

## Using the Newly Dead for Practising Resuscitation Procedures

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Using the recently dead to train a new generation of health care professionals in difficult procedures has gone on for many years. (Iserson, 1993) However because this is done behind closed doors, the public has generally been unaware of its existence. Debate has surfaced in the last ten years about whether consent should be obtained before this can be done. (Ardagh, 1997; Perkins & Gordon, 1994; Hayes, 1994; Iserson, 1994)

### Assumptions

We need to acknowledge that there are some techniques in medicine that are difficult to perform. Intubation and placing a central intravenous line are two such procedures that are often required in life-threatening situations when fast and effective treatment can be crucial to prevent the death of a patient. It is not appropriate to allow the necessary time for the instruction and practice of these techniques at the point of need when the patient's very life is dependent on the action of a practitioner skilled in resuscitation techniques. A poorly done technique by someone in training may place the patient's life in more jeopardy than a procedure done quickly and effectively by an expert. (Orlowski, Kanoti, & Mehlman 1988). Obviously there is a need in our society for people who have the necessary skills in resuscitation, but where should this new generation of people learn their skills?

Suggestions have been made that practitioners could use mannequins to hone their skills. However, many people feel that mannequins lack the necessary anatomical variability that naturally occurs in the community. Also mannequins are artificial and as such do not equate to living tissue; because of this they have limited use as a teaching resource. (Ardagh, 1997)

Using volunteers has been suggested as a way of getting more practice in these techniques. Consenting patients undergoing an anaesthetic prior to

surgery could be one source of teaching material. However other authors argue that these techniques are not without risk and may unnecessarily increase the dangers for these patients. (Ashby, 1996; Hayes, 1994; Ardagh 1997)

Many authors consider that the best way for physicians to master the skills necessary to take to the emergency situation remains practising resuscitation techniques on the recently dead. (Iserson, 1993; Perkins & Gordon, 1994) Within the first few hours following death, the anatomical structures will act much like the structures of those found in the living. The anatomy found in the recently dead will supply the variability that is required to match that which enters the emergency room. While we may be clear about the usefulness of cadavers for this purpose, questions arise about whether this practice should go on without the express consent of the deceased or representatives of the deceased?

### Arguments

Some of the arguments in this debate are as follows:

#### *1 Consent from the patient may be impossible and proxy consent from relatives may take too long*

Consent from the person may be useful in this situation. Many people may have altruistic views about the use of their body after death. The idea that in death their body might benefit the living lies behind the willingness of people to donate organs to others and to gift their bodies to medical schools for the purpose of medical teaching and research. However if a patient came into an emergency room unconscious and then subsequently died, consent from the patient would be impossible to get. The time taken to trace relatives may exceed the two or three-hour window of opportunity for which a cadaver can be used for the

purpose of practising resuscitation techniques. Following this time rigor mortis makes the use of a cadaver difficult. (Perkins & Gordon, 1994)

In the case of a recently dead neonate consent obviously cannot be obtained from the patient at any stage. We have no way of knowing what the wishes of this person would have been. However the parent or parents of this child will nearly always be available to ask for consent.

#### *2 Asking for consent would be too distressing for the relatives*

Distress is a common reaction to the death of a loved one and particularly so when it is the death of a newborn baby. Many people find that the death of someone young, who has not had an opportunity to experience life to the full, is especially distressing. Asking parents to consent to having their dead baby used to practise resuscitation measures could appear to compound the distress.

However relatives are currently asked if they would be willing to donate the organs of a dying or recently dead person, which is a much more invasive procedure than the the practising of intubation. Does the fear of causing distress prohibit clinicians from asking for the donation of organs? It could be said that if we can ask for the donation of organs, then surely we can ask for the use of a body for intubation practice.

However the difference between the donation of organs and the use of a body for teaching intubation raises more than just the invasive nature of the procedure. Many people agree to the donation of organs because a part of their loved one will live on after they have gone. For some people the donation of organs to help others is something good resulting from something considered to be bad. While there will be benefits for others from a health professional knowing how to intubate ef-

fectively the next critically ill person, these benefits may be considered less tangible than those resulting from the donation of an organ.

Distress of the family may be one reason that clinicians would not want to approach to ask families for permission for this procedure to be done. However avoiding asking relatives about the practice of intubation on a recently deceased loved one and doing the procedure behind closed doors may have more to do with the discomfort felt by health professionals than with fear of adding to the family's distress. An important question for health professionals is: are the motives of health-care workers in not asking for permission to use a body for intubation practice truly aimed to benefit the family, or are they really designed to relieve their own feelings of distress and discomfort in this difficult situation? Fear of distressing the family should not be used to cover-up for discomfort in the health professional.

### 3 *Consent is not likely to be given if asked*

In a review of the literature on this topic, some authors had completed surveys to discover the attitudes of people to the use of their relatives for practising intubation techniques. Brattebo et al (1993) states that 58 per cent of a random selection of Norwegians would give consent to the use of a close relative for practising intubation if that relative had died in hospital. McNamara et al (1995) found that when families of patients who had recently died were asked for consent for the use of their relative to practise retrograde tracheal intubation, 59 per cent agreed to this procedure being carried out. Interestingly, McNamara et al came to the conclusion that as consent can be gained, then physicians should consider adopting a practice which asked for consent from relatives. On the other hand, Brattebo et al in a letter to the *New England Journal of Medicine* (1995) argue that because the majority of people in their study agreed to have the procedure carried out on their loved one, they have concluded that for minor procedures consent need not be obtained. However they do suggest that for more extensive and invasive procedures consent should be obtained. Both studies have come up with very similar results and yet the conclusions reached are different.

Many people feel that if we ask for consent from relatives to use a recently dead body for practising intubation then the relatives would say 'no'. People who follow this line suggest that there should be a policy of 'don't ask and don't tell', a strategy that keeps this practice hidden behind closed doors. (Bloom, 1995) However if the expected response from the relatives is 'no', should we carry out procedures we consider people if asked would likely refuse?

### 4 *If clinicians can't practise on the dead, then they will have to practise on the living*

Alarm has been raised by clinicians that if practice cannot be carried out upon the dead, then it will necessarily be done on the living. This is a serious concern and one which may cause immeasurable harm to the living. If a family member entered the emergency room or intensive care unit, or a newborn was delivered with serious breathing difficulties I know that I would wish to have the most experienced and expert clinician placing the airway for my relative. No one would wish this to be a time for learning. Iserson (1994) argues that consent for practising intubation is not necessary. He argues that by placing barriers between clinicians and ready access to the recently dead, many clinicians would not ask for consent nor practise the technique. Iserson sees that this is sacrificing the living while protecting the dead and is a farcical extension of patient rights. However, the call for respect for the wishes of the relatives need not lead to an abandonment of practice on the dead. People are willing for their relatives or themselves to be used for this purpose (see above). By increasing the awareness of this practice and the need for it to be carried out, there may be a corresponding acceptance and willingness for this to occur within our community.

### 5 *By entering the emergency room, intensive care unit, or birth in delivery suite, patients have consented to these procedures*

It is true that people entering these facilities are there for the intention of getting expert medical care. Once there, active resuscitation may be carried out to attempt to save the life of the patient. If despite all attempts the resuscitation fails and the patient dies, what is wrong with doing the same

procedure again following death that was done immediately prior to death? Ardagh (1997) argues that what is acceptable prior to death in the context of the therapeutic relationship is not acceptable immediately following death because the intent of the action is no longer therapeutic. 'When the objective is no longer to help the patient then the previous contract is irrelevant and a new contract must be entered into. To proceed to intubate the deceased under the old contract is a violation of the trust inherent in the previously formed doctor patient relationship ...' (Ardagh, 1997: 292)

### Finding Comparisons

Are there any comparisons already going on that can help to resolve this issue. In New Zealand in 1988 an inquiry was set up to look into matters surrounding the treatment of cervical cancer at National Women's Hospital in Auckland. During this inquiry, Judge Sylvia Cartwright uncovered a practice that was going on in the hospital for the purpose of teaching students. Women who were anaesthetised ready for surgery were having repeated vaginal examinations carried out by students without the patient's consent. The rationale for this policy was that the women would not be aware of the activity, it would do them no harm, and students would get practice and skills in a technique which is often difficult to get women to consent to for a group of students in the clinical setting.

Many people may identify problems with comparing this teaching issue with practising intubation on the recently deceased. Some differences between these two groups is that the women are live patients, and there are other means of getting vaginal examinations for students that are not available for teaching intubation. However, the comparison that can be made between these two procedures is the notion of a breach of trust. When the public finds out about practices such as teaching vaginal examinations using non-consenting anaesthetised women, there is a loss of trust. When a woman goes to her doctor and is scheduled for surgery there is a large measure of trust involved. The woman needs to be able to trust that the surgeon is competent and can do the job. Submitting to an anaesthetic requires that the patient trust the anaesthetist to carry out the job efficiently and competently. There is also a belief that

the patient be kept safe while they are unable to care for and protect themselves. To discover that the patient has been used for students to practise vaginal examinations could accompany a feeling that the trust the women had in her caregivers has been abused. The same sense of abused trust could arise from discovering that a close relative who has recently died has been used for practising intubation or other resuscitation procedures without any notification or request for consent. The policy of 'don't ask, don't tell' which endorses these activities behind closed doors where the public is unaware of their existence could, when revealed, cause harm because of the resulting distrust of the medical profession by the general public.

If we accept that consent is required for use of the dead bodies for teaching, does this mean that we need consent to train all other people who work on dead bodies. Should pathologists get the consent of relatives if they plan to train junior pathologists in the art of autopsies on their recently deceased family member? Do embalmers get consent for the teaching of junior embalmers? What is the difference between the practice of teaching on the dead in these different surroundings? Obviously there are some differences, it appears less contentious in the autopsy and embalming setting than it does in the clinical setting, but why is this? One answer may lie in the purposes for the action. We know that autopsy may be necessary and may be requested by the state in the case of an unexpected death. We also know that the body will usually go to the funeral director and be prepared for burial. These are processes that are known about by most people in the community and considered to be required for the preparation of a body following death. Using a body for practising intubation is not considered to be one of those processes that are required for getting a body ready for burial. The reason the person enters the emergency room or intensive care unit is to get expert medical care. While the person is in that care they may consent to (or wish for, if they were not able to consent) all that is necessary to save their life. Once it has been conclusively decided that life has ended, then to continue to carry out those procedures is outside the realms of the therapeutic relationship that existed between the clinician and the patient. This procedure lies beyond

## At the Centre

The Centre is planning to host an **environmental ethics conference** in 2000. The conference will be sponsored by the International Association of Law, Ethics and Science (part of the World Health Organisation, based in Geneva). They have a biennial conference which has been held in various parts of Europe until now and are wanting to convene a conference in the Southern Hemisphere. The Bioethics Centre has been chosen as the venue and we are beginning to set up the early stages of planning for that conference. Previous conferences held by the Association have been on artificial procreation, the genetic revolution, neurosciences and the brain, and bioethics, human rights, and access to health care. The emphasis for this conference is going to be on bioethics, the environment and human rights. We are hoping to involve numerous Australasian environmental groups.

The focus will be upon global questions but the organisation is aware that environmental issues have had a very high profile in the Pacific region. They are very aware that in New Zealand in particular these matters have received a lot of public attention.

The Director would be delighted to hear from any bodies interested in environmental ethics who would like to be involved in the conference.

At present there are about twenty-six **postgraduate students**, most of whom are registered in taught

masters courses for which they write a research dissertation making up about half of the degree. Many of these are in the masters scheme in Bioethics and Health Care Law. This is jointly convened by the Faculty of Law at Otago and the Bioethics Centre. The dissertations all have to contain some relevance to law and bioethics, though they can major in one or the other. Then there are a number of other students who can do a Master of Health Sciences degree: they can use a Bioethics issue for their research topic. At the moment we have a relatively small number of PhD students: just four. Two PhD students are working in environmental ethics. John McMillan has submitted his thesis in the philosophy and ethics of psychiatry. Michael Ardagh is working on maleficence in intensive care ethics. We have a new PhD student starting next semester who has had very considerable experience in the health reforms in New Zealand who is now about to begin a research project in the area of resource allocation and health care provision. Beginning next year we have three full-time PhD students coming to us from Canada. We have a medical postdoctoral student coming to us from Australia.

The Research and International office (of the University of Otago) has evaluated all the departments in the University. The Centre was recently awarded the status of centre for research excellence at Otago.

those boundaries required by our society for the purposes of preparing a body for burial.

There are other times that the dead are used for teaching and learning – this is the use of cadavers for medical education, and research. In this example people bequeath their bodies to the medical school prior to their death. In New Zealand the Human Tissues Act 1964 governs the use of bodies for dissection. Under this Act it is very important that the donation is voluntary.

There is an exception to this voluntary element: medical superintendents of psychiatric hospitals or prison superintendents may authorise the donation of a body except where the person or their family members have stated otherwise. (Campbell et al, 1997: 46) The demands in the Act for the donation of bodies for medical teaching and research to be voluntary tell us something about how we as a society think that the dead body should be treated. But what does this mean when we consider using a recently

dead person for practising intubation? In both situations the rationale behind the use of these bodies for teaching purposes is ultimately for the benefit of society. There are obvious differences in the ways in which the bodies are used. In the dissection room the bodies undergo extensive dissection and dismembering, whereas in the emergency room the recently dead bodies are used only for 'minor' procedures. While these procedures may be considered minor from a medical point of view,

### Travels Abroad

Professor Grant Gillett has already this year visited the University of Vancouver where he was consulting for the Bioethics program. He delivered a number of public lectures. He is currently at Case Western Reserve Bioethics Center. Later in the year he will be enjoying a five-month sabbatical period in Europe, where among other things he will be a visiting professor at the Universities of Wales and Bristol, the Semmelweis university in Budapest, and Magdalen College, Oxford.

Professor Donald Evans will be working with the Council for Medical Ethics Teachers in Hungary in August. He will be guest speaker at the International Conference on Perinatology in the United Arab Emirates in November, when he will also be a visiting fellow at the Institute for Health Science at the University of Oxford. He has also been invited to give the annual Nordmeijer lecture at the Wellington Clinical School of Medicine in October.

Barbara Nicholas will be delivering a paper at an Australian conference. Later in the year she will be enjoying a conference and study leave in North America.

John McMillan will be taking up his new post as Junior Research Fellow at University College, Oxford, in October.

Lynley Anderson and Sandy Elkin delivered a paper on the place of ethics in physiotherapy to the physiotherapy national conference held in Napier in May. They also ran a conference session, presenting a hypothetical.

they may be interpreted as significant by future patients or their relatives.

Attitudes to death in our community have changed. It used to be unthinkable for a woman to hold or even view her stillborn child. It was thought that the sight of the child might excessively distress the mother. Maternity workers thought that by not allowing the woman to view the dead child, they were saving her from needless grief and worry. Many mothers found that not knowing what their baby looked like actually increased their grief, as it left them to imagine the worst. In recent years this approach has changed. Mothers and families are now encouraged to see and hold the child. It has become common practice for mothers to dress the child, to take photos, to choose a name, and to have a funeral for their baby. It is now thought that going through the process of grief and acknowledgment of the dead child that a funeral allows is important to the family. Gone are the days of the paternalistic maternity team trying to protect the mother from the grief of a dead child. As in the maternity setting, health care professionals elsewhere need to take care not to assume how people may feel. By not asking the families and executing the procedure anyway, they are removing the possibility of meaningful choice from the family. Relatives who consent may do so in the knowledge that they are helping future patients and so find some meaning in the death of a family member.

### Conclusion

Practising intubation and other resuscitation measures is necessary, and it is important to our society that we have plenty of people skilled in this technique. Using models or the living for this purpose is less than ideal. Therefore using the dead seems to be the most viable alternative. The issue is whether this should proceed with or without the consent of the patient themselves (prior to death) or by proxy consent from relatives. From a review of some of the arguments that exist in this debate, and by examining some comparisons, it appears that consent should be obtained prior to practising intubation procedures on the recently deceased. A policy of unspoken procedures behind closed doors only serves to increase the mistrust of the medical community by the general public. A survey of a percentage of the New Zealand population as

to their feelings on these matters would provide valuable information that can be used as a guide for future activity as well as serve to inform the public of the need for this kind of education for the benefit of us all.

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