

Using the Newly Dead for Medical Education and Family Consent: Endotracheal Intubation Training

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Introduction

Case: A paramedic unit brings a man in cardiac arrest to the Emergency Room. He appears to be in his mid-fifties. The paramedics have already intubated the patient and begun an intravenous line to administer drugs. Since both appear to be working well at the time the patient arrives, the emergency department physician and a resident continue to use them during the resuscitation. Ninety minutes later, the patient still cannot be converted from asystolic cardiac rhythm and is declared dead. Before the body is removed, the Emergency Department physician would like to quickly instruct the resident and practice intubation.⁽¹⁾

Historically, dead bodies have made valuable contributions to society. They have been used as study material for anatomy classes, research subjects in pathological studies, and treatment materials in organ transplantation. Through these contributions, dead bodies have contributed at the macro-level to the advancement of medicine and science for the good of society, and — at the micro-level — promoted the health and lives of patients. Moreover, dead bodies have been useful for fact-finding

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⁽¹⁾ Case Studies, *Using a Cadaver to Practice and Teach*, 16 (3) HASTINGS CENTER REP. 28 (1986). The author simplified the details of the original case for the purpose of this article.

in promoting justice in criminal investigation and for maintaining public health. They also have been important in serving private interests, for example — insurance payments. Appropriate systems have been developed and applied for these uses to maintain the balance between the bodies' instrumental value and their intrinsic value, worthy of respect for sanctity and dignity.

Recent developments in medicine further expand the scope of the use of dead bodies, leading to a call for review of the current system of their management. Endotracheal intubation training (hereinafter "intubation training") of the newly dead is one such new use. As more instrumental values are found along with new uses, demand for dead bodies as useful resources has escalated, creating a chronic shortage as typically seen in the context of organ transplantation.

The case presented at the outset involves questions regarding intubation training on a newly dead patient. Should the ER physician simply proceed with intubation training? If so, how should it be done? And why? This paper challenges the practice of intubation training without obtaining family consent from legal point of view, by recommending public disclosure of the practice to make the Uniform Anatomical Gift Act (hereinafter "UAGA") applicable beyond well-recognized uses of dead bodies, arguing that the trend of courts' recognizing property interests of families in dead bodies protects the bodies' intrinsic value against arbitrary instrumental use.

Part I of this paper introduces the fact of intubation training on the newly dead without first obtaining family consent, and analyzes arguments for and against it from an ethical point of view. In order to legally evaluate the practice, Part II briefly explores informed consent in clinical medical education by reviewing it in treatment and research in medicine generally, and in emergency medicine in particular. Part III then examines the current law on using dead bodies and the role of family consent in medical contexts. The paper concludes by contending that family consent prior to intubation training on the newly dead is legally required.

I. Intubation Training on the Newly Dead Without Obtaining Family Consent: Facts and Problems

A. Endotracheal Intubation: Facts

Endotracheal intubation is the placing of a tube in a patient's trachea for the purpose of airway management. It is a lifesaving procedure that clearly benefits patients in cardiopulmonary arrest or with breathing difficulties. Intubation training is essential to master quick and skillful performance of the procedure under the stressful environment of the emergency room. The need for intubation training is undisputed since performance of the procedure by inexperienced or unskilled persons can be deadly. Not only may lack of training result in a failure to revive a patient who could otherwise be resuscitated, it also could precipitate respiratory arrest or death. Unskilled attempts at intubation may so damage and distort the patient's anatomy that subsequent attempts by competent persons to save the patient's life may be prevented.⁽²⁾

The training method for intubation includes practice on mannequins, animals, and human bodies. The first two are not perfect alternatives because of differences in anatomical structures and tissue flexibility.⁽³⁾ Trainees must practice on humans before they can be said to be fully qualified.⁽⁴⁾ Human bodies include both the living and the dead. While

⁽²⁾ See James P. Orlowski et al., *The Ethics of Using Newly Dead Patients for Teaching and Practicing Intubation Techniques*, 319 NEW ENG. J. MED. 439, 439 (1988).

⁽³⁾ Political difficulty with regard to animal use is also a concern from the animal rights point of view. See e.g., Marc S. Nelson et al., *Models for Teaching Emergency Medicine Skills*, 19 ANNALS EMERG. MED. 333, 333 (1990).

⁽⁴⁾ But see Michael K. Gilbert et al., *A Computer Based Trauma Simulator for Teaching Trauma Management Skills*, 179 AM. J. SURG. 223 (2000); Lars Wik et al., *An Automated Voice Advisory Manikin System for Training in Basic Life Support Without an Instructor: A Novel Approach to CPR Training*, 50 RESUSCITATION 167 (2001); C. Kaufmann & A. Liu, *Trauma Training: Virtual Reality Applications*, 81 STUD. HEALTH TECHNOL. INFORM. 236 (2001); Henri G. Colt et al., *Virtual Reality Bronchoscopy Simulation: A Revolution in Procedural Training*, 120 CHEST 1333 (2001); D. K. Morhaim & M. B. Heller, *The Practice of Teaching Endotracheal Intubation on Recently Deceased Patients*, 9 J. EMERG. MED. 515 (1991) (showing many advances in training mannequins and computer simulators increasingly narrow the relative advantages of using dead body.) There was also a study suggesting those

anesthetized patients could be used with their consent⁽⁵⁾, scarcity of personnel and patients of such to accommodate everyone who needs training⁽⁶⁾, and the risk to the patients prevent them from being a major source of teaching resources in intubation training.

The newly dead, on the other hand, are ideal teaching resources for the procedure in terms of quality — with typical neck tissue resilience, something that is unavailable with stiff and embalmed cadavers.⁽⁷⁾ Furthermore, there is no risk of harming the patient although the possibility of damaging the body is present. Many influential authorities such as the chairman of the Academic Affairs Committee of the American College of Emergency Physicians and the American Heart Association's representatives support this method as necessary and justifiable.⁽⁸⁾

The problem accompanying intubation training on the newly dead is that it is commonly performed without first obtaining family consent.⁽⁹⁾ Despite the nature of the procedure, the fact of intubation training is

who trained intubation on mannequins alone were as proficient as those who trained on mannequin and cadavers. S. J. Stratton et al., *Retrospective Study of Manikin-Only Versus Manikin and Human Subject Endotracheal Intubation Training of Paramedics*, 20 ANNALS EMERG. MED. 1314 (1991). However, this study has been criticized and later studies support the common perception that intubation training on cadavers is superior. M. Hauswald et al., *Adequate Training for Endotracheal Intubation*, 21 ANNALS EMERG. MED. 1168 (1992); R. D. Stewart et al., *Effect of Varied Training Techniques on Field Endotracheal Intubation Success Rates*, 13 ANNALS EMERG. MED. 1032 (1984).

⁽⁵⁾ Vulnerability of such patients is also a problem for their consent based on free and voluntary choice.

⁽⁶⁾ See Kenneth V. Iserson, Commentary, *supra* note 1, at 28–29.

⁽⁷⁾ To practice on life-like cadavers, the intubation training must be done within 2–4 hours after death, after which rigor mortis usually sets in. See Orlowski et al., *supra* note 2.

⁽⁸⁾ See Emergency Cardiac Care Committee and Subcommittees: American Heart Association, *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Part VIII: Ethical Considerations in Resuscitation*, 268 JAMA 2282 (1992); Crawford T., *Intubation Training Seems Mysterious*, 13 PHYSICIAN EXECUTIVE 25 (1987).

⁽⁹⁾ While the patient is generally considered to have priority in decisionmaking over the family regarding the disposition of his/her body after death, respect for autonomous decision about posthumous matters seems less binding in American law. In this article, I will focus on family consent as a practical and present issue, and I will not explore the normative question of how to reconcile a conflict of wishes between the patient and the family about disposition of the dead body.

hidden from public and professional scrutiny.

Previous research indicates that this is a common practice in many emergency departments of health care facilities in the United States⁽¹⁰⁾, and Australasia (Australia and New Zealand)⁽¹¹⁾, while a 1997 study in Canada⁽¹²⁾ showed less prevalence. Regarding consent prior to the practice, none of these studies shows consent was obtained in advance.

B. Guidelines and Regulation on Intubation Training on the Newly Dead

The British⁽¹³⁾ and Norwegian⁽¹⁴⁾ Medical Associations' guidelines prohibit the practice of intubation on recently dead patients. By contrast, the United States and Canada have no such guidelines.⁽¹⁵⁾ The only guidance available for this practice in the United States has been the report issued in the 1970s by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,

⁽¹⁰⁾ In the survey in summer of 1992, among 353 responses from training programs, 136 (39%) of hospitals indicated that they use newly deceased patients for intubation training. 63% of emergency departments and 58% of neonatal critical care programs also do so. See Burns et al., *supra* note 8. The rates were nearly equal in both teaching and non-teaching hospitals.

⁽¹¹⁾ An April 1995 survey on all 55 emergency departments in Australia and New Zealand accredited for training by the Australasian College for Emergency Medicine, 22 (46%) out of 48 responses (response rate, 87%) indicated that resuscitation skills were taught using the bodies of newly deceased patients. None of those 22 obtained consent from relatives and only one of the 48 respondents had a written policy governing the practice. See Corinne Ginifer & Anne-Maree Kelly, *Teaching Resuscitation Skills Using the Newly Deceased*, 165 MED. J. AUST. 445 (1996).

⁽¹²⁾ Christopher J. Denny & Daniel Kollek, *Practicing Procedures on the Recently Dead*, 17 J. EMERG. MED. 949, 949 (1999).

⁽¹³⁾ The British Medical Association and the Royal College of Nursing make an exception to allow using recently deceased patients with severe craniofacial injuries for no alternatives are available for training in such difficult intubation. See Tonk A, *Intubation Practice on Cadavers Should Stop*, 305 BMJ 332 (1992); Royal College of Nursing, *Intubation Training: An Ethical Practice?*, 7 NURSING STANDARD 38 (1993).

⁽¹⁴⁾ See Guttorm Brattebo et al., *Public Opinion on Different Approaches to Teaching Intubation Techniques*, 307 BMJ 1256, 1256 (1993).

⁽¹⁵⁾ See Christopher J. Denny & Daniel Kollek, *Practicing Procedures on the Recently Dead*, 17 J. EMERG. MED. 949, 949 (1999).

entitled *Research Involving the Comatose and Cadavers in Implementing Human Research Regulations*. It said, “those conducting the research are expected to make a reasonable effort to obtain specific consent from next of kin when the research is ‘beyond the normal scope of teaching and research.’”⁽¹⁶⁾ Apart from the question if “training” is included within the concept of research, the matter of whether intubation training is “beyond the normal scope of teaching” is left for interpretation. Many medical professionals, locate it within the normal scope and thus justified as non-consensual practice.

In 2001, the Council on Ethical and Judicial Affairs of the American Medical Association issued recommendations to suggest developing institutional policies on training with newly deceased patients, in which the interests of all the parties are respected by (1) making intubation training the culmination of a structured training sequence under close supervision, (2) inquiring about the expressed wishes of the deceased regarding postmortem handling of the body, and — in the absence of such preferences — requesting permission from the family in advance to decide whether to proceed with the training.⁽¹⁷⁾

No state statutes specifically prohibit the teaching of procedures with the use of newly dead patients, and no court has considered this issue.⁽¹⁸⁾

C. Ethics of Non-Consensual Use of Newly Dead for Intubation Training

The ethics of non-consensual intubation training on the dead has been discussed in the medical and bioethics literature since the mid-1980s.⁽¹⁹⁾ A notable split of opinion emphasizes the need to

⁽¹⁶⁾ See PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *IMPLEMENTING HUMAN RESEARCH REGULATIONS* 39–41 (1983).

⁽¹⁷⁾ http://www.ama-assn.org/apps/pf_online/pf_online?f_n=browse&doc=policyfiles/CEJA/E-8.181.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/ (Accessed September 18, 2003).

⁽¹⁸⁾ See Jeffery P. Burns et al., *Sounding Board, Using Newly Deceased Patients to Teach Resuscitation Procedures*, 331 NEW ENG. J. MED. 1652, 1653 (1994).

⁽¹⁹⁾ See, e.g., *supra* note 1.

evaluate the practice carefully from a legal point of view later.

(1) Argument for Non-Consensual Use of the Dead for Intubation Training

Several arguments support the current practice, *i.e.*, non-consensual use of the newly dead for intubation training.⁽²⁰⁾

First, the necessity and benefits of training. The lack of adequate alternatives to this important life-saving procedure is frequently cited to support non-consensual intubation training on the dead. The benefit society derives from well-trained doctors is also stressed. These claims, however, are not primary reasons to justify non-consensual use of the newly dead. Instead, the hypothesis that if consent is to be sought, it rarely would be granted, and training opportunities would not be secured, is the principal reason for the current non-consensual practice.

Second, advocates for non-consensual use of the newly dead argue the consent requirement has its foundation in the principle of respect for patient autonomy, and that there is no need to respect patient autonomy after death.⁽²¹⁾ The physician-patient relationship, it is said, ends at the time of patient's death, and accordingly many obligations of physicians such as respecting patient autonomy also end at the same time.

Third, advocates point to the impracticality of administering the consent requirement in emergency settings. In the case of sudden and unexpected death, the majority of deaths at emergency departments where intubation training takes place, family members are often not available

⁽²⁰⁾ Kenneth V. Iserson is a leading advocate of this argument. See *supra* note 6 (hereinafter *Commentary*); Kenneth V. Iserson, *Requiring Consent to Practice and Teach Using the Recently Dead*, 9 J. EMERG. MED. 509 (1991) (hereinafter *Requiring Consent*); *id.*, *Postmortem Procedures in the Emergency Department: Using the Recently Dead to Practice and Teach*, 19 J. MED. ETHICS 92 (1993) (hereinafter *Postmortem Procedures*); *id.*, *DEATH TO DUST: WHAT HAPPENS TO DEAD BODIES?* 182–215 (1994) (hereinafter *DEATH TO DUST*); *id.*, *Life Versus Death: Exposing a Misapplication of Ethical Reasoning*, 5 J. CLIN. ETHICS 261 (1994); *id.*, *Law Versus Life: The Ethical Imperative to Practice and Teach Using the Newly Dead Emergency Department Patient*, 1995-25 *Annals Emerg. Med.* 91 (1995) (hereinafter *Law Versus Life*); *id.*, *Practicing Procedures on the Newly Dead*, in KENNETH V. ISERSON ET AL., *ETHICS IN EMERGENCY MEDICINE* 123–29 (2d ed. 1995).

⁽²¹⁾ See, e.g., Iserson, *Requiring Consent*, *supra* note 20, at 509.

for some time. In order to take full advantage of using the newly dead, time is critical. Also, even if family members are accessible, asking for consent for intubation training is difficult both for medical professionals and for the grieving family.

Fourth, the limited extent of invasiveness of the procedure is cited. Unlike other invasive procedures on dead, such as dissection or organ removal, no surgical incision usually accompanies the intubation training.⁽²²⁾ It does not disfigure the appearance of the dead body, or leave visible marks. At most, a missing or broken tooth will be the only foreseeable damage to the body, and that could be cosmetically rectified by a competent undertaker.⁽²³⁾

Fifth, presumed consent as an alternative form of consent is proposed to support the current practice. Unlike other claims, this understanding does not argue for no-consent, but attempts to rationalize the practice by presumed consent for two reasons. First, in emergency medicine, consent to medical intervention is presumed as an exception to the doctrine of informed consent for medical interventions, if urgency and the benefit of the intervention is evident for patients unable to express their wishes.⁽²⁴⁾ Second, as his/her health care facility is a teaching hospital, the patient's consent to participate in medical training is presumed.⁽²⁵⁾

Sixth, and finally, the "Guttman scale" is suggested to approve current practice.⁽²⁶⁾ Like the claim of presumed consent, this approach does not argue for no-consent, but instead regards the practice as consented if separate consent is provided for a more extreme procedure. Thus, for example, if the patient has already consented to organ donation,

⁽²²⁾ The intubation called retrograde tracheal intubation involves puncturing the cricothyroid membrane with a needle. However, it is considered minimally invasive, leaving only a small needle mark. See Robert M. McNamara et al., *Requesting Consent for an Invasive Procedure in Newly Deceased Adults*, 273 JAMA 310, 310 (1995).

⁽²³⁾ See Orlowski et al., *supra* note 2, at 439.

⁽²⁴⁾ See *infra* Chapter II. B., p. 14.

⁽²⁵⁾ See Henry S. Perkins & Anna M. Gordon, *Should Hospital Policy Require Consent for Practicing Invasive Procedures on Cadavers? The Arguments, Conclusions, and Lessons from One Ethics Committee's Deliberations*, 5 J. CLIN. ETHICS 204, 205 (1994).

⁽²⁶⁾ See Michael Ardagh, *May We Practice Endotracheal Intubation on the Newly Dead?*, 23 J. MED. ETHICS 289 (1997).

anatomical or pathological dissection, no additional consent for less invasive procedure such as the intubation training is required.

(2) Argument Against Non-Consensual Use of the Dead for Intubation Training

Counter-arguments refute each claim of proponents for the current non-consensual intubation training on the newly dead.

First, a legitimate goal does not necessarily justify all means to achieve it.⁽²⁷⁾ Thus, no matter how great the necessity of the training and societal benefit, they do not automatically validate the non-consensual use of the newly dead for intubation training. The fear of a fatal decrease of training opportunities by the expected refusal by patients if asked lacks evidence. On the contrary, several studies of people's perspectives on practicing procedures on the newly dead indicate a majority would be willing to have the procedure performed on them or on relatives after death.⁽²⁸⁾ There are also other studies in which consent was actually sought in real cases for a certain period, and the majority of the approached families provided consent to the procedure on their deceased family members.⁽²⁹⁾ While serious societal interests may be given priority over family consent for post mortem procedures such as autopsies in criminal investigations, no public consensus exists on appropriating dead bodies for physician training.⁽³⁰⁾ Needless to say, a consensus also does not exist in the more urgent and directly life-threatening context where organ transplantation from cadavers to patients is blocked by family objection.

Second, the ethical principle of respect for personal autonomy is not the only ground for requiring consent. A family's interest in controlling

⁽²⁷⁾ See Orlowski et al., *supra* note 2, at 441. ("The practice is justified; the deception is not.")

⁽²⁸⁾ Kathleen S. Oman et al., *Perspectives on Practicing Procedures on the Newly Dead*, 9 ACAD. EMERG. MED. 786 (2002); Craig A. Manifold et al., *Patient and Family Attitudes Regarding the Practice of Procedures on the Newly Deceased*, 6 ACAD. EMERG. MED. 110 (1999); Brattebo et al., *supra* note 14.

⁽²⁹⁾ See McNamara et al., *supra* note 22; D. Gary Benfield et al., *Teaching Intubation Skills Using Newly Deceased Infants*, 265 JAMA 2360 (1991).

⁽³⁰⁾ See Jeffery T. Berger et al., *Ethics of Practicing Medical Procedures on Newly Dead and Nearly Dead Patients*, 17 J. GEN. INTERN. MED. 774, 776 (2002).

what happens to the body of its deceased relative must also be carefully taken into account. As discussed later, the legal status of family interests in dead bodies has been gradually changing, with more protection tending to be given.⁽³¹⁾

Third, impracticability is weak as an acceptable excuse to omit a consent requirement and deny opportunities to make a decision to families reachable by telephone even in the case of sudden death. Previous studies showed that telephone contact is also effective way to reach family for seeking consent.⁽³²⁾

Psychological difficulty or emotional distress on the part of medical professionals to approach and communicate with the family to report death and ask for their permission for the training has the same hurdle as other postmortem procedures such as organ removal or pathological dissection. Such difficulties, however, have never been automatically accepted as a justification for non-consensual use of dead bodies. The study reporting a high probability of family consent also suggested that assuring the process of getting consent is preferable for greater trust in the profession not only by the family directly involved but also by the public in general.⁽³³⁾ Also, the difficulty of facing family in grief seems to have a positive implication in that it may prevent the medical profession from regarding dead bodies merely as teaching materials.⁽³⁴⁾ The development of a training program for medical professionals to handle emotional difficulties, instead of omitting family consent, seems desirable.⁽³⁵⁾

Regarding the distress among medical trainees, it is also worth paying attention to the discomfort associated with non-consensual use of the dead for training purpose. One study reported feelings of hesitation and uneasiness among medical trainees who performed the intubation training without obtaining family consent.⁽³⁶⁾

⁽³¹⁾ See *infra* Chapter III. D., pp. 23–24.

⁽³²⁾ See McNamara et al., *supra* note 22, at 311.

⁽³³⁾ See The Council on Ethical and Judicial Affairs of the American Medical Association, *Performing Procedures on the Newly Deceased*, 77 ACAD. MED. 1212, 1214 (2002).

⁽³⁴⁾ See, e.g., Perkins & Gordon, *supra* note 25, at 207.

⁽³⁵⁾ See Berger et al., *supra* note 30, at 776–77.

⁽³⁶⁾ See Benfield et al., *supra* note 29, at 2362; S. S. Tachakra et al., *Teaching Intubation Skills Using Newly Deceased Infants*, 266 JAMA 1649 (1991).

Fourth, the distinction between “minimally invasive” and “more invasive” procedures seems arbitrary, and its implication on the requirement of consent is unclear.⁽³⁷⁾ For example, is the consent for postmortem organ removal required because it causes a physical loss of the organ from the body and is identifiable by the third party? Or, is consent required because organ removal implicates treating the dead body as useful object for an external goal, *i.e.*, transplantation? If there is no visible mark on the body afterwards, is no consent required for procedure on the dead body?⁽³⁸⁾ Requiring consent only if the procedure is identifiable later by the family seems deceptive, and cannot be morally justified.

Fifth, the doctrine of presumed consent is not applicable to all medical interventions in emergency departments. It applies to circumstances where unconscious patients are provided with *treatment* for saving their lives.⁽³⁹⁾ Justification of applying this doctrine relies upon the best interest of the patients who happen to be incompetent to express their wishes and for whom immediate treatment is necessary to save their life. Intubation training, however, does not provide an equivalent benefit to the dead patient.⁽⁴⁰⁾ The application of presumed consent to this context can be legitimate if instead, altruism, communitarianism, and utilitarianism are objective and universal values in the society and can be compelled upon all members without exception. In the world of diversity, however, presumed consent will be a disadvantage without an

⁽³⁷⁾ See Berger et al., *supra* note 30, at 774. See also Gregory J. Hayes, *Issues of Consent: the use of the Recently Deceased for Endotracheal Intubation Training*, 5 J. CLINIC. ETHICS 211 (1994) (pointing out that what constitutes outrage to ordinary sensibilities or disfigurement and ridicule of the cadaver may vary from community to community and from person to person based on cultural, ethnic, religious, and personal beliefs, and many American Indians, for example, would feel intubation training on the newly dead as ridiculing dead bodies.)

⁽³⁸⁾ There is another way of distinction suggested that any procedure involving penetration into the tissues or body cavities of a cadaver (emphasis by author) should raise the question of consent. See Perkins & Gordon, *supra* note 25, at 205.

⁽³⁹⁾ Presumed consent applies only to life-saving treatment requiring immediate action, but in reality, many incidents are reported where presumed consent is applied to ER cases assessed as non-urgent visits. See John C. Moskop, *Informed Consent in the Emergency Department*, 17 EMERG. MED. CLINICS N. AM. 327 (1999).

⁽⁴⁰⁾ See, *e.g.*, Ardagh, *supra* note 26, at 291–92.

effective means to decline consent for the minority who would not share the same value system. A similar debate can be seen in postmortem organ donation.

Alternative reasoning to support application of the presumed consent based on the patient's voluntary admission to a teaching hospital cannot be sustained, either. Available evidence denies public support for such a presumption.⁽⁴¹⁾ Patients' motivations for visiting academic hospitals vary, and some simply expect expert care unaware of all the implications of choosing an academic hospital.⁽⁴²⁾ Moreover, emergency hospitalization and expiration precludes a patients' choice of academic or non-academic facility.

As seen above, the argument for non-consensual practice focuses upon scientifically proved benefits of the intubation training and how to promote them with maximum efficiency in the demanding clinical settings in emergency medicine. The argument against non-consensual practice, on the other hand, acknowledges the importance of the practice, but tries to balance the competing interests of those involved in using the dead by carefully analyzing preceding studies and theories regarding intubation training. The latter argument seems more convincing for its deliberate application of the theories and supporting evidence from empirical data gathered in previous studies.

D. Legal Implication of the Non-Consensual Intubation Training on the Dead

As opposed to the continuous debate on the ethical implications of the intubation training on the newly dead in medical and bioethical literatures, the discussion in legal literature is strikingly scarce. Thus far, only one law journal article has examined the issue thoroughly.⁽⁴³⁾ Does this mean non-consensual training on the dead is not a legal concern, and

⁽⁴¹⁾ See Manifold et al., *supra* note 28.

⁽⁴²⁾ See Berger et al., *supra* note 30, at 776.

⁽⁴³⁾ See Alice Fleury Kerns, Comment, *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*, 13 J. CONTEMP. HEALTH L. & POL'Y 581 (1997).

family consent is just a matter of ethics or good medical practice? Should the discussion be limited within moral and ethical dimensions?

For the purpose of challenging non-consensual intubation training from a legal viewpoint, a general and broader picture will be drawn in the following section as a backdrop for exploring a legal basis for criticizing the current practice of non-consensual intubation training on the newly dead.

II. Informed Consent in Clinical Medical Education: Patient as Teaching Resource

A. Informed Consent: General

Informed consent is a well-known ethical and legal requirement in medical treatment and research. The healthcare provider must obtain the patient's informed consent prior to medical treatment, and the researcher must do so from research subjects in order to respect their personal autonomy. Under the common law, treating a patient without his or her consent constitutes battery, whereas treating a patient based on inadequately informed consent constitutes negligence. In the case of an unauthorized touching in research, criminal assault is another possible ground for legal action. In order to satisfy the requirement of informed consent, three conditions must be fulfilled: (1) disclosure, (2) capacity, and (3) voluntariness. First, the patient must be informed of the necessary information for making a choice, such as the nature, benefits, and risks of the procedure. Second, the patient must have capacity to understand the provided information, and make a choice. Third, the patient's consent must be voluntary.

The informed consent doctrine intends to promote respect for patient autonomy, and the family is expected to play a role in limited circumstances. In the case of health care for incompetent patients such as infants and the mentally impaired, the family can provide proxy consent. It is presumed that family members can make a decision for the best interest of the patient. In the case of an end-of-life decision, however, the family's substitute decision must be carefully scrutinized, and additional

safeguards are imposed to protect the patient in a vulnerable state.⁽⁴⁴⁾

B. Informed Consent in Emergency Medicine: Unique Situations

In emergency medicine, obtaining patients' informed consent is difficult in many cases involving those unable to make autonomous decisions due to acute conditions. The requirement is satisfied by the doctrine of presumed consent where incompetent patients' are presumed to approve of necessary immediate medical intervention in a life-threatening condition. The application of presumed consent in emergency treatment is based on promoting the best interest of the patients.

Informed consent for research in emergency medicine is more challenging. The presumed consent doctrine is not applicable for research settings since medical intervention for the purpose of research does not intend to promote patient's interests. In order to enable ethical research in emergency medicine, the Food and Drug Administration (FDA) and the Department of Health and Human Services (DHHS) has issued regulations to govern the conduct of "emergency research" without informed consent.⁽⁴⁵⁾ They set criteria for eligible patients and provide additional protection by requiring informed consent by family notification, community consultations, public disclosure before and after the research, and approval by the FDA or the DHHS in addition to the Institutional Review Board (IRB).

Thus, both in general and emergency medicine, the doctrine of informed consent to respect patients' autonomy has made its way into treatment and research settings with considerable variations. What then of informed consent in medical intervention for the purpose of education or clinical training? This issue has hardly been raised and discussed.

⁽⁴⁴⁾ See *In re Karen Quinlan*, 355 A.2d 647 (N.J. 1976); *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

⁽⁴⁵⁾ 21 C.F.R. §50.24 (2003), 45 C.F.R. §46.101 (i) (2003).

C. What is “Medical Education”?: Issue of Definition

When considering informed consent in medical education, “medical intervention as education” must be clearly defined. Medical intervention provided by unlicensed students in teaching hospitals as part of clinical medical education is a typical example. However, licensed residents or physicians also need continuing education or training to master new skills and maintain proficiency in techniques.⁽⁴⁶⁾ Thus, the identification of the personnel — whether the person is a medical student, a resident, or experienced physician — is not a critical factor to distinguish medical intervention as education from that as treatment. Rather, if the intervention is practiced as education/training, it must be considered educational medical intervention.

D. Ethics of Informed Consent in Medical Education

Informed consent in medical education as an ethical requirement can be examined as the initial step for exploring the legal implications of non-consensual intubation training. Lack of informed consent in medical education came into view with several empirical studies on recent medical literatures.⁽⁴⁷⁾

⁽⁴⁶⁾ See Editorial, *To Inform or Not to Inform Patients About Students*, 62 J. MED. EDUC. 861 (1987).

⁽⁴⁷⁾ Yvette Coldicott et al., *The Ethics of Intimate Examinations: Teaching Tomorrow's Doctors*, 326 BMJ 97 (2003) (indicating a quarter of examinations in anesthetized or sedated patients seem not to have adequate consent from patients.); Amanda Howe & Janie Anderson, *Involving Patients in Medical Education*, 327 BMJ 326 (2003) (arguing that it is no longer possible to assume that patients will choose to participate in medical education, and consent should be sought before the start of a learning encounter.); Jude T. Waterbury, *Refuting Patients' Obligations to Clinical Training: A Critical Analysis of the Arguments for an Obligation of Patients to Participate in the Clinical Education of Medical Students*, 35 MED. EDUC. 286 (2001) (arguing patients' right to refuse participation must be protected in teaching hospitals.); Len Doyal, *Closing the Gap Between Professional Teaching and Practice: A Policy Can Help Protect Students from Being Asked to Behave Unethically*, 322 BMJ 685 (2001) (arguing for creating a policy to protect rights of patients to participate in educational activities separate from their clinical care.); Andrew West, *Learning Respect*, 322 BMJ 743 (2001) (arguing that patient's consent is needed for training procedures as well as treatment even if the patient is anaesthetized or dead, by which the medical

As a normative approach to this issue, the United States government formally indicated the necessity to guarantee the rights of patients in teaching hospitals in a 1973 commission report.⁽⁴⁸⁾ In support of this recommendation, the Joint Committee on Accreditation of Hospitals (JCAH) promulgated guidelines regarding the rights of patients in teaching hospitals.⁽⁴⁹⁾ Despite clear federal recommendations and JCAH guidelines pertaining the rights of patients in teaching hospitals and the responsibilities of medical educators and administrators, the implementation of the policy is prevented by heterogeneity of opinions among professionals responsible for the administration of teaching hospitals and the education of medical students.⁽⁵⁰⁾ According to a study in the 1984–85 academic year, a majority of teaching hospitals did not specifically inform patients at the time of admission that medical students would be involved in their assessment and care. Also, about half of medical schools gave their students no specific verbal or written instructions as to how to introduce themselves to patients, and clarify their roles in patient assessment and care.⁽⁵¹⁾

A strong argument for non-compliance with the informed consent policy for student involvement in patient care is that “blanket” consent satisfies the requirement since students are regarded as part of the health care team and identification of each individual member of the team does not matter.⁽⁵²⁾ The sufficiency of this justification, however, seems suspect in satisfying the level of detailed disclosure.

In June 2001, the American Medical Association Council on

profession can learn respect for the living and for the dead, and thereby earn public respect.)

⁽⁴⁸⁾ REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE (1973), cited in Daniel L. Cohen et al., *Informed Consent Policies Governing Medical Students’ Interactions with Patients*, 62 J. MED. EDUC. 789, 789 (1987) (hereinafter, *Informed Consent Policies*).

⁽⁴⁹⁾ JOINT COMMITTEE ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS /1985 EDITION, cited in Cohen et al., *supra* note 48, at 790.

⁽⁵⁰⁾ See Cohen et al., *Informed Consent Policies*, *supra* note 48; Daniel L. Cohen et al., *A National Survey Concerning the Ethical Aspects of Informed Consent and Role of Medical Students*, 63 J. MED. EDUC. 821 (1988).

⁽⁵¹⁾ See Cohen et al., *Informed Consent Policies*, *supra* note 48, at 793.

⁽⁵²⁾ See *id.* at 796–97.

Ethical and Judicial Affairs issued a policy entitled "Medical Student Involvement in Patient Care" suggesting a similar informed consent policy to the federal recommendations and the JCAH guidelines provided.⁽⁵³⁾

E. Law of Informed Consent in Medical Education

It is not clear from case law whether informed consent in medical education is a legal requirement. There is no actual case in which anyone successfully sued for failure to disclose training status to a patient.⁽⁵⁴⁾ With the exception of one California case in 1932⁽⁵⁵⁾ involving the conduct of 12 medical students performing pelvic and rectal examinations on a pregnant woman over her objection, there appears to be no reported case involving the clinical participation of a medical student against the

⁽⁵³⁾ http://www.ama-assn.org/apps/pf_online/pf_online?fn=browse&doc=policyfiles/CEJA/E-8.087.HTM&st=&st.p=&nth=1&prev.pol=policyfiles/ (accessed September 18, 2003).

⁽⁵⁴⁾ See Marshall B. Kapp, *Legal Implications of Clinical Supervision of Medical Students and Residents*, 58 J. MED. EDUC. 293, 294 (1983). According to an article published in 1995, only six cases have been decided on issues of informed consent in malpractice allegations involving residents. The cases focused primarily on the problem of whether the patient knew that the resident, and not the supervising physician, would be providing the care. The trend in litigation applying the same standard of care for residents and attending physicians may have served to undermine this line of cases, and residents frequently prevailed in these cases. See Lelia B. Helms et al., *Litigation in Medical Education: Retrospect and Prospect*, 11 J. CONTEMP. HEALTH L. POL'Y 317, 352 (1995) (citing *Wachter v. United States*, 877 F.2d 257 (4th Cir. 1989); *Young v. United States*, 648 F. Supp. 146 (E.D. Va. 1986); *Zimmerman v. New York City Health and Hospi. Corp.*, 458 N.Y.S.2d 551 (App. Div. 1983); *Hill v. Steward*, 470 N.Y.S.2d 971 (App. Div. 1983); *Prooth v. Walsh*, 432 N.Y.2d 663 (App. Div. 1980); *German v. Nichopoulos*, 577 S. W.2d 197 (Tenn. Ct. App. 1978)). But see *Dingle v. Belin*, 749 A.2d 157 (Ct. App. MD, 2000) (holding that consideration other than risks, benefits, collateral effects, and alternatives of the treatment, at least if raised by the patient, may also need to be discussed and resolved, and who precisely will be conducting the procedure is one of those considerations in an expanding era of more complex medical procedure, group practices, and collaborative efforts among health care providers. A physician is bound to an agreement with the patient, if any, to a specific allocation of the responsibility or a specific limitation on his/her discretion to the procedure, absent some emergency or other good cause.)

⁽⁵⁵⁾ *Inderbitzen v. Lane Hospital*, 124 Cal. App. 462, 12 P.2d 744 (1932).

refusal by patients. Theoretically speaking, the failure to identify the student status of the one who is participating in the patient's care might constitute a ground for a criminal fraud charge, or a civil tort action for battery or negligence.⁽⁵⁶⁾ In any event, the status of the individual as a trainee, irrespective of the nature of the procedure as education/training, is a main concern in practice and theory.

Discussion on informed consent in medical intervention so far has focused on living patients as the subject for protection. The following section will then deal with medical intervention upon dead patients and accompanying consent issues.

III. Using the Dead and the Issue of Consent

A. UAGA for Therapeutic, Educational, and Research Use of the Dead Body

At the moment a patient dies, the applicable framework applicable for the consent requirement to medical intervention changes. Needless to say, the consideration of medical treatment is no longer necessary. Whether an autonomous decision of the individual about posthumous matter is binding after one's death is debatable. So far, at least in case law, the answer is that it is not.⁽⁵⁷⁾ How do we then handle consent issues in using the dead for research and education?

While using the dead for research and education dates back to the medieval era⁽⁵⁸⁾, ethics and law of consent for these uses have long been without a uniform approach. In the United States of the 1950s, individuals could donate their bodies for anatomical studies after death in some states where statutory provisions allow one to do so, but if the person died

⁽⁵⁶⁾ *But See* Bowlin v. Duke University, 423 S.E.2d 320 (N.C. Ct. App. 1992). (holding no statutory or common law duty for an attending surgeon to inform a patient of the particular qualifications of individuals who will be assisting, and it is common practice for medical students at teaching hospitals to assist in medical procedures.)

⁽⁵⁷⁾ *See* Tillman v. Detroit Receiving Hospital, 360 N.W.2d 275, 277 (Mich. App. 1984).

⁽⁵⁸⁾ *See* Dolothy Nelkin & Lori Andrews, *Do the Dead Have Interests? Policy Issues for Research After Life*, 24 AM. J. L. & MED. 261, 262–65 (1998) (introducing examples of using the dead for anatomical dissection in Medieval days and Renaissance.)

in another state without an equivalent rule, his or her wish to donate was no longer valid.⁽⁵⁹⁾ Surviving family members, on the other hand, have been responsible for disposition of the dead body, and a limited common law right has been recognized for the control and possession of the body of a deceased relative to conduct a proper burial.⁽⁶⁰⁾ What this common law right implies in the context of donating the body of their deceased family member, however, was unclear.⁽⁶¹⁾

The need for a uniform rule, instead of a state-by-state approach, for postmortem body donation became clear. Transplantation had evolved from an experimental procedure to a more widely-used treatment option. An efficient system was needed to supply necessary organs. Thus, the model law, the Uniform Anatomical Gift Act (hereinafter UAGA) was drafted in 1968.⁽⁶²⁾

The UAGA provided in its prefatory note that many different wishes of involved parties must be balanced and respected with regard to disposition of the body. In order to do so, the UAGA established a statutory entitlement for an individual to donate his/her body after death, and in the case where the wishes of the individual were not clear, the surviving family could donate their loved one's body.⁽⁶³⁾ The uses of the dead bodies covered by the UAGA were not limited to organ transplantation. It instead covered an anatomical gift for the purpose of transplantation, therapy, research, and education.⁽⁶⁴⁾

While the consent requirement has been established by the UAGA takes the form of a statutory entitlement for an individual and the surviving family, several exceptions exist where using the dead is necessary for the public interest, such as an authorized autopsy for criminal

⁽⁵⁹⁾ See UNIF. ANATOMICAL GIFT ACT of 1968 (amended 1987), Prefatory Note, 8A U.L.A. 64 (1993). See also, E. Blythe Stason, *The Uniform Anatomical Gift Act*, 23 BUS. LAW. 919, 921–24 (1968).

⁽⁶⁰⁾ See, e.g., *Pierce v. Swan Point Cemetery*, 10 R.I. 227 (1872).

⁽⁶¹⁾ See *infra* III. C. & D., pp. 21–24.

⁽⁶²⁾ See UNIF. ANATOMICAL GIFT ACT of 1968 (amended 1987), 8A U.L.A. 63 (1993).

⁽⁶³⁾ See UNIF. ANATOMICAL GIFT ACT of 1968 (amended 1987), §2 (a), (b), 8A U.L.A. 99 (1993).

⁽⁶⁴⁾ See UNIF. ANATOMICAL GIFT ACT of 1968 (amended 1987), Prefatory Note, *supra* note 59.

investigations or public health reasons.⁽⁶⁵⁾

B. Application of the UAGA to Intubation Training on the Newly Dead

Since the UAGA sets the rules for using dead bodies for educational purposes without specifying details, it seems applicable to intubation training on the newly dead. However, many features of intubation training do not fit within the range of education that the UAGA appears to have expected.

First, intubation training does not entail transfer and storage of the dead body for a period of time that is normally incidental to a traditional anatomical gift. It is performed on the site where the patient expires swiftly. Thus, “gift” or “donation” is not a suitable expression to describe using the dead body for intubation training, at least within the normal thinking of the general public.

Second, as stated in previous section, no surgical intervention is necessary for intubation training. It is thus hard to locate intubation training within the same educational classification as using the dead body for anatomical class. Intubation and extubation are not as appealing as cutting the body and examining it in anatomical dissection. No matter how important intubation training may be for improving the quality of emergency medicine, it is hard for the general public to see equivalent values in these procedures from the educational point of view.

Third, accordingly and unfortunately, almost no one intends to take advantage of the UAGA and exercise a statutory entitlement to donate his/her body for intubation training. Unlike anatomical classes for medical students and organ transplantation for patients in fatal conditions, the importance of the intubation training is hardly known to the general public, though people may understand it as a lifesaving procedure if being explained.

These difficulties in recognition come from unawareness regarding

⁽⁶⁵⁾ See Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U.L. REV. 681, 691 & n. 40 (1988). See also, UNIF. ANATOMICAL GIFT ACT of 1968 §7 (d) (amended 1987), 8A U.L.A. 124 (1993).

the reality and the necessity of intubation training on the newly dead. If intubation training on the newly dead is widely known as an important use, people will be able to understand it within the concept of “gift,” “donation,” and “educational use of the dead body.” Some, then, will be more eager to make a positive decision for donating their own dead body or those of relatives for intubation training.

C. The Common Law Right of the Surviving Family in the Dead Body

Besides the potential applicability of the UAGA based on statutory entitlement of the individual and the family for consent, as discussed above, the development of a common law right of surviving family members with regard to the body of their deceased relative is a realistic and practical ground for a legal challenge to non-consensual intubation training.

The common law right of the family has been called a quasi-property right. It was invented as a legal concept in order to solve disputes over the dead body in the United States where there is no Ecclesiastic Court.⁽⁶⁶⁾ When disputes occur with regard to the dead body, such as mishandling, the surviving family can make a legal claim based on this right.⁽⁶⁷⁾

The questions of what the quasi-property right in the dead body means outside the burial context, and whether it is protected as a property right in the constitutional dimension, have been raised in court whenever surviving family’s interests in a dead body were involved.

For example, in early court cases on the constitutionality of state presumed consent laws that authorize corneal removal from dead bodies under medical examiners’ jurisdiction, if no family objection was known

⁽⁶⁶⁾ In Old English Common Law, the so-called “no property rule” in a dead body was broadly accepted since the Common Law Court did not have jurisdiction over the dead body. The Ecclesiastic Court, instead, held exclusive power on it.

⁽⁶⁷⁾ See, e.g., *Burney v. Children’s Hospital in Boston*, 47 N.E. 401 (Mass. 1897); *Whitehair v. Highland Memory Gardens*, 327 S.E.2d 438, 440–41 (W.Va. 1985); *Painter v. United States Fid. & Guar.*, 91 A. 158 (Md. 1914); *Patrick v. Employers Mut. Liab. Ins.*, 118 S.W.2d 115, 125 (Mo. Ct. App. 1938); *Brown v. Broome*, 197 N.Y.S.2d 679, 680, 681 (1960); *Stripe v. Liberty Mut. Ins.*, 47 S.W.2d 1004, 1005 (Ky. App. 1932); *Snyder v. Holy Cross Hospital*, 352 A.2d 334, 340 (Md. Ct. App. 1976).

without obtaining explicit consent or even without notifying them⁽⁶⁸⁾, the court was hesitant to locate family's quasi-property right in the dead body within a constitutionally-protected property right, and denied the plaintiff family's claim for unconstitutionality of such laws based on procedural due process.⁽⁶⁹⁾ The court restricted the scope of the family rights in the dead body, and suggested that other options would be available to seek legal remedy, such as the torts of intentional or negligent infliction of emotional distress.⁽⁷⁰⁾ These alternatives, however, require the plaintiff's surviving family to meet a more demanding burden of proof to establish the claim,⁽⁷¹⁾ provide the successful family an inadequate remedy, and lack consistency among different jurisdictions.⁽⁷²⁾

It seems that the courts in these cases could not handle the competing interests in the dispute on using a dead body in high demand. In particular, they seemed troubled by the possibility of giving too much weight to the surviving family members at the risk of losing tangible benefits such as life and health of living people promoted by the use of the dead.⁽⁷³⁾

⁽⁶⁸⁾ See generally Naoko Morimoto, *Due Process in Harvesting Organs from the Dead: Analyzing U.S. Cases on Presumed Consent Law in Corneal Removal*, 37 HIKAKU HOGAKU 1 (2003) (original text in Japanese.)

⁽⁶⁹⁾ See *Tillman*, *supra* note 57; *Georgia Lions Eye Bank v. Lavant*, 335 S.E.2d 127 (Ga. 1985); *State v. Powell*, 497 So. 2d 1188 (Fla. 1986).

⁽⁷⁰⁾ See *Tillman*, 360 N.W.2d at 277; *Lavant*, 335 S.E.2d at 128–29; *Powell*, 497 So. 2d at 1191–92.

⁽⁷¹⁾ See *Lacy v. Cooper Hospital/University Medical Center*, 745 F. Supp. 1029 (D.N.J. 1990).

⁽⁷²⁾ See Remigius N. Nwabueze, *Biotechnology and the New Property Regime in Human Bodies and Body Parts*, 24 LOY. L.A. INT'L & COMP. L.REV. 19, 29–31 (2002).

⁽⁷³⁾ See *Powell*, 497 So. 2d at 1190–91, 1194 (emphasizing how beneficial the presumed consent law is to promoting corneal transplantation and brought sight back to the large blind population, and to eliminate state welfare expenditure to the blind to uphold the constitutionality of the state law, but also pointing that reconciling the conflict between social needs and individual interests in removal of human tissues for transplantation is a policy question involving moral, ethical, theological, philosophical, and economic concerns, which the court is not a suitable institution to answer.)

D. Expansion of Property Concept: Possible Solution

In the 1990s, the trend of courts' denying constitutional protection for the surviving family's right with regard to dead bodies of deceased relatives gradually changed. Presumed consent laws for corneal removal have been repeatedly challenged as unconstitutional violations of procedural due process, by surviving families who by accident discovered unconsented removal of corneal tissue and/or eye balls from the body of their deceased relatives later.

In three cases decided by two federal appeals courts, the family's interests in the dead body gave rise to a "legitimate claim of entitlement" and, thus, a property right protected under the procedural due process of the Fourteenth Amendment to the Constitution.⁽⁷⁴⁾ In order to take such an innovative approach, these courts carefully reviewed the long tradition of identifying family's interests in the dead body as a quasi-property right, and found it obsolete and inadequate to protect these interests in the dead, as dead bodies have become more valuable resources due to medico-scientific progress.⁽⁷⁵⁾

It is a remarkable achievement for courts to look squarely at new developments in medicine regarding use of dead bodies. The decisions in the corneal removal cases resulted in the courteous protection of the intrinsic value and the respect for the dead body in the name of family interests.⁽⁷⁶⁾ In addition to the corneal removal cases, a trend is developing of conceiving of human body (parts) of both living and dead as property. This is so both in academic writings and court decisions.⁽⁷⁷⁾

⁽⁷⁴⁾ See *Brotherton v. Cleveland*, 923 F. 2d 477 (6th Cir. 1991); *Whaley v. County of Tuscola*, 58 F.3d 1111 (6th Cir. 1995); *Newman v. Sathyavaglswaran*, 287 F.3d 786 (9th Cir. 2002).

⁽⁷⁵⁾ See *Brotherton*, 923 F. 2d at 481; *Whaley*, 58 F.3d at 1115; *Newman*, 287 F.3d at 789-98.

⁽⁷⁶⁾ See, e.g., *Newman*, F.3d at 798.

⁽⁷⁷⁾ See, e.g., Walter F. Kuzenski, *Property in Dead Body*, 9 MARQ. L.REV. 17 (1924); Paul Matthews, *Whose Body? People as Property*, 36 CURRENT LEGAL PROBS. 193 (1983); Bernard M. Dickens, *The Control of Living Body Materials*, 27 UNIV. TORONTO L.J. 142 (1977); *id.*, *Living Tissue and Organ Donors and Property Law: More on Moore*, 8 J CONTEMP. HEALTH L. & POL'Y 73 (1992); Amy S. Pignatella Cain, *Property Rights in Human Biological Materials: Studies*

It is important to stress that this trend is not intended to abolish the taboo of providing economic and market values for human bodies, which has existed since emancipation of slaves. Instead, this is a legal fiction to help deserving plaintiffs who used to be left without a just remedy for violation of the dead bodies of their relatives by lack of a more updated legal framework.

Coming back now to non-consensual intubation training on the newly dead, if the surviving family has a property right in the dead body, non-consensual use of it would constitute the tort of trespass, subject to civil action. Needless to say, that might not necessarily end the entire debate in a victory for the surviving family. As seen in corneal removal cases, the surviving family must clear other hurdles to successfully establish a constitutional claim for violation of procedural due process.⁽⁷⁸⁾ Nevertheless, the curse of Old English Common Law and subsequent case law up to the 1980s for no-property in the dead body is no longer valid to justify the law's incompetence to combat non-consensual intubation training on the newly dead. In this sense, expansion of the property concept toward dead bodies is an important step forward for the law to intervene in a dispute over using dead bodies, an improvement over the chaos and inconsistency that has impeded justice for many decades.

in Species Reproduction and Biomedical Technology, 17 ARIZ. J. INT'L & COMP. L. 449 (2000); RICHARD E. GOLD, *BODY PARTS: PROPERTY RIGHTS AND THE OWNERSHIP OF HUMAN BIOLOGICAL MATERIALS* (1996); Keith Sealing, *Great Property Cases: Teaching Fundamental Techniques with Moore v. Regents of the University of California*, 46 ST. LOUIS L.J. 755 (2002); Nuwabueze, *supra* note 72. See also *Hecht v. Superior Court*, 20 Cal. Repr. 2d. 275 (Ct. App. 1993); *Davis v. Davis*, 842 S.W.2d 588 (Tenn. 1992).

⁽⁷⁸⁾ For a valid due process claim, a plaintiff must establish 1) deprivation, 2) of property, 3) under color of state law. See, e.g., *Brotherton*, 923 F.2d at 479–82. Additionally, what process is due must be examined. The requirement for pre-deprivation hearing depends on whether there are “extraordinary situations.” Also, state interests in using the dead for training purpose must be examined to determine what kind of procedural protection must be guaranteed for the surviving family. See *Newman*, 287 F.3d at 799.

IV. Conclusion

Intubation training on the newly dead without first obtaining family consent is not only ethically unacceptable, but also legally questionable. Regardless of the ambiguity of the common law doctrine on informed consent in medical intervention for the purpose of education/training and particularly in cases involving dead patients, public disclosure of the fact and the necessity of the practice of intubation training on the newly dead will make the UAGA applicable to the procedure. Also, recent judicial developments to recognize a property right interest in the surviving family in the dead body for the purpose of protection against arbitrary use indicate a possibility to conceive of the practice as a tort upon property.

Non-consensual intubation training on the newly dead is not a trivial matter that society must tacitly permit for the sake of its good, but rather a kindling charcoal that might trigger a blast, and thus must be carefully examined.