unreasonable search and seizure violation did not apply when the county coroner, while fulfilling his legal duty, performed an autopsy on plaintiff's wife against his wishes); Whaley v. County of Tuscola, 58 F.3d 1111, 1116-17 (6th Cir. 1995) (holding that Fourteenth Amendment procedural due process claims may be brought successfully against agents of the state in this case for the removal of decedents' eyeballs or corneas); Carney v. Knollwood Cemetery, 514 N.E.2d 430, 431-35 (Ohio 1986) (awarding $56,000 to the plaintiffs based on infliction of emotional distress and mishandling of a dead body when cemetery knowingly dug up the remains of plaintiff's relative and discarded them in a refuse pile so that another body could be buried in its place); Muniz v. United Hosp., 379 A.2d 57, 58 (N.J. 1977) (suggesting potential tort claims of outrage, breach of implied contract, infliction of emotional distress, and medical malpractice against a hospital that mishandled plaintiff's dead infant for three weeks); Finley v. Atlantic Transp. Co., 220 N.Y. 249, 249 (1917) (awarding plaintiff damages for mental anguish, suffering, and nervous shock when plaintiff's father's body was cast into the sea by defendant cruise ship, 20 hours from port, as plaintiff was waiting to exercise his right of possession for burial); Lacy v. Cooper Hosp., 745 F. Supp. 1029, 1034-36 (D.N.J. 1990) (denying plaintiff's claim of negligence and medical malpractice when defendant physician performed pericardiocentesis on a newly deceased patient without familial consent).

33. See Burney v. Children's Hosp. in Boston, 47 N.E. 401 (Mass. 1897) (holding that plaintiff may bring an action against the hospital that performed an autopsy on the body of his dead child without his consent); Snyder v. Holy Cross Hosp., 352 A.2d 334 (Md. Ct. Spec. App. 1976) (finding that an autopsy may be performed over the religious objection of decedent's family when that state has a compelling reason for its requirement). "[T]his court rejects the theory that a surviving custodian has quasi-property rights in the body of the deceased, and acknowledges the cause of action for mishandling of a dead body as a subspecies of the tort of infliction of serious emotional distress." Carney v. Knollwood Cemetery, 514 N.E.2d 430, 435 (Ohio 1986).

34. See generally Fuller v. Marx, 724 F.2d 717 (8th Cir. 1984) (denying plaintiff damages because no physical injury accompanied the emotional distress negligently inflicted upon her when medical examiner failed to return organs to her deceased husband's body following autopsy); Detling v. Chockley, 436 N.E.2d 208 (Ohio 1982) (finding conscious and deliberate disregard for others interests as a prerequisite to a punitive damages award); Schwartz v. State, 616 N.Y.S.2d 921, 928 (N.Y. Ct. Cl. 1994) (awarding parents $7,500 in damages for unauthorized performance of autopsy on their deceased inmate son
1. Whose Rights Are Involved?

The first step in determining whether the deceased patient's family would have civil claims against a physician or hospital, for unauthorized use of the body for teaching purposes, is establishing "whose" rights are at issue. It is a well settled legal principle that every living person has rights in his or her own body. The United States Supreme Court, however, has recognized that the right is not absolute, and thus state regulation is appropriate. For example, a person's body is her property in that she can permanently color it with a tattoo, yet she is not permitted to go so far as to sell organs or "sell her entire body" in the form of prostitution.

Regardless of how these amorphous property rights in one's body are defined, such rights extinguish at death and are not transferable to the estate of the decedent. Therefore, claims must be brought by someone with an interest in the deceased patient's body. The claimant most likely will be the spouse or family, because they have personal feelings at stake and possess legal rights with regard to the corpse. The type and extent in violation of their religious beliefs and objections); Carney, 514 N.E.2d at 430 (awarding $56,000 to the plaintiffs based on infliction of emotional distress and mishandling of a dead body when cemetery knowingly dug up the remains of plaintiff's relative and discarded them in a refuse pile so that another body could be buried in its place).


The paradigm not only places boundaries around the body, to keep others from intruding on the body or invading one's property, but also excludes others from choices about the body, or from intervening in decisions of an intimate nature. The language of property thus functions to give persons control, and it is a part of the general concept of property that this be a right to exclusive control.

36. Id. The landmark Supreme Court decision, Roe v. Wade, makes clear that while individuals may make many decisions regarding their bodies, this discretion is not without limits. Privacy rights are not absolute and must at times give in to state regulation. 410 U.S. at 153. Courtney Campbell favors a unique possessory right and points out one extreme implication if a person's body had all of the characteristics and features of property: a person could lose her property, i.e. body, in payment of a debt, due to the executable nature of property. Campbell, supra note 35, at 39-40.


38. State v. Powell, 497 So. 2d 1188, 1190 (Fla. 1986) (citing Roe v. Wade, 410 U.S. 113 (1973)).


If, however, the gravamen of the action is the mental anguish resulting from the
of these rights, however, is far from clear.40

2. Quasi Property Rights

The judiciary's struggle to define what rights over a deceased person's body a family possesses can be seen as early as 1897 in Burney v. Children's Hospital in Boston.41 In Burney, the Supreme Court of Massachusetts held that a father had a cause of action against a hospital that had been treating his son and then performed an autopsy on the newly deceased child's body without the father's consent.42 The court looked to England as well as other state decisions and found no property right in the body of the dead.43 Instead, the court recognized a right of possession for purposes of burial and other lawful disposition.44 This "quasi" property right to the body of a deceased family member has been accepted in most states.45 The dilemma remains in identifying the rights that accompany a declared "quasi" property right.46 William Prosser

act done to the dead body, it would seem that any one who suffered mentally from the act should have a right of action. Almost all courts, however, limit the right of suit to the surviving spouse, or if none, to the next of kin. Were the dead body property which would pass by the laws of intestacy, the action might be considered in the nature of a suit in trespass by the owner of the body. But if the plaintiff wins simply because he has suffered mentally there seems to be no basis for a rule that allows one individual a right of action and denies it to another who has essentially identical interests and has suffered equally from the wrong.


40. See supra notes 33 and 34 and accompanying text.
41. 47 N.E. 401 (Mass. 1897).
42. Id. at 401.
43. Id. at 401-02.
44. Id. at 401.
46. That there is no right of property in a dead body, using the word in its ordinary sense, may well be admitted. Yet the burial of the dead is a subject which interests the feelings of mankind to a much greater degree than many matters of actual property. There is a duty imposed by the universal feelings of mankind to be discharged by some one towards the dead, - a duty, and we may also say a right, to protect from violation, and a duty on the part of others to abstain from violation. It may therefore be considered as a sort of quasi property, and it would be discreditable to any system of law not to provide a remedy in such a case. Burney, 47 N.E. at 402 (quoting Pierce v. Cemetery, 10 R.I. 227, 237 (1872)). New York also has recognized a right of possession:

The right is to the possession of the corpse in the same condition it was in when
writes:

[Cl]ou[ts have talked of a somewhat dubious 'property right' to the body, usually in the next of kin, which did not exist while the decedent was living, cannot be conveyed, can be used only for the one purpose of burial, and not only has no pecuniary value but is a source of liability for funeral expenses. It seems reasonably obvious that such 'property is something evolved out of thin air to meet the occasion, and that it is in reality the personal feelings of the survivors which are being protected, under a fiction likely to deceive no one but a lawyer.¹⁷

3. Causes of Action

a. Tort Claims: Infliction of Emotional Distress

In Strachan v. John F. Kennedy Memorial Hospital,⁴⁸ plaintiffs' twenty-year-old son was diagnosed as brain dead, and yet, he was kept alive on life support machines for several days despite his parents' requests to the contrary.⁴⁹ Plaintiffs claimed successfully that the hospital negligently withheld the body from the family, and "posed a plain affront to their dignity and autonomy and exposed them to unnecessary distress at a time of profound grief."⁵⁰

The New Jersey Supreme Court found that "for more than a half century this state has recognized a quasi property right in the body of a dead person."⁵¹ The court held that the hospital was negligent in its failure to...
honor the parents' request for the body. In addition, the court implied that there is no distinct tort for the mishandling of a corpse, but rather that the tort actually was based on the wrongful infliction of emotional distress. The court went on to imply that the resulting harm necessary for a plaintiff to establish an emotional distress claim is often difficult to prove. This is true because the court is leery of spurious claims, unsupported by tangible evidence such as physical injury. When the issue involves negligent mishandling of a corpse, however, courts more easily are convinced of the harm element.

In Lacy v. Cooper Hospital/University Medical Center, the U.S. District Court of New Jersey agreed that mishandling a corpse is not a tort in and of itself, but rather it "is actionable only as a cause of action for intentional or negligent infliction of emotional distress." The court explained the necessary elements in a claim for intentional infliction of emotional distress: 1) "the defendant acted intentionally or recklessly," 2) such conduct must be so outrageous as to be "utterly intolerable in a civilized community," 3) such conduct is the proximate cause of the emotional distress, and 4) the emotional distress would be unbearably severe for a reasonable person to withstand. For negligent infliction of emotional distress the plaintiff must show: 1) the defendant owed a duty to

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52. Id. at 350-51.
53. Id. at 352-53; See also Restatement (Second) of Torts § 868 (1979) (recognizing a tort of interfering with the right of burial based on infliction of emotional distress, not quasi property rights). "One who intentionally, recklessly or negligently removes, withholds, mutilates or operates upon the body of a dead person or prevents its proper interment or cremation is subject to liability to a member of the family of the deceased who is entitled to the disposition of the body." Id.
54. Strachan, 538 A.2d at 353.
55. Id. "Legal authorities have long acknowledged the likelihood of mental anguish resulting from the mishandling of dead bodies." Carney v. Knollwood Cemetery Ass'n, 514 N.E.2d 430, 433 (Ohio App. 1986). What all of these cases appear to have in common is "an especial likelihood of genuine and serious mental distress, . . . which serves as a guarantee that the claim is not spurious." Strachan, 538 A.2d at 353.

As to the possibility of actions based on fictitious injuries, a court should not deny recovery for a type of wrong which may result in serious harm because some people may institute fraudulent actions. Our trial courts retain sufficient control, through the rules of evidence and the requirements as to the sufficiency of evidence, to safeguard against the danger that juries will find facts without legally adequate proof. . . . To hold that all honest claims should be barred merely because otherwise some dishonest ones would prevail is stretching the public policy concept very close to the breaking point.

57. Id. at 1034.
58. Id. at 1034-35.
the plaintiff, 2) the defendant breached that duty, and 3) the plaintiff was injured as a result of the breach.\textsuperscript{59}

In \textit{Lacy}, the parents of the decedent brought claims of emotional distress against a hospital for repeating a medical procedure (pericardiocentesis) on the body of their son after he had been pronounced dead.\textsuperscript{60} The court concluded that the mental distress suffered by the family was not severe enough to meet the requirements for intentional or negligent infliction of emotional distress; the hospital was not held liable for its acts.\textsuperscript{61}

In determining whether there is a possible claim for intentional infliction of emotional distress against a doctor or hospital for using a newly deceased patient to teach intubation techniques, the four necessary elements of the cause of action must be evaluated. The first question is whether the hospital or doctor acted intentionally or recklessly. Clearly, there was the intention to perform the teaching technique. Whether or not this act was reckless is debatable. Doctors and hospitals may argue that it is not reckless because the practice is necessary in gaining medical expertise. Conversely, patients’ families may contend that while training is necessary, so too is consent.

The second issue is whether performing intubation training on the newly dead is so outrageous as to be intolerable to a civilized community. Hospitals could find support in \textit{Lacy} to argue that their conduct is not outrageous. They might argue that the conduct is required in a society that demands skilled medical professionals. Plaintiffs, on the other hand, will rely on the recognized importance of respect toward the dead, and the ensuing need for consent. Plaintiffs also may cite studies suggesting that there are enough people willing to consent to provide adequate learning opportunities.\textsuperscript{62}

The third element requires a showing that the practice of intubation is the proximate cause of the emotional distress. While medical personnel may argue that the death alone was the cause of the family’s distress, a court would not be unjust in siding with plaintiffs’ in their claim of proxi-

\textsuperscript{59} \textit{Id.} at 1035. The hospital “has a duty to meet the standard of care reasonably to be expected of [one] dealing with corpses.” \textit{Id. But see} Fuller v. Marx, 724 F. 2d 717, 719 (8th Cir. 1984) (finding “[u]nder Arkansas law, damages for emotional distress caused by negligence are not recoverable unless accompanied by physical injury”).

\textsuperscript{60} \textit{Lacy}, 745 F. Supp. at 1032.

\textsuperscript{61} \textit{Id.} at 1036.

\textsuperscript{62} See Benfield et al., \textit{supra} note 16, at 2360; Robert M. McNamara et al., \textit{Requesting Consent for an Invasive Procedure in Newly Dead Adults}, 273 \textit{JAMA} 310, 310 (1995).
mate cause; the court might find the training performed on the deceased patient's body, and not the patient's death, was the cause of the emotional distress. To successfully assert a claim of proximate cause, a plaintiff must convince the court that the emotional distress resulting from nonconsensual intubation training is unbearably severe. The court's perception of the severity of the injury is pivotal to the decision. While medical personnel could attempt to convince the court of the necessity and relative insignificance of the actions, there are many public policy arguments discussed below that support the plaintiff family's claim of unbearable emotional distress.

Plaintiffs may also make a strong case that the nonconsensual practice of intubation on their deceased loved one constitutes negligent infliction of emotional distress. Doctors and hospitals have a duty to respect the wishes of deceased patients' families, and must prove that they also have fulfilled the duty of treating the corpses with reasonable care. If plaintiffs can prove that intubation training occurred without their consent, then they have a strong argument that these duties were breached. Finally, plaintiffs could aver severe injury, based on the intense suffering they experienced upon learning that their loved one had been violated immediately following his or her death. A court could thus reasonably find in favor of a decedent's family on both intentional and negligent infliction of emotional distress claims.

b. Similarities to Cornea Removal Statutes

"The threat of criminal sanctions could be eliminated by the passage of new legislation expressly permitting the use of corpses for nondisfiguring training purposes." This suggestion is based upon a recent trend in state legislation; several newly enacted statutes now allow for the removal of the corneas of deceased persons under certain circumstances. Michigan's statute, which is similar to those of many states, dictates that cornea removal is permitted only when: an autopsy is authorized by the county medical examiner, the examiner has no knowledge of an objection to the cornea removal by the decedent's family, and the removal will not disfig-
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ure or alter the decedent's appearance. Under this and similar statutes, families have asserted claims for relief based on the removal of the deceased's corneas without their consent. Although the courts have struggled with these cases, their decisions have resulted in the majority of families being forced to leave the courtroom empty handed. An examination of the issues presented in these cases is useful in determining potential causes of action available to a family for nonconsensual tracheal intubation, and also may be helpful in forecasting how such claims would fare.

In State v. Powell, a decedent's family brought an action attacking Florida's cornea removal statute, § 732.9185. This statute is more restrictive than the generally sketched guidelines above. It permits the removal of the corneas only when an eye bank has requested the cornea for transplant, the decedent is under the jurisdiction of the medical examiner, and an autopsy is required by law. Significantly, the statute releases the examiner from all criminal and civil liability for failure to obtain consent. The plaintiffs in Powell claimed no notice had been provided nor had consent been requested prior to the wrongful removal of their son's corneas.

The plaintiffs set forth five legal arguments in their pursuit for relief. First, they attacked the statute as an unconstitutional expansion of legislative power. In rejecting this argument, the court stated: "[W]e recognize that a legislative act carries with it the presumption of validity and the party challenging a statute's constitutionality must carry the burden of establishing that the statute bears no reasonable relation to a permissible legislative objective." The court discussed the importance of the

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68. See supra notes 70-99 and accompanying text. See also Georgia Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d 127 (Ga. 1985) (upholding cornea removal statute as constitutional despite plaintiff's claim that her deceased infant's cornea tissue was removed without notice or opportunity to object).
69. But see Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991) (allowing recovery for plaintiff, whose husband's corneas were removed without her consent, under 42 U.S.C. § 1983).
70. 497 So. 2d 1188 (Fla. 1986).
71. Id. at 1190.
73. Id. § 732.9185.
74. Powell, 497 So. 2d at 1190.
75. Id.
76. Id. (citing Johns v. Mays, 402 So. 2d 1166, 1169 (Fla. 1981)).
goals of the statute. In addition, the court pointed out that the number of people who have benefitted from the cornea transplants under the statutorily permitted removal has increased vastly in comparison to the voluntary donation system in place prior to the statute’s enactment. The court further stated that the removal of corneas is a minor intrusion with minimal lasting traces as compared with autopsy procedures. Based on those facts, the court was comfortable in upholding the constitutionality of the statute; it implied that the immense benefits to society outweigh the minor personal sacrifice.

The second claim advanced was one of property rights, and like the Court of Special Appeals of Maryland in Snyder v. Holy Cross Hospital, the Florida Supreme Court declared that there are no property rights in the body of a deceased family member. In refusing to find an elevated “quasi” property right, Powell held that the rights of the next of kin are

77. Id. at 1190-91.
78. Id. at 1191. Prior to the statute’s enactment in 1977, only 500 corneas in Florida were obtained for transplant in 1976. In 1985, after the statute was enacted, 3,000 were made available. Additionally, many corneas obtained prior to the statute’s enactment were unusable due to the advanced age of most donors. In 1985, approximately 80-85% of the corneas obtained were suitable for transplant. Id. at 1191.
79. Id.
80. Id.

'The preservation of the public health is one of the duties devolving upon the State as a sovereign power. In fact, among all the objects sought to be secured by governmental laws, none is more important than the preservation of the public health'. . . . 'Health regulations are of the utmost consequence to the general welfare; and if they are reasonable, impartial, and not against the general policy of the State, they must be submitted to by individuals for the good of the public, irrespective of pecuniary loss.'

Georgia Lions Eye Bank, 335 S.E.2d 127, 129 (quoting Abel v. State, 13 S.E.2d 507 (Ga.Ct.App. 1941)). But see Brotherton v. Cleveland, 923 F.2d 477, 482-83 (6th Cir. 1991). While the court found the statute contained "intentional ignorance" to bypass the consent requirement, and would not tolerate this, the dissent argued that the value to society outweighs any other interests as there are no property rights in the body. Id.
82. Powell, 497 So. 2d at 1191.

It is recognized universally that there is no property in a dead body in a commercial or material sense. '[I]t is not part of the assets of the estate (though its disposition may be affected by the provision of the will); it is not subject to replevin; it is not property in a sense that will support discovery proceedings; it may not be held as security for funeral costs; . . . it is not common law larceny to steal a corpse. Rights in a dead body exist ordinarily only for purposes of burial and, except with statutory authorization, for no other purpose.'

Snyder, 352 A.2d at 340 n.12 (quoting P.E. Jackson, The Laws of Cadavers and of Burial and Burial Places (2d ed. 1980)).
limited to possession of the body for purposes of burial. The third claim addressed was whether § 732.9185 acted as a “taking” of private property by state action for a non-public purpose in violation of the Florida Constitution. The court rejected this claim because of its earlier finding that there is no property at issue. Plaintiffs may have common law rights in support of a tort action. A loss of these rights, however, is not the equivalent of a constitutional taking and does not necessarily constitute a substantive due process violation.

The plaintiff’s fourth claim was that their right to control the remains of their deceased child constitutes a “fundamental right of personal liberty protected against unreasonable government intrusion by the due process clause” of the United States Constitution. In relying on a series of Supreme Court decisions, the plaintiffs attempted to equate their interest in the deceased patient’s body to the privacy rights already recognized under the due process clause. The court rejected this attempt, distinguishing constitutionally protected fundamental rights, from the family’s ordinary right “to a tort claim for interference with burial.” It emphasized that in the area of public health, some government intrusion on individual privacy will be tolerated.

Finally, plaintiffs argued to overturn the statute, claiming that it violated the equal protection clause by invidiously discriminating against the next of kin in cases where autopsies were required by law. The court rebuffed this attack by drawing support from the Supreme Court and concluding that some statutes inevitably will treat some people differently than others.

Although the court held that § 732.9185 is constitutional, the majority

83. Powell, 497 So. 2d at 1192. See also Georgia Lions Eye Bank, 335 S.E.2d at 128. But see Brotherton, 923 F.2d at 479. Plaintiff claimed a violation of due process under the Fourteenth Amendment, and the court found the necessary elements were present for such claim: “(1) [d]eprivation, (2) of property, (3) under color of state law.” Id.
84. Powell, 497 So. 2d at 1192.
85. Id.
86. Id.
87. Id. at 1193. Plaintiffs wanted the court to evaluate the statute under strict scrutiny, arguing that it infringed on a fundamentally protected right of family privacy. Id.
88. Id. The plaintiffs cited a string of Supreme Court cases which protect free choice in fundamental decisions found to be important to the family. Id.
89. Id. See generally Roe v. Wade, 410 U.S. 113, 152 (1973) (holding that “only personal rights that can be deemed fundamental or implicit in the concept of ordered liberty . . . are included in [the] guarantee of personal privacy”).
90. Powell, 479 So. 2d at 1193.
91. Id.
92. Id. (quoting Parham v. Hughes, 441 U.S. 347, 351 (1979)).
realized the sensitive nature of the issues involved and invited the legislature to reevaluate the statute in light of public policy concerns:

[W]e note that laws regarding the removal of human tissues for transplantation implicate moral, ethical, theological, philosophical, and economic concerns which do not readily lend themselves to analysis within a traditional legal framework. Applying constitutional standards of review to section 732.9185 obscures the fact that at the heart of the issue lies a policy question which calls for a delicate balancing of societal needs and individual concerns more appropriately accomplished by the legislature.93

Judge Shaw wrote a strong dissent arguing for the elevation of the next of kin's rights.94 Judge Shaw took the position that the families' interests are protected as religious, liberty, and property rights under the Florida Constitution.95 Judge Shaw also pointed to § 732.9185(1)(b) which recognizes a families' right to prevent the donation of a decedent's cornea.96 His conclusion was that this legislative grant of the power to object must have been based on a right of control by the family.97 He expressed concern that the majority was speaking with its heart based on its desire to provide the blind with opportunities to see, yet was straying from the letter of the law.98 Judge Shaw's dissent reflected concern that at a time of once unimaginable medical advancements, the majority cast a severe blow to personal autonomy and individual rights.99

In contrast to Powell, the decedent's wife in Brotherton v. Cleveland was successful in bringing a 42 U.S.C. § 1983 claim in federal court for the wrongful removal of her husband's corneas.100 The Ohio statute in question, Ohio Revised Code Annotated § 2108.60, is similar to that in Powell.101 The Sixth Circuit in Brotherton found: a) deprivation, b) of

93. Powell, 479 So. 2d at 1194.
94. Id. at 1195 (Shaw, J. dissenting). See also Georgia Lions Eye Bank v. Lavant, 335 S.E.2d 127, 129 (1985) (Marshall, J. dissenting) (arguing that the cornea removal statute fails to give adequate notice and opportunity to object, and is therefore violative of due process).
95. Powell, 497 So. 2d at 1198.
96. Id.
97. Id.
98. Id.
99. Id.
101. OHIO REV. CODE ANN. § 2108.60 (Anderson 1994); FLA. STAT. ANN. § 732.9185 (West 1995). Both statutes permit the removal of the corneas of decedents when: an autopsy is required by law, the removal will not interfere with the autopsy, and the coroner or medical examiner has no knowledge of objection. Both statutes protect those removing
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In struggling with the property analysis, the court declared that "[a]lthough the existence of an interest may be a matter of state law, whether that interest rises to the level of a ‘legitimate claim of entitlement’ protected by the due process clause is determined by federal law." The court went on to find the bundle of rights held by the plaintiff under Ohio statutory and case law was substantial enough to support her claim. Eager to attack the failure of the Ohio statute to adequately ensure consent, the majority found that the law induced "intentional ignorance" on the part of the persons removing the corneas, and held that the interests of the next of kin are important enough to justify ensuring consent.

Four years after *Brotherton*, the Sixth Circuit, in *Whaley v. County of Tuscola*, revisited the question of whether decedent’s relatives were deprived of their Fourteenth Amendment rights to procedural due process when Michigan state medical examiners removed a decedent’s corneas or eyes without prior consent. The court found that "Michigan [law] recognizes the same basic rights in a deceased person’s body as Ohio, [and therefore] *Brotherton* controls." In concluding that the plaintiffs did have an actionable right to the deceased relative’s body, the court relied on a combination of state statutory and common law to justify this implied right.

the corneas from civil and criminal liability based on a lack of consent, as long as they act in good faith and without knowledge of objection. Neither statute mandates that the person removing the corneas must attempt to obtain consent; instead the concern is only with known objections.

102. *Brotherton*, 923 F.2d at 479-82.

103. *Id.* at 481-82 (citing Memphis Light, Gas & Water Div. v. Craft, 436 U.S. 1, 9 (1978)).

104. *Brotherton*, 923 F.2d at 482.

105. *Id.*

106. 58 F.3d 1111 (6th Cir. 1995).

107. *Id.* at 1112. The court acknowledged that the Fourteenth Amendment is only relevant when a state deprives a person of life, liberty, or property without due process of law. So the question here is "whether the next of kin have a property interest in the body, including the eyes, of a deceased relative." *Id.* at 1113.

108. *Id.* at 1114. "The Supreme Court of Michigan has repeatedly held that the next of kin ‘are entitled to possession of the body as it is when death comes, and that it is an actionable wrong for another to interfere with that right by withholding the body or mutilating it in any way.’" *Id.* at 1115 (quoting Doxtator v. Chicago & W. Mich. R.R., 79 N.W. 922 (Mich. 1899)).

109. *Id.* at 1114-15. The court found that Michigan law grants the next of kin virtually the same rights as does Ohio, and therefore *Brotherton* and its acknowledgement of a
While it is uncertain how a court would treat claims of criminal or civil violations against doctors or hospitals for non-consensual intubation training, the possibilities of guilt and conviction are very real.\textsuperscript{10} Powell suggests that a statute allowing intubation training without consent could be upheld on the basis of legitimate state interests over a non-disfiguring procedure.\textsuperscript{11} In the absence of such a statute, however, the threat of criminal sanctions is not eliminated. Under current law, hospitals and doctors continuing to train on newly deceased patients without the family's consent are risking legal recourse.

III. Public Policy

The legality of nonconsensual resuscitation training on the newly dead is purely speculative; thus, it is valuable to consider public policy arguments that may bear on a court's decision. These factors, when weighed in their entirety, provide strong support for requiring medical personnel to obtain consent prior to taking liberties with newly deceased patients.

A. Availability and Need for Consent

One major factor to consider when evaluating the appropriateness of using newly deceased patients to teach intubation skills is the evidence that consent can be obtained in a majority of situations.\textsuperscript{12} Dr. Benfield and his colleagues at the Regional Neonatal Intensive Care Unit at Children's Medical Center in Akron, Ohio, performed a study to evaluate the responses of families of newly deceased infants when consent was requested to intubate the child's body for teaching purposes.\textsuperscript{13} The results indicated that seventy-three percent of the families who were asked granted permission for the procedure.\textsuperscript{14}

\textsuperscript{110} See, e.g., Campbell, supra note 35, at 35.
\textsuperscript{111} 497 So. 2d 1188 (Fla. 1986). See also infra notes 70-93 and accompanying text.
\textsuperscript{112} Benfield et al., supra note 16, at 2360; McNamara et al., supra note 62, at 310.
\textsuperscript{113} Benfield et al., supra note 16, at 2360.
\textsuperscript{114} Id. The Regional Neonatal Intensive Care Unit (NICU) at Children's Medical Center in Akron, Ohio, is a specialized facility for treatment of severe neonatal complications. Id. Dr. Benfield's study was designed to examine both the usefulness of intubation training, as well as the procedure for ensuring consent. Id. The study lasted from Septem-
Dr. McNamara and his colleagues conducted a similar study at the Medical College of Pennsylvania. Families of newly deceased adults were asked to consent to the teaching of retrograde tracheal intubation. This procedure, used when traditional intubation fails, is more invasive because a tube is threaded into the trachea through a hole punctured in the cricothyroid membrane. This study found that fifty-nine percent of the families were willing to consent to the teaching procedure.

The studies reveal that death of a family member commonly is a stressful experience, not only for families but for doctors and trainees as well. These feelings of apprehension and discomfort are intensified when the newly deceased patients are used in clinical training without family consent. Therefore, easing the minds of medical trainees, not...
just families, is yet another reason to require consent.

Those who favor the continuation of using newly deceased patients as teaching tools despite a lack of consent offer several sound, though unconvincing, reasons in support of their conviction. One argument relies strictly on the need to educate physicians in this procedure; some doctors argue that the need is so acute that it warrants an exception to informed consent. Others feel that the procedure is just not invasive enough to require consent. Others still say the social benefits, lack of risk to the deceased patient, and minimal likelihood of upsetting the family mandate an exception to requiring consent. Simply balancing both sides of the argument and coming out in favor of medical advancements over sentiment is yet another approach.

1. Proposed Alternatives to Consent

One suggestion that has been made is to have the patient or the patient's parents sign a blanket permission form when admitted to the hospital or ICU, rather than asking for consent after a patient has died. This policy could serve as a sufficient legal safeguard, but the drawbacks are that it is both under and overinclusive.

The proposal is underinclusive because it does not account for patients who enter the hospital as emergency cases, or who experience sudden changes, turning a routine condition suddenly into a critical, life threatening one. These patients might not have the opportunity to sign a blanket consent form either because they arrive at the hospital already unable to consent, or because their hospital stay begins because of a condition so

122. Orlowski et al., supra note 2, at 441.
123. Burns et al., supra note 2, at 1652. In contrast, others argue that any intervention upon the body of a newly deceased patient warrants family consent. Stryker, supra note 6, at 396. "Entry into the bodily sanctuary without both special authorization and a profound purpose (saving life, restoring quality of life) constitutes intrusion." Campbell, supra note 35, at 35.
124. Burns et al., supra note 2, at 1653.
125. Feinberg, supra note 6, at 35.
126. Kolata, supra note 121.

To be sure persons sometimes need to "learn how to shudder," but it is even more commonly the case that people have to learn how not to shudder. Newly dead bodies cannot be made live again, nor can they be made to vanish forever in a puff of smoke. . . . [M]edically useful practices need not be done crudely, indiscreetly, or disrespectfully. They are the work of professionals and can be done with dignity.

Id.
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minor that it does not justify contemplating death and presenting the consent form. Arguably, this is an extremely important group, as it is in these types of critical situations that resuscitation procedures most often are required; consequently, the medical professionals working in this area are in the most need of competence in these extreme procedures.127

The blanket permission form is overinclusive because while it may be unnecessary to teach resuscitation techniques on every person who dies in the hospital, the form should be given to all patients, as standard procedure, so that hospital personnel do not have to guess who most likely will die shortly in their determination of who to provide a form. Furthermore, in the name of time and cost management, the form should be an all-or-nothing type of release, granting consent to the practice of even the most extreme procedures if the opportunity were to arise. The amount of detail that necessarily must be included in such a release may, however discourage patients from consenting to any form of teaching use of their body.

Another proposed alternative to requesting consent of the family is to adopt a strategy that presumes consent.128 Advocates of this approach argue that once the practice is disclosed to the public, making them aware of the needs and benefits of such training, "potential patients will be able to refuse the procedure by advance directive."129

Aside from the fact that presumed consent on its face is an "ethically problematic concept,"130 this solution suffers under scrutiny for several reasons. First, it is unreasonable to assume that, prior to the need for hospitalization, patients and their families will be aware of the practice of using newly deceased patients as teaching devices. Due to this potential lack of awareness, the practice is too controversial to relieve the medical profession of the duty of ensuring specific informed consent.131 The vast number of deaths that result directly from emergency situations further complicates the issue. Emergency patients often die suddenly, and they may never have considered granting permission to use their bodies as teaching tools. Yet, in spite of that possibility, their silence would be read as consent. Second, many people hold religious convictions that oppose

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127. Burns et al., supra note 2, at 1653; McNamara et al., supra note 62, at 312.
128. Letter from Guttorm Brattebo et al., to Editor, 274 JAMA 128, 129 (1995). See also Orlowski, supra note 2, at 441.
129. Brattebo et al., supra note 128, at 129.
130. Orlowski et al., supra note 2, at 440.
131. Intubation certainly is less invasive than organ donation or an autopsy; however, the fact that presumed consent is not accepted in those instances indicates a societal rejection of such a liberal approach. See Stryker, supra note 6, at 396.
any use or disturbance of the bodies of the dead. Respect of their wishes could be guaranteed only by specific consent.

Finally, philosophically, by implying consent in the absence of a clear indication from the patient, people who want to actively help medicine are denied the opportunity to make a freely given "gift." Weighing voluntary organ donation against routine organ salvaging through presumed consent, ethicist Paul Ramsey argued that "[the routine taking of organs would deprive individuals of the exercise of the virtue of generosity."

Ramsey found that the symbolic value in "giving" would tip the scale toward a voluntary, consent driven system, despite the vast social benefits that would result from routine "salvaging."

The shortcomings listed above demand that doctors request consent from the families of deceased patients prior to, and directly in contemplation, of the specific procedures to be practiced. While the moment of the request may be an awkward and uneasy one for both doctors and families, the thought of hospitals taking liberties with deceased patients' bodies certainly seems more unnerving.

B. Need for Trained Personnel

The importance of timely and successful intubation on a living patient cannot be minimized. If the procedure is performed incorrectly, precious time is lost and death may result needlessly. Proponents of the practice of intubation on deceased patients argue that it is the only method by which medical trainees can adequately learn the procedure. They further argue that mannequins, animals, and even cadavers fail to

\begin{footnotes}
\footnote{132. See \textit{id}. See also infra notes 185-192 and accompanying text.}
\footnote{133. \textsc{Paul Ramsey, The Patient as Person: Explorations in Medical Ethics} 210, 214 (1974). Ramsey's article discusses organ donation and salvaging, but by consenting to intubation practice, the deceased's body similarly has been given to science. \textit{id}.}
\footnote{134. \textit{id.} at 210.}
\footnote{135. \textit{id.} Ramsey observed: "A society will be a better human community in which giving and receiving is the rule, not taking for the sake of good to come." \textit{id.}}
\footnote{136. Orlowski et al., \textit{supra} note 2, at 439. See also Brattebo et al., \textit{supra} note 128, at 128.}
\footnote{137. Orlowski et al., \textit{supra} note 2, at 439. When intubation is performed incorrectly, usually due to a lack of experience or skill, there are several risks. \textit{id}. The primary risk is failure to revive a patient who may otherwise be resuscitated, but there is also the very real possibility of unnecessary "precipitation of respiratory arrest or death." \textit{id}. Additionally, "unskilled attempts at intubation may so damage and distort the victim's anatomy that subsequent attempts by skilled and competent persons, to save the patient's life" may prove futile. \textit{id.}}
\footnote{138. Brattebo et al., \textit{supra} note 128, at 128.}
serve as adequate substitutes for a living or recently dead body.\textsuperscript{139} Newly deceased patients also are ideal because there are no risks to them.\textsuperscript{140}

One basic objection to this rationale is that although the concerns may be genuine, they still do not justify bypassing consent.\textsuperscript{141} Doctors in favor of the practice do support some restrictions, such as only permitting non-mutilating procedures,\textsuperscript{142} but this does not respond adequately to concerns regarding consent.

One physician, Dr. Robert Matz, takes the position that the need for intubation training, and its ultimate use in the field, is not nearly as dire as others have indicated.\textsuperscript{143} He suggests that emergency intubation should be done only by "extremely skilled personnel," and proposes that a less demanding "bag-and-mask" technique of ventilation would provide adequate air passage for patients in most instances.\textsuperscript{144} This argument, supporting the elimination of intubation practice on newly deceased patients, invites attack, however, because as he acknowledged, ventilation is not always an appropriate alternative to intubation.\textsuperscript{145} His suggestion fails to explain how anyone could receive adequate intubation training. Dr. Orlowski questions, "where [are] personnel who are skilled in intubation techniques and who have 'long years of practice'... going to come from in the future."\textsuperscript{146} One possible response to Dr. Orlowski's concern

\textsuperscript{139} Orlowski et al., \textit{supra} note 2, at 439. Many doctors find the real anatomy and precise degree of tissue resilience of a newly deceased patient impossible to mimic in any model. Brattebo et al., \textit{supra} note 128, at 128. Others see only limited value in working with mannequins because their heads "offer[ ] an experience that differs markedly from that of intubating live or newly dead structures." Benfield et al., \textit{supra} note 16, at 2361. In Ohio, trainees practiced on cats, but due to "rapidly rising costs, complex federal regulations, and the possibility of adverse publicity from animal rights activists," the practice was terminated. \textit{Id.}

\textsuperscript{140} Burns et al., \textit{supra} note 2, at 1653. Autopsies performed on newly deceased, intubated infants revealed no significant damage to the airway distinguishable from that caused by respiratory measures taken while the child was living. Benfield et al., \textit{supra} note 16, at 2362.

\textsuperscript{141} "Sustaining life is an urgent argument for any measure, but not if that measure destroys those very qualities that make life worth sustaining." Willard Gaylin, \textit{Harvesting the Dead, in} Bioethics: Basic Writings on the Key Ethical Questions that Surround the Major, Modern Biological Possibilities and Problems 413, 423 (Thomas A. Shannon ed., 1976).

\textsuperscript{142} Burns et al., \textit{supra} note 2, at 1654.


\textsuperscript{144} \textit{Id.}

\textsuperscript{145} Orlowski et al., \textit{supra} note 20, at 397 (indicating that "bag and mask" ventilation also requires special training, and that intubation may still be preferable because of the benefits it produces).

\textsuperscript{146} \textit{Id.}
is that the skills might be obtained through training sessions performed on newly deceased patients after family consent has been secured.

C. Societal Interests

Advocates who support the position that family consent is *not* necessary believe that society’s interests may, at times, prevail over the interests of the individual.\(^{147}\) The general population will benefit from better trained medical personnel; thus according to their argument, an individual’s right to consent or withhold consent must, at times, be compromised.\(^{148}\) Dr. Orlowski further implies that society’s needs are even more dominant when the “individual” is no longer living.\(^{149}\) This position mirrors an “ends justifies the means” philosophy\(^ {150}\) because the technique of tracheal intubation is minimally invasive and the benefit to society is immense.\(^{151}\) Some doctors argue that although respect for the dead is important, “one had better not sentimentalize the newly dead body as a symbol of the deceased at the expense of real ‘people out there suffering.’”\(^ {152}\)

\(^{147}\) Id. at 396; Orlowski et al., *supra* note 2, at 440-41; Burns et al., *supra* note 2, at 1653.

\(^{148}\) Orlowski et al., *supra* note 2, at 441 (noting, however, that the patients would have an opportunity to object through advance directive and information regarding the procedure).

\(^{149}\) Id.

“One may never use another person for one’s own purposes.” This principle is universal in scope (it excludes no one) and absolute in application (there are no exceptions). However, its application assumes that one is a person. A dead body is no longer a person. Even though corpses must be respected because they were once living persons, the obligation of respect has less force than when it is applied to living persons. In the case of intubating newly dead bodies, the respect is limited to avoiding disfigurement or ridicule of the cadaver. *Id.* (citation omitted).

\(^{150}\) Michael J. Newton, *Moral Dilemmas in Surgical Training: Intent and the Case for Ethical Ambiguity*, 12 J. MED. ETHICS 207, 207 (1986) (suggesting that some medical trainees believe that “the individual’s right to the best available care can be subordinated to the more general need for skilled physicians in the future”). Dr. George Kanoti, Chairman of the Department of Bioethics at Cleveland Clinic Foundation argues that it is ethical to use a body to teach intubation without consent “if the family [can] not be found in time.” *Kolata, supra* note 121, at A22. Kanoti acknowledges the controversial stance he is taking, yet he argues that sometimes individual rights must be compromised for the social good. *Id.*

\(^{151}\) See *supra* notes 147-49, and accompanying text.

\(^{152}\) William F. May, *Religious Justifications for Donating Body Parts*, HASTINGS CENTER REP., Feb. 1985, at 38. See also Feinberg, *supra* note 6, at 32. In addressing organ transplants, Feinberg comments:

[A] newly dead human body is a sacred symbol of a real person, but to respect the
Another commentator expressed her concern for the good of society in saying: "the individual has responsibilities of mutual aid and benefit toward the community, the rejection of which is a form of ingratitude and a denial of dependency." In this vein, proponents might ask, what better way to give something back to the community than allowing minimally invasive procedures that yield such positive results?

On the other hand, there are individuals with a deeply rooted fear of the sacrifice of personal rights in the name of the common good. One extreme expression of this fear is embodied in Willard Gaylin's poignant article, *Harvesting the Dead.* Gaylin envisions a futuristic "bioemporium" where row upon row of brain dead, but respirator supported, bodies, he calls "neomorts," would be maintained and put to various medical uses. The neomorts would serve not only as training, testing, and experimentation tools, but would also be "harvested" for various commercially marketable materials such as blood, bone marrow, and organs.

Gaylin predicts that neomorts dramatically would enhance medical training and research while at the same time benefitting innumerable patients. In addition, he argues that the bioemporiums would not only pay for themselves through commercially profitable enterprises, but would also decrease dramatically what today have become exorbitant health care expenses. Undoubtedly, Gaylin's "Brave New World" type of vision is shocking to the conscience, even for Gaylin himself:

And yet, after all the benefits are outlined, with the lifesaving potential clear, the humanitarian purposes obvious, the technology ready, the motive pure, and the material costs justified how are we to reconcile our emotions? Where in this debit-

symbol by banning autopsies and research on cadavers is to deprive living human beings of the benefits of medical knowledge and condemn unknown thousands to illnesses and deaths that might have been prevented. That is a poor sort of "respect" to show a sacred symbol.

*Id.* He also brings up an interesting question in the context of organ donation as to whether a dying person or his next of kin should or do have the legal right to deny another the use of his organs after he has died a natural death. *Id.*
credit ledger of limbs and livers and kidneys and costs are we to weigh and enter the repugnance generated by the entire philanthropic endeavor?\textsuperscript{161}

While his scenario can be disregarded as clearly science fiction, and something that we would never resort to in our "civilized society," a recent real life occurrence in California serves as a reminder of the fine line between societal good and the breakdown of moral ethics.

In 1978, in an effort to more accurately measure the degree of passenger protection in automobiles, researchers, with the consent of the next of kin, used human cadavers in the place of crash test dummies.\textsuperscript{162} Upon learning of this practice, a California congressman forwarded "an angry letter to the Secretary of Transportation charging that 'the use of human cadavers for vehicle safety research violates fundamental notions of morality and human dignity, and must therefore permanently be stopped.'"\textsuperscript{163} Despite the Department's protest that banning this practice would "set back" safety protection progress, the use of cadavers was discontinued permanently.\textsuperscript{164} Interestingly, the events in California suggest that even with family consent, there are some practices that an ethical society will not accept, no matter what the benefits may be for society.

\textbf{D. Doctors: Protecting Patients, Society and Themselves}

Some argue that only in emergency situations can doctors justify performing invasive procedures without consent.\textsuperscript{165} The rationale is that the urgency excuses the need for securing consent prior to acting.\textsuperscript{166} There are no "life threatening" concerns with a deceased patient, and thus consent should be a prerequisite to teaching intubation on their bodies.

Another argument against the sacrifice of individual interests in the name of society is based upon the fear that a blanket excuse will result in medical practitioners and lay citizens alike losing sight of their ethical responsibilities to humanity.\textsuperscript{167} Arguably, bypassing consent prior to invading the human body may start the medical profession, and society in

\begin{itemize}
  \item \textsuperscript{161} \textit{Id.} at 421.
  \item \textsuperscript{162} Feinberg, \textit{supra} note 6, at 31.
  \item \textsuperscript{163} \textit{Id.}
  \item \textsuperscript{164} \textit{Id.}
  \item \textsuperscript{165} Abramson, \textit{supra} note 11, at 2829.
  \item \textsuperscript{166} \textit{Id.}
  \item \textsuperscript{167} Newton, \textit{supra} note 150, at 209. In discussing the ethics of surgical training on patients, Michael Newton is certain that the ability to act correctly is dependant on an individual's personal sense of ethical intent, and not on external authority or fear of rule violation. \textit{Id.} He fears that by granting unchecked authority to act for the good of society,
general, down a path ultimately leading to the dehumanized environment depicted in Gaylin's bioemporiums. Advocates of pulling back the reins warn, "'act so that you treat humanity . . . always as an end and never as a means only.'"\textsuperscript{168}

One justification for an exception to the requirement of informed consent is the idea that, in asking, doctors would "violate the moment."\textsuperscript{169} At a time of emotional trauma physicians do not want to offend the family or add to their grief.\textsuperscript{170} Requesting consent arguably could make a bad situation worse; however, Dr. Benfield's study reported no such results: "We did not observe any unusual family reactions to suggest that our requests for consent might have been emotionally upsetting or harmful in other ways."\textsuperscript{171}

Dr. William Meadows, a neonatologist and ethicist at the University of Chicago, argues that requesting consent of a family who has just suffered the death of their infant would simply be too insensitive.\textsuperscript{172} Interestingly, it is not clear who the request would be more stressful for—the family or the doctor. Some physicians acknowledge that requesting consent to perform teaching exercises on newly deceased patients puts them in an uncomfortable position, and that they would prefer not having to approach the family with the request.\textsuperscript{173} The fact that physicians would rather not have to approach the family is not a justification for bypassing consent. If consent is required, then the doctors will simply have to reckon with this difficult part of their jobs.

Doctors Tachakra, Robinson, and Mitchell, of London, England, suggest that requesting consent may be inappropriate for doctors in an emergency room setting.\textsuperscript{174} The reasoning behind this is that they do not have physicians may be tempted to hide behind this shield instead of grappling adequately with the ethical questions involved. \textit{Id.}

\textsuperscript{168} \textit{Id.} at 208.

\textsuperscript{169} Kolata, \textit{supra} note 121, at A22 (quoting Dr. William Meadows, neonatologist and ethicist at University of Chicago).

\textsuperscript{170} Orlowski et al., \textit{supra} note 2, at 440. "[M]any health care providers will not approach a patient or family to obtain consent because they consider it inappropriate and insensitive to do so." \textit{Id.}

\textsuperscript{171} Benfield et al., \textit{supra} note 16, at 2362. Similarly, in Dr. McNamara's study, unfavorable response to the consent request was noted in only 18 of 44 instances. In several cases families were positive, finding a sense of worth in an otherwise tragic occurrence. McNamara et al., \textit{supra} note 62, at 311.

\textsuperscript{172} Kolata, \textit{supra} note 121, at A22.

\textsuperscript{173} \textit{Id.} \textit{See also} Benfield et al., \textit{supra} note 16, at 2363.

\textsuperscript{174} Tachakra et al., \textit{supra} note 120, at 1649.
time to develop a rapport with the patient’s family. Dr. Benfield’s study shows, however, that of the families who gave consent to use their newly deceased infants, thirty-eight percent of the infants died within ten hours after admission to the ICU, and twelve percent died within two hours. Several of those families granted consent even over the phone. This evidence suggests a lack of correlation between duration of the doctor-patient relationship and a family’s willingness to consent.

In another study by Dr. McNamara, three medical personnel who spoke with families of newly deceased patients were asked to rate their own level of comfort in requesting the consent. The two physicians studied reported feeling comfortable ninety-six percent of the time, whereas the one student nurse studied felt comfortable only eleven percent of the time. Interestingly, although she felt uneasy making the request, the student nurse was able to secure consent fifty-five percent of the time. The conclusion may be drawn that requesting consent may not be “easy,” but this fact does not necessarily bear on whether consent ultimately will be granted.

Another reason for requiring consent prior to using newly deceased patients for teaching intubation is to combat mistrust of the medical profession. No one can deny the importance and contributions of the work of physicians, yet a tenor of skepticism toward the profession historically has permeated society. The combination of doubt and fear is sure to be aggravated when evidence suggests that doctors are not disclosing information, or even worse, that they are taking medical liberties with patients without first obtaining consent.

Doctors who support the consent requirement realize that the whole issue presents risks to their reputation, and they argue that in order to protect their profession from further erosion of trust in the eyes on the public, they must secure the family’s acceptance before using a deceased

175. Id. But see Benfield et al., supra note 16, at 2362. Some health practitioners report increased emotional difficulty when intubating a patient they have treated for some time. Id. This suggests that anonymity or a less intimate relationship with the patient and family could actually ease the emotional stress of the situation. Id.


177. Id.

178. McNamara et al., supra note 62, at 311.

179. Id.

180. Id. One doctor reported a success rate of 70%, and the other, 33%. Id.

181. Stryker, supra note 6, at 396.

182. See supra notes 6-8 and accompanying text.
The results of Dr. Gary Benfield's study imply that people want to trust and to assist physicians—as is evidenced by the large number of families who did consent when asked, and by the "common theme" expressed by consenting families of a willingness to consent "if it will help [physicians] to help other babies in the future." In order to maintain this willingness, families must feel that their consent is necessary prior to doctors performing any procedures.

E. Respect for Religious Convictions

Although the tenants of many religions view the body as sacred, a temple, a sanctuary, or a gift "on loan" from God, the treatment of the body with reverence is not unique to religious faith. Societal beliefs in general, regarding the sacredness of the human body, command that it be treated with dignity and forethought. The effect a medical procedure has on the integrity of the body is tantamount in the deliberation regarding its value. "The body commands a form of respect or reverence independent of the instrumental uses to which it may be put." This moral expectation continues to exert itself after death. Consequently,

183. Burns et al., supra note 2, at 1653. See also Stryker, supra note 6, at 396. In discussing the use of brain-dead patients for teaching, Dr. Stryker expresses concern that if consent is presumed, then public confidence in the medical profession and in hospitals as institutions of healing will be at stake. Id. Dr. Guttorm Brattebo of Norway believes that in his country, the medical community has been reluctant to publicly acknowledge or discuss intubation teaching on the newly dead for fear of public criticism. Letter from Guttorm Brattebo et al., to Editor, 266 JAMA 1649, 1650 (1991). There is a fear that because biomedical research has become so commercialized, the research community has shifted its focus from healing, to a sophisticated business that takes advantage of individuals. Campbell, supra note 35, at 37.

184. Benfield et al., supra note 16, at 2361. Dr. Benfield's study found that 73% of the families consented when asked if their newly dead infants could be used to teach intubation. Id. at 2360. See Campbell, supra note 35, at 38. "'Your body, you know, is the temple of the Holy Spirit, who is in you since you received him from God. You are not your own property; you have been bought and paid for. That is why you should use your body for the glory of God.'" Id. (quoting 1 Cor. 6:19, 20).

185. Id. at 35; May, supra note 152, at 38-42.

186. Id. at 35; May, supra note 152, at 38-42.


188. Id. at 35.
the need for reverence cannot be separated out when contemplating the use of newly deceased bodies for teaching purposes.

The Christian Science religion denies all medical intervention, preferring the pursuit of spirituality over wellness of the physical body.\textsuperscript{189} In contrast, Lutherans hold as a matter of faith that life should be preserved, regardless of cost.\textsuperscript{190} Other Christian groups occupy a broad range of beliefs. Some believe that the self-donation sacrifice allows them to give entirely of themselves as Christ did.\textsuperscript{191} Others believe that it is necessary to preserve the body that God created in his own image in anticipation of resurrection.\textsuperscript{192} This wide spectrum of beliefs can only be honored properly by a medical profession that respects individual choice at every level of intervention. For this reason, intubation practices on newly deceased patients can coexist with all religious faiths only if informed consent is required and is granted by the patient’s family.

IV. Proposed Procedures

The interest of the medical profession in using newly deceased patients to teach resuscitation techniques and the right of the family to consent to such uses need not be at odds with each other. The two can coexist harmoniously through implementation of a structured policy. Hospitals should be required to ask families for consent and to restrict the practice itself to “structured learning sequence[s], rather than opportunistic and sporadic event[s].”\textsuperscript{193}

Families must be treated with compassion, and their refusal to consent must be accepted without debate or coercion, either stated or implied. In the interest of informing future patients and families of the request that

\begin{itemize}
  \item \textsuperscript{189} May, supra note 152, at 39.
  \item \textsuperscript{190} John A. Most, Autonomy and Rights: Dignity and Right, 11 J. CONTEMP. HEALTH L. & POL’Y 473, 475 (1995).
  \item \textsuperscript{191} May, supra note 152, at 42.
  \item \textsuperscript{192} \textit{Id.} at 41-42.
  \item In Jewish Law, except for a situation of saving a community or the act of saving another person’s life, it is not permissible to tamper in any way with another person’s body. . . . Rabbi Silverman of the “B’nai B’rith Hillel Foundation, University of Maryland,” stated that “Judaism is very, very strong and very adamant in maintaining the purification and the wholeness and completeness of the body. . . . God himself views the sanctity of a body, in its completeness it should be returned to the ground. . . . God takes the soul away, but the body is to remain in perfect condition and treated with the utmost respect, more so than one’s living body.”
  \item \textsuperscript{193} Burns et al., supra note 2, at 1654.
\end{itemize}
Better to Lay it Out on the Table

one day may be asked of them, health professionals should bring the issue to the public’s attention, as has been done recently with organ donation. This exposure would provide people with the occasion to consider how they would respond to such a request. If the actual situation subsequently were to present itself, then the family will have had the opportunity to consider whether or not to grant consent, and hopefully the request itself will not be met with shock or outrage.

If consent is granted, the resuscitation practice must be performed under close supervision, in an environment of solemnity and respect, and only by persons who need genuinely to learn and develop these skills. This training should be the last step in a structured educational program preceded by textbook study and practice on a mannequin or other substitute. When these requirements have been met, consent must then be secured for each type of resuscitation training to be practiced, and only those practices that would not mutilate the body should be requested.

V. Conclusion

Doctors and hospitals are violating patients’ families’ rights by invading, without invitation, the most sacred of all objects: the human body. While there are several medically appropriate and legitimate reasons for using newly deceased patients in resuscitation training, none can overcome the importance of first obtaining the families’ approval. In a society where biomedical technology is making remarkable strides, there persists a fear of the unknown that can be calmed only by ensuring informed consent. The medical profession must be concerned with its obligations to both the deceased patient as well as the family. “When the human body is invaded nonconsensually...[,] the injustice is not only to the body, but also to the person who has wrongfully been denied a voice in the matter.”

The importance of using newly dead patients in clinical training is undeniable. So, too, is the right of the family to grant or withhold consent to such use. In light of the possible legal consequences for hospitals and doctors, the evidence that families are often willing to consent to intubation training on newly deceased patients, and the policy arguments that demand consent, there is no need for the current trend of bypassing con-

194. See Orlowski et al., supra note 2, at 439; see also Burns et al., supra note 2, at 1654.
195. See Orlowski et al., supra note 2, at 439; see also Burns et al., supra note 2, at 1654.
196. Burns et al., supra note 2, at 1654.
197. Campbell, supra note 35, at 37.
sent to continue. If the suggested protocol from this article were implemented today, medical educators and citizens alike could feel confident that trainees are still getting the education they need, but not at the expense of informed consent.

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