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Breaking Through the Silence: Illegality of Performing Resuscitation Procedures on the "Newly-Dead"

*Daniel Sperling**

I. INTRODUCTION

For more than thirty years, hospitals in most developed countries of the world have been performing resuscitation procedures in order to restore consciousness, vigor, or "life" to patients whose hearts have stopped beating or whose lungs have stopped functioning. Resuscitation procedures include endotracheal intubation, placement of central venous catheters, surgical venous cutdown, thoracotomy, pericardiocentesis, cricothyroidotomy, liver biopsy, and intraosseous needle placement.[1] While these procedures are critical components of effective and life-saving healthcare, the methods by which physicians are trained to perform such procedures are suspect.

In order to train medical students to do successful resuscitation procedures, the procedures are practiced on "newly-dead" patients. This is necessary because these procedures cannot be performed on a person who is alive or on someone who has been dead too long. However, in many cases, the practice of resuscitation procedures is carried out in a secretive way without consent from the patient or next-of-kin. Coverage of these procedures is limited and often is restricted to physicians writing short articles in favor of the procedures. Like the United States and other developed nations, Canada takes part in this "educational" effort, and like other nations, the matter is free from the scrutiny of the Canadian Medical

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1. Jeffrey P. Burns et al., *Sounding Board, Using Newly Deceased Patients to Teach Resuscitation Procedures,* 334 NEW ENG. J. MED. 1652, 1652 (1994) (stating that the intubation procedure is the most common resuscitation procedure and that, according to a survey made in 1992, nearly forty percent of U.S. training programs in critical care performed these procedures).

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Association. Recently, however, the American Medical Association (AMA) established new guidelines for physicians, requiring consent for these procedures, and re-establishing respect for the recently deceased and the next-of-kin.[2] Some hospitals in the United States have announced that they will review their policies as well; perhaps this indicates a change.[3]

Although this paper will not touch upon many delicate philosophical questions such as the moral and legal status of the dead, whether the dead have legal rights, and if so, what duties are owed to the dead,[4] it will question whether the dead can suffer harm or wrong in a way that is protectable by law.[5]

The first section of this paper will discuss the different medical associations' guidelines on practicing resuscitation procedures on newly dead patients. The second part provides an analysis of the theoretical and ethical discussion on such procedures. This will be done by applying the four principles of bioethics to the practice of resuscitation procedures on the newly dead: respect for autonomy, nonmalfeasance, beneficence, and justice. The issue of consent and whether it should be required before certain procedures are preformed will be discussed. The background of the consent requirement will be examined by looking at four different sources: the general common law principles of consent, the statutes that deal with consent in general, the statutes that discuss the treatment of the corpse, and the regulations concerning research on human beings. Two basic questions will then be examined: (1) whether implied or presumed consent is sufficient for practicing resuscitation procedures on the "newly-dead," and (2) who is the appropriate substitute decision-maker from whom consent should be obtained. After answering these questions, the legal consequences arising from performing the practice on deceased persons

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2. Reports of the Council on Ethical & Judicial Affairs (CEJA), Am. Med. Assoc. (AMA), Performing Procedures on the Newly Deceased for Training Purposes (5-A-01); CEJA OPINION 8.181: PERFORMING PROCEDURES ON THE NEWLY DECEASED FOR TRAINING PURPOSES, 77 ACAD. MED. 1212-16 (2002), *available at* http://www.ama-assn.org/ama/pub/category/8509.html [hereinafter CEJA ETHICS OPINION E-8.181]

3. Paul Glader, *Doctors Question Use of Dead or Dying Patients for Training*, WALL ST. J., Nov. 12, 2002, at B1.

4. *See* Daniel Sperling, *Maternal Brain Death*, AM. J.L. & MED. (forthcoming 2004). *See also* Joel Feinberg, *The Mistreatment of Dead Bodies*, 15 HASTINGS CTR. REP. 31 (1985); Mathew H. Kramer, *Do Animals and Dead People Have Legal Rights?*, 14 CAN. J.L. & JURIS. 29 (2001) (discussing legal rights). For a broader discussion on the issue of the dead's interest see Jessica Berg, *Grave Secrets: Legal & Ethical Analysis of Postmortem Confidentiality*, 34 CONN. L. REV. 81, 90-93 (2001).

5. *See generally* Joan C. Callahan, *On Harming the Dead*, 97 ETHICS 341 (1987) (arguing against the claim that the dead can be harmed). *Cf.* 1 JOEL FEINBERG, THE MORAL LIMITS OF THE CRIMINAL LAW: HARM TO OTHERS 83-84 (1984) (arguing for a posthumous harm made to the surviving interests of the deceased).

without consent will be reviewed.

II. THE MEDICAL PERSPECTIVE

The problem raised in this paper presents an ethical dilemma: the choice between the obligation to educate medical trainees effectively and the obligation to protect the physical and psychological integrity of the patients and their families facing the death of their beloved. If typical resuscitation procedures, such as opening an airway with a tube through the mouth and into the trachea, drawing blood from a major vein, inserting a needle or knife and a tube into the neck, and opening the chest wall, can be performed without asking for consent from the family,[6] then the obligation to educate future clinicians must have a strong justification. But is this so?

There are some existing guidelines from ethical medical institutions that address the issue of the newly dead. While the Canadian Medical Association (CMA) does not have specific guidelines on the issue of practicing on the newly dead, the CMA Code of Ethics has a good description of the conflict that confronts physicians.[7] The Code requires the physician to "consider first the well-being of the patient,"[8] to treat "all patients with respect,"[9] and to "refuse to participate in or support practices that violate basic human rights."[10] However, the Code also encourages physicians to "engage in lifelong learning and to maintain and improve professional knowledge, skills, and attitudes,"[11] to "teach and be taught,"[12] and to "accept a share of the profession's responsibility to society in matters relating to . . . health education."[13]

As evidenced, the Code consists of contradicting articles when applied to the practice of resuscitation procedures on the recently deceased. Article 14 of the Code may resolve the conflict by providing that, if a procedure is recommended for the benefit of others (for example, in matters of public health), then the physician is asked to inform the patient of this fact and to proceed only with explicit informed consent.[14]

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6. D. Gary Benfield et al., *Teaching Intubation Skills Using Newly Deceased Infants*, 265 JAMA 2360, 2360 (1991). *See* Christopher J. Denny et al., 17 J. EMERGENCY MED. 949, 951 (1991) (setting forth reasons for not obtaining consent).

7. CAN. MED. ASSOC. (CMA), CODE OF ETHICS, PREFACE, *available at* http://www.cma.ca [hereinafter CMA CODE OF ETHICS].

8. *Id.* at ART. 1.

9. *Id.* at ART. 2.

10. *Id.* at ART. 33.

11. *Id.* at ART. 5.

12. *Id.* at ART. 36.

13. CMA CODE OF ETHICS, *supra* note 7, at ART. 30.

14. *Id.* at ART. 14.

A different situation exists in the United States. The AMA issued specific guidelines on practicing resuscitation procedures on the recently deceased in December 2002. The AMA recommends that training procedures should not be undertaken without reasonable efforts to obtain informed consent from the families within a reasonable time frame.[15] However, when these efforts fail, the AMA states that training supervisors *must* forgo the training opportunity.[16] AMA guidelines also emphasize that teaching life-saving skills should be the culmination of a structured training sequence, rather than random opportunities, and that practice on the newly dead should be performed in a dignified way.[17]

Other American groups have been setting guidelines for performing procedures on the newly dead. The "Research Involving the Comatose and Cadavers" Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research[18] also supports the position that a reasonable effort is necessary to obtain specific consent from the next-of-kin when the research is "beyond the normal scope of teaching and research."[19]

A more general instruction on practicing resuscitation procedures has been issued by the American Heart Association (AHA). The AHA stated in its 1992 guidelines that the practice of resuscitation procedures is ethically justifiable and that sensibilities of the family and staff involved in it should be compassionately respected. It also stated that consent should be obtained whenever practical.[20]

In comparison to North America, stronger professional guidelines appear across Europe. The Norwegian Medical Association's Ethics Committee has ruled that the use of newly dead patients for instruction of intubation

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15. CEJA ETHICS OPINION E-8.181, *supra* note 2. It is interesting to note the reason for the AMA's consent requirement. The AMA stated that obtaining consent respects both the wishes of the family and the memory of the deceased. In the author's opinion, it should be exactly for the opposite reason: respect for the wishes of the deceased and respect for the (current) memory of the family.

16. *Id.*

17. *See* James P. Orlowski et al., *The Ethical Dilemma of Permitting the Teaching and Perfecting of Resuscitation Techniques on Recently Expired Patients*, 1 J. CLIN. ETHICS 201, 202 (1990).

18. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, RESEARCH INVOLVING THE COMATOSE AND CADAVERS, *in* IMPLEMENTING HUMAN RESEARCH REGULATIONS 39-41 (1983) [hereinafter PRESIDENT'S COMM'N STUDY]. *See also* Orlowski et al., *supra* note 17, at 204.

19. PRESIDENT'S COMM'N STUDY, *supra* note 18, at 39-41.

20. Emergency Cardiac Care Comm. & Subcomm., Am. Heart Assoc., *Guidelines for Cardiopulmonary Resuscitation & Emergency Cardiac Care VIII: Ethical Considerations in Resuscitation*, 268 JAMA 2282, 2282 (1992).

techniques should be discouraged in Norway.[21] The British Medical Association's guidelines also prohibit the practice of intubation on recently dead patients, except in the cases of patients with severe craniofacial injuries.[22]

It is clear that most of the medical associations, even if they have guidelines on the issue of practicing on deceased patients, are not-for-profit membership organizations and only represent physicians. Much of their work in ethics is intended to provide guidance to physicians, but it is not expected that it will be endorsed by every healthcare entity in the country where they practice. Thus, healthcare facilities do not have the authority to sanction physicians for unethical conduct, and medical practices that are related to physicians' work is likely to be governed by state law or common law principles in general, rather than the healthcare facility.

III. THE ETHICAL PERSPECTIVE

A. Principles of Biomedical Ethics

Four major principles exist in biomedical ethics: respect for autonomy, the principle of nonmalfeasance, the principle of beneficence, and the principle of justice.[23] Respect for autonomy means not only a respectful attitude but also respectful action;[24] it involves acknowledging decision-making rights and enabling persons to act autonomously.[25] Therefore, since the newly dead cannot make decisions regarding the appropriate treatment of their body after death (assuming that there is not an advance directive), it is an ethical imperative to enable the next-of-kin to make these decisions on behalf of the recently dead on the principle of autonomy. Upon death, people enjoy autonomy in some regards. One such aspect is the proper handling of the body after death. The source of such autonomy exists in the social circumstances in which the dead was *and still is* (with regard to certain issues) engaged.

The second principle of biomedical ethics, the principle of nonmalfeasance, asserts an obligation not to inflict harm on another.[26] While to "wrong" someone means to violate someone's right, the concept of "harm" in this context need not involve such violation nor be restricted to

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21. Denny et al., *supra* note 6, at 949.
22. *Id.*
23. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 12 (4th ed. 1995).
24. *Id.* at 125.
25. *Id.*
26. *Id.* at 189.

rights possessed.[27] Rather, the term is so broad that it includes discomfort, humiliation, and offense.[28] Even if the deceased's family experiences the humiliation or the emotional discomfort, the proposed medical procedure on the dead is the direct cause for such harm.

The principle of beneficence requires protecting and defending the rights of others, preventing harm to others, and removing conditions that will cause harm to others.[29] While there is hardly any doubt that practicing and training life-saving procedures is enhances the welfare of others (and society in general), it is still necessary to respect the newly dead by requesting consent. By protecting some of the potential rights the dead hold, or alternatively, by preventing harm to the dead and consequently the next-of-kin, one is acting in accordance to the principle of beneficence. More importantly, performing secretive medical procedures away from the public eye with the intent of "benefiting" from an irreversible medical situation creates mistrust and disrespect for the medical profession. In the long run such a practice, when performed without consent, cannot be beneficial to medicine and medical professionals.

The last principle of biomedical ethics is justice. Justice is traditionally interpreted as fair, equitable, and appropriate treatment in light of what is due or owed to persons.[30] To deny the recently deceased the benefit of respectful treatment guaranteed by the legal and ethical mechanism of consent or to distribute burdens unfairly upon a group of people just because they are accessible in the emergency departments is to act unjustly.[31]

Having addressed these general principles and their application to the practice on the "newly-dead," the arguments for and against the consent requirement will be reviewed.

B. Opponents of the Consent Requirement

Opponents of the consent requirement argue that medical techniques that are practiced on the newly dead are minimally invasive[32] and do not disrupt "areas of the body exposed in a casket."[33] They further claim that

27. *Id.* at 190.

28. *Id.* at 192.

29. BEAUCHAMP & CHILDRESS, supra note 23, at 259.

30. *Id.* at 327.

31. *Id.* at 329.

32. James P. Orlowski et al., *The Ethics of Using Newly Dead Patients for Teaching and Practicing Intubation Techniques*, 319 N. ENG. J. MED. 439, 439 ("At worst, a tooth may be broken or dislodged.").

33. Kenneth V. Iserson, *Law Versus Life: The Ethical Imperative to Practice and Teach Using the Newly Dead Emergency Department Patient*, 25 ANNALS EMERGENCY MED. 91, 91

performing and perfecting these techniques is justifiable from a medical necessity and risk standpoint.[34] Accordingly, if the procedure is performed incorrectly, precious time is lost and death may result. It is argued that practicing resuscitation procedures not only has substantial social benefit, but that society has a substantial interest in maintaining an optimal number of emergency departments and emergency medical system personnel proficient in life-saving procedures.[35] The importance of these practices derives both from societal and utilitarian ethics that impose a duty on emergency personnel to practice and teach life-saving skills.[36] Indeed, it is emphasized that from a teleological analysis using cadavers for teaching purposes will benefit many living persons[37] and that based on various studies, there is an altruistic nature to the human being such that they would consent to use of their body for the benefit of the greater good.[38]

Further, opponents of the consent requirement add that practicing on cadavers is better than other practices because it allows students to actualize what they have been taught in the classroom.[39] Further, they argue that it is hard to justify inflicting suffering on animals to practice these procedures when postmortem teaching is frequently available.[40] The other alternative, prolonging resuscitations beyond the point where living patients can possibly benefit, is ethically corrupt and violates the ethical precepts of patient autonomy and non-malfeasance when clinicians practice and teach procedures on unsuspecting anesthetized patients in the operating room.[41]

Opponents of the consent requirement also highlight practical difficulties that emerge from such a requirement. They argue that considering the immediacy of the death, it is difficult and insensitive to request a proxy consent and it creates discomfort for the person requesting the consent. Further, they argue that it is preferable not to ask for permission from the family because it is often refused, and thus, a decreased number of clinical personnel will be trained should consent be required.[42] Asking for permission is also not practicable since usually the resuscitation team

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(1995).

34. Orlowski et al., *supra* note 17, at 201; Orlowski et al., *supra* note 32, at 439.

35. Kenneth V. Iserson, *Requiring Consent to Practice and Teach Using the Recently Dead*, 9 J. EMERGENCY MED. 509, 509 (1991).

36. Iserson, *supra* note 33, at 94.

37. Orlowski et al., *supra* note 32, at 440.

38. Iserson, *supra* note 35, at 509.

39. Benfield et al., *supra* note 6, at 2363 (comparing the effectiveness of medical students' training on cadavers as opposed to other techniques).

40. Iserson, *supra* note 33, at 92.

41. *Id. See also* Glader, *supra* note 3, at B1 (stating that hospitals continue to bill the nearly dead patients' insurance company for the procedures performed for medical training).

42. Iserson, *supra* note 35, at 509.

members are dispatched to other duties in the emergency department or the hospital, the body is sanitized, and the equipment and the room are cleaned and prepared for the next patient.[43]

In addition to the arguments for performing procedures without consent, opponents of the requirement of consent offer some ethical (and legal potential) constructions for consent. In their view, consent can be presumed because the next-of-kin "knows" in some way that techniques are practiced on newly dead patients.[44] Consent can also be presumed since a patient's admission into a teaching hospital is tantamount to giving permission to receive care from trainees under faculty supervision.[45] From this perspective, it is preferable to presume consent because the next-of-kin have irrational reactions to death, reactions of fear and guilt that inhibit survivors.[46] It is further argued that patients who die in emergency departments have implicitly given at least limited consent to practice and teach life-saving techniques by using the services of emergency medical personnel and by merely living in modern society which provides everyone a right to this care.[47] Even if this is not the case, opponents of the requirement of consent argue that it is unclear whether survivors have a right to refuse this permission.[48] According to this view, the right to make decisions concerning the integrity of one's body is a personal one that ends with death and may not be claimed by the next-of-kin.[49] A dead body is no longer believed to be a person and the obligation of respect has less force than when it is applied to living persons.[50] It is also argued that the dead have no claim for autonomy.[51] Accordingly, these patients can sustain injuries during the training sessions without violation of their rights.

C. *Supporters of the Consent Requirement*

Supporters of the consent requirement argue that consent (and in relevant cases, proxy consent) is a prerequisite for all medical touching, and that the

43. Iserson, *supra* note 33, at 93.

44. A.D. Goldblatt, *Don't Ask, Don't Tell: Practicing Minimally Invasive Resuscitation Techniques on the Newly Dead,* 25 ANNALS EMERGENCY MED. 86, 86 (1995).

45. Orlowski, *supra* note 32, at 440 (citing a study which found that only 37.5% of responding teaching hospitals specifically informed patients that medical students were involved in providing care).

46. Iserson, *supra* note 35, at 509.

47. Iserson, *supra* note 33, at 93 (questioning whether members of some religious groups who oppose "wronging" the dead can recuse themselves from such techniques, but later benefit from the knowledge gained in performing these techniques on others).

48. *Id.* at 92.

49. Orlowski et al., *supra* note 32, at 441.

50. *Id.* at 440.

51. Iserson, *supra* note 35, at 509.

likelihood of refusal of consent is an insufficient justification for not requiring consent.[52] They acknowledge the difficulty in requesting consent of surviving family members, but stress the fact that many requests for consent are made in analogous situations, for example organ and tissue donations and autopsies.[53]

In response to the argument that seeking consent from the next-of-kin will heighten grief or create anxiety,[54] supporters of the consent requirement argue that it is not as difficult to obtain consent as suggested.[55] They also argue that, even in situations where there is not sufficient time to establish rapport with the patient and family, requests that are sensitively made and framed around the importance of educating future physicians result in consent.[56] In addition and contrary to expectations, supporters note that studies have found a negative correlation between the discomfort that physicians experience while requesting consent and their ability to obtain consent.[57] Although physicians would rather not approach the family of the newly deceased to gain consent for potentially objectionable procedures, this discomfort does not override the benefits of obtaining consent.[58]

More importantly, using newly dead bodies without permission often makes physicians and trainees uncomfortable because their actions are hidden from the public.[59] This behavior associates the acts with something shameful or controversial.[60] When asked, physicians acknowledge that

52. Goldblatt, *supra* note 44, at 87.

53. *Id.* at 88.

54. Benfield et al., *supra* note 6, at 2363.

55. Robert M. McNamara et al., *Requesting Consent for an Invasive Procedure in Newly Deceased Adults*, 273 JAMA 310, 311 (providing results from a study that examined consent for endotracheal intubation in newly deceased infants and found that fifty-nine percent of the families gave consent to perform the procedures). *See* Mitchel B. Sosis & Ladd Shaner, *Letter to the Auditor*, 266 JAMA 1649, 1650 (1991) (discussing a study on the practice of dead infants that found that in eighty percent of the cases, consent was obtained). *See also* Benfield et al., *supra* note 6, at 2361 (setting forth results of a study in which resuscitation procedures were practiced on dead infants and where in seventy-three percent of the cases, consent was obtained).

56. Orlowski et al., *supra* note 17, at 203. *Cf.* McNamara et al., *supra* note 55, at 311 (citing a study showing the opposite conclusion, namely that the rate for consent was greater in cases classified as unexpected deaths (seventy-seven percent) compared with expected deaths (forty-one percent)).

57. McNamara et al., *supra* note 55, at 312.

58. CEJA ETHICS OPINION E-8.181.

59. Goldblatt, *supra* note 44, at 86. *See* Sosis & Shaner, *supra* note 55, at 1650 (providing the results of a questionnaire where 69.6% of student nurses and 86.9% of qualified nurses performing these procedures discussed their personal feelings on such procedures with their colleagues). *See also* Denny, *supra* note 6, at 953 (providing similar results of a Canadian study).

60. Benfield, *supra* note 6, at 2363 (arguing that the concept of "self-protection" of physicians may shed light on the lack of postmortem intubation studies in the literature).

while the practice can be justified, the deception cannot.[61] Thus, even from a personal standpoint, physicians and healthcare providers will greatly benefit from obtaining consent.

Other claims touch upon the negative consequences of not requesting consent. Some argue that using cadavers merely for the sake of education and training is disrespectful to the body and find support for such assertion in the deontological Kantian principle according to which "one may never use another person for one's own purposes."[62] There may also be a risk of psychological trauma to family members if they think this practice is an abuse or violation of their relative.[63] More generally, supporters of the requirement of consent argue that modern society is not one that enforces acts of altruism, but rather protects individual rights and freedoms.[64] In contrast to civil law, common law courts do not compel a person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person's health, even in cases where denying aid would result *in the death* of the endangered person.[65]

More significantly, the thought that others will be protective of their body's vulnerability after death often comforts people.[66] A special role is given to the next-of-kin. Indeed, a limited scope of statutes requiring autopsies or permitting harvesting organs acknowledges the right of the next-of-kin to protect the corpse.[67] In addition to these statues, the next-of-kin have legal duties to perform after the death of their beloved. It is thus inferred that not only do next-of-kin have quasi-property rights in the body of the dead,[68] but they also have moral claims on the body of a loved one, which include ensuring it be treated with respect.[69]

Finally, supporters of the consent requirement argue that the need to practice on newly-dead patients is relative as there are other alternatives available, such as practicing on animals or on artificial models.[70]

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61. Orlowski, *supra* note 17, at 204. *See also* Charles M. Culver, *Commentary to K.V. Iserson: Using a Cadaver to Practice and Teach*, 16 HASTINGS CTR. REP. 28, 29 (1986) (emphasizing the idea of deception).

62. Orlowski et al., *supra* note 17, at 203.

63. *Id.* at 201.

64. Goldblatt, *supra* note 44, at 87.

65. *See* McFall v. Shimp, 10 Pa. D. & C.3d 90 (Allegheny County Ct. 1978) (refusing to order Shimp to donate bone marrow, which was necessary to save the life of his cousin).

66. Goldblatt, *supra* note 44, at 88.

67. *Id.*

68. *See* Alice F. Kerns, *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, 588-89 (1997).

69. Orlowski et al., *supra* note 17, at 202.

70. *Id.* at 205.

Moreover, it has been indicated that using only mannequins and didactic sessions for teaching these skills is not less successful than using cadavers.[71] Hence, according to this view, practicing on a corpse without consent is an offense that can injure or offend not only the dead, but the living persons as well.[72]

IV. THE LEGAL PERSPECTIVE

What is the law's response to practicing resuscitation procedures on the newly-dead without consent? First, there is a question as to whether consent is a prerequisite to performing resuscitation procedures. Based on a legal analysis of the general common law principles of consent, the statutes that deal with consent in general, the statutes that discuss treatment of the corpse and the rules concerning research on human beings, consent is a legal prerequisite to performing resuscitation procedures. A second question, whether implied or presumed consent can be sufficient to the requirement of consent with regard to practice on the newly dead, will also be answered. A third and final question relates to the appropriate substitute decision-maker from whom consent should be obtained. Lastly, the legal consequences arising from performing the procedure without consent will be discussed.

A. The Necessity of Consent

1. Common Law

The notion of consent is a fundamental doctrine in law and medical ethics. Its origin lies in the common law maxim, according to which medical intervention can only be provided where the consent of the individual (usually the patient) to be treated has been obtained.[73] In *Malette v. Shulman* the court held that, as a matter of law, a medical intervention in which a doctor touches the body of a patient constitutes battery if the patient did not consent to the intervention.[74] It is agreed that the requirement of consent derives from the "greatest right"[75]—the right to inviolability of a person and to bodily integrity. Conceptually, such a right

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71. Samuel J. Stratton et al., *Prospective Study of Manikin-Only Versus Manikin and Human Subject Endotracheal Intubation Training of Paramedics*, 20 ANNALS EMERGENCY MED. 1314, 1316 (1991).

72. Goldblatt, *supra* note 44, at 89.

73. Schloendorff v. N.Y. Hosp., 105 N.E. 92 (N.Y. 1914). *See also* Pratt v. Davis, 118 Ill. App. 161, 166 (1905).

74. Malette v. Shulman, [1990] 71 O.R.2d 417 (Can.).

75. *Pratt*, 118 Ill. App. at 166.

is not extinguished with death.

Under common law, there are two general exceptions to the rule of consent. First, when healthcare providers are faced with legitimate emergencies, they can administer treatment without express consent.[76] Here, the treatment is usually necessary to save a life or to avoid health complications when the patient cannot provide consent. However, it is well established that the "emergency exception" does not apply where the reason for undertaking the procedure without consent has more to do with convenience than with an immediate need for treatment.[77] Under the second exception, treatment can be administered without consent if there is an explicit legislative provision allowing so.[78] Typically, there are two types of legislation with regard to this exception: mental health legislation and public health legislation concerning, for example, preventing the spread of a communicable disease.[79]

Practicing resuscitation procedures on the newly dead is not an emergency situation. In this context, the procedure does not aim to save the life of the patient. Although the goal of the procedure may be to improve the knowledge and ability of physicians in training so that they may save others' lives in the future, this does not fit within the original purpose of the exception to the consent requirement. As to the second exception, there is no explicit legislation that supports performing this practice without consent.

2. General Consent Legislation

The notion of the consent requirement has a place in the Canadian legislation and all provincial Acts clearly set forth this requirement. In Ontario, health practitioners who propose treatment for a person can not administer the treatment, and must take reasonable steps to ensure that it is not administered, unless (a) they believe the person is capable with respect to the treatment, and the person has given consent, or (b) they believe the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf.[80] "Treatment" in this context is defined broadly as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose,

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76. *See, e.g.*, Marshall v. Curry, [N.S. 1933] 3 D.L.R. 260, 268 (Can.); Murray v. McMurchy, [B.C. 1949] 2 D.L.R. 442, 443-44 (Can.). *See also* 64 CIVIL CODE OF QUEBEC 1(13) (1991) (providing statutory support).

77. ERIN NELSON, THE FUNDAMENTALS OF CONSENT, *in* CANADIAN HEALTH LAW & POLICY 111, 118 (Jocelyn Downie et al. eds., 2d ed. 2002).

78. *Id.* at 116.

79. *See, e.g.*, Public Health Act, R.S.A. ch. P-37, § 29-36 (2000) (Can.).

80. Healthcare Consent Act, S.O., ch. 2, sched. A § 10(1) (1996) (Ont.).

and includes a course of treatment, plan of treatment, or community treatment plan.[81] Practicing resuscitation procedures on the "newly-dead" can, of course, fall into the definition of an "other health-related purpose."

In British Columbia, the requirement of consent applies to any medical procedure defined as "healthcare."[82] Healthcare is divided into major and minor procedures.[83] The "major" procedures include surgery; any treatment involving general anesthetic, major diagnostic, or investigative procedures; or any healthcare designated by regulation as major healthcare.[84] The "minor" procedures include routine tests to determine if healthcare is necessary and routine dental treatment that prevents or treats a condition or injury caused by disease or trauma.[85]

The general rule in British Columbia is that a healthcare provider must not provide any healthcare to an adult without the adult's consent.[86] Further, if the patient is presently unable to give consent, the provider cannot decide whether to give or refuse substitute consent to the procedure unless having made every reasonable effort to obtain consent from the adult patient.[87] However, with regard to major healthcare, a healthcare provider may provide major healthcare to an adult without the adult's consent if, after consulting with appropriate people related to the adult, the provider decides that the adult needs the treatment and is incapable of giving or refusing consent to it.[88] In addition, the provider can make such a decision when the adult does not have a substitute decision-maker, guardian, or representative who is authorized to consent to the major healthcare; or when someone who has authority consents to the major healthcare, provides substitute consent, and the healthcare provider complies with the conditions set forth above.[89]

A sound interpretation of the Act is that practicing on dead patients is the same as treatment which involve a general anesthetic, and thus, not only does it fall into the category of "healthcare" but it also carries the characteristics (and hence the consequences) of statutorily defined "major," as opposed to minor, healthcare. In order to perform such a procedure without consent the exception requirements must be met or else such a

81. S.O., ch. 2, sched. A, § 2(1) (1996).
82. Healthcare (Consent) and Care Facility (Admission) Act, R.S.B.C, ch. 181, §§ 1, 5(1) (1996).
83. R.S.B.C., ch. 181, § 1.
84. R.S.B.C., ch. 181, § 1.
85. R.S.B.C., ch. 181, § 1.
86. R.S.B.C., ch. 181, § 5(1).
87. R.S.B.C., ch. 181, § 5(2).
88. R.S.B.C., ch. 181, § 11 (1996).
89. R.S.B.C., ch. 181, § 14(1) (1996).

performance may be illegal.

In Nova Scotia, a "patient" is defined as "a person who receives diagnosis, lodging or treatment at or in a hospital."[90] The definition of treatment is broad and includes any treatment performed in the hospital. According to this definition, a patient does not necessarily have to be alive to receive treatment. The general rule states:

> [W]here a person in a hospital requires medical or surgical treatment and is incapable of consenting to the required medical or surgical treatment for any reason and such person does not have a guardian or there is no one recognized in law who can give consent on his behalf to the required medical or surgical treatment, then the Trial Division of the Supreme Court or a judge thereof may upon *ex-parte* application by the Public Trustee authorize the required medical or surgical treatment.[91]

Under this section, a series of requirements must be fulfilled before performing any procedure and the health-care provider is not allowed to perform the treatment without consent. If the patient cannot obtain consent, a court decides the issue.[92]

The province of Quebec has a different model of the consent requirement. The general rule on consent in Quebec states that "no person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent."[93] However, "if the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place."[94] Similar to the Nova Scotia statute, the Quebec statute sets forth a broad definition to what is required for consent ("care of any nature") that clearly can include the practice on the newly dead for training purposes.

In sum, Canada's general consent legislation has incorporated the common-law requirement of consent to medical treatment, usually performed by the healthcare provider, and defined this treatment in a broad way that can include the practice on the recently dead. According to this legislation, a healthcare provider is not allowed to perform such treatment without obtaining consent of substitute decision-maker, family members, guardian, or court.

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90. Nova Scotia Statutes Hospitals Act, R.S.N.S. ch. 208 (1989).
91. R.S.N.S., ch. 208, § 9(1).
92. R.S.N.S., ch. 208 § 9(1).
93. 64 CIVIL CODE OF QUEBEC 11 (1991).
94. 64 CIVIL CODE OF QUEBEC 11.

3. Legislation and the Treatment of Dead Bodies

Not only does Canada have general consent statutes which imply that practicing on the newly dead could be illegal but there are also specific statutes dealing with the proper treatment and handling of corpses. In Alberta, for example, adult persons may consent, either in writing or orally during their last illness, "that [their] body or the part or parts of it specified in the consent be used after [their] death for therapeutic purposes, *medical education* or scientific research."[95] When a person has not given consent as described above, or, in the opinion of a physician, is incapable of giving consent because of injury or disease, and death is imminent, the statute authorizes the spouse of the patient, any adult children, adult siblings, adult next-of-kin, or the person lawfully in possession of the body, to consent on behalf of the patient for the same purposes, including medical education.[96] It is thus, very clear that the legislature did not intend to authorize the use of the patient's body for medical education without obtaining consent. The statute authorizes sanctions whenever this provision is violated.[97] The British Columbia[98] and Ontario[99] statutes are articulated in the same manner as the Alberta statute, requiring consent from someone able to give it before the body is used for any purpose.

In Quebec, there is no special or separate statute for treating the body of a deceased, and the general rule and the specific rule are consolidated in section 11 to the Civil Code of Quebec.[100] As mentioned, section 11 requests consent for "care of any nature." It is thus easy to assume that practicing on the newly dead falls into this category.

The provincial model of "gift acts" that address consent and disposal of the body after death is not unique to the Canadian legal system. In the United States, the Uniform Anatomical Gift Act (UAGA), consistent with the common law and adopted in some form by most states, expressly grants the next-of-kin the right to control disposal of the body.[101] Consent is a major component of the UAGA and has provisions that allow family

95. *See* HUMAN TISSUE GIFT ACT, R.S.A., ch. H-15, § 4(1) (2000) (Can.) (providing that the consent must be in writing and signed by the patient or the patient may give consent orally but there must be at least two witnesses) (emphasis added).

96. R.S.A., ch. H-15, § 5(1) (2000) (Can.).

97. R.S.A., ch. H-15, § 13 (2000) ("Every person who knowingly contravenes this Act is guilty of an offence and liable to a fine of not more than $1000 or to imprisonment for a term of not more than 6 months or to both.").

98. Human Tissue Gift Act, R.S.B.C., ch. 211 §§ 4(1), 5(1), 9, 14 (1996) (Can.).

99. Trillium Gift of Life Network Act, R.S.O., ch. H-20 §§ 4(1), 5(2), 9(1), 12 (1990) (Can.).

100. 64 CIVIL CODE OF QUEBEC 11 (1991).

101. UNIFORM ANATOMICAL GIFT ACT (UAGA), NAT'L CONFERENCE OF COMM'RS ON UNIFORM STATE LAWS, § 3 (1987).

members to make decisions concerning these issues.[102]

Another specific model, a rather progressive one, is the Israeli model.[103] In Israel, a new amendment to the "Anatomy and Pathology Act of 1954" now allows doctors to practice medical procedures on dead patients if the patient granted written permission in advance or if the family consented after the patient's death.[104] In addition to the written permission, new regulations require that three physicians sign a document stating that the procedure was aimed at treating patients, and only procedures on a specified list are permitted.[105]

4. Rules Relating to Research on Human Beings

Practicing on dead bodies for educational purposes is, arguably, for the benefit of patients. Those in favor of practicing resuscitation procedures on the recently dead argue that it is a form of "therapeutic research"; that is, research where the aim is to produce generalizable, practical knowledge.[106] Performing such research requires consent, and usually prior approval must be obtained from a research ethics board.[107] Moreover, with regard to consent required for research, courts tend to have a more demanding standard of disclosure where no intended benefit is expected for participants, as compared to the standard required for therapeutic procedures.[108]

Choosing to describe the practice of resuscitation procedures as research

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102. UAGA § 3. The Act also includes a provision that governs how individuals can give their bodies to medical schools/hospitals for various purposes.

103. Anatomy and Pathology Act, 1954 (1953-1954) (Isr.).

104. Anatomy and Pathology Act, 1954, § 6(c)(1) (Isr.).

105. Anatomy and Pathology Act, 1954 (Isr.) (including procedures such as inserting an air tube; inserting a laryngeal mask into the airway; performing a tracheostomy; performing a vena section; inserting a catheter into the saphenous vein; inserting a catheter into the external jugular vein; inserting a catheter into a subclavian vein; locating and exposing the malleolus; inserting an intraossous needle; inserting an intercostal trochar (drain) and attaching it properly to the chest drain; releasing pressure using a large needle; inserting a catheter into the bladder; and performing an artificial heart transplantation). For discussion on the new Israeli rules see Judy Siegel-Itzkovich, *Israeli Doctors May Now Use Cadavers for Training Purposes*, 322 BRIT. MED. J. 511 (2001) *available at* www.findarticles.com/cf_0/m0999/7285_322/72431794/pl/article.jhtml.

106. Orlowski et al., *supra* note 32, at 439. For an elaborate picture of different uses for research purposes done on cadavers see KENNETH V. ISERSON, DEATH TO DUST: WHAT HAPPENS TO DEAD BODIES? 119-21 (2d ed. 2001). *See generally* Dorothy Nelkin & Lori Andrews, *Do the Dead Have Interests? Policy Issues for Research After Life*, 24 AM. J.L. & MED. 261 (1998).

107. 64 CIVIL CODE OF QUEBEC 22 (1991). *See also* ETHICS REVIEW, RESEARCH REQUIRING ETHICS REVIEW, ART. 1.1-1.14 (Can.), *available at* www.ncchr-cnerh.org/english/code_2/sec01.html.

108. NELSON, *supra* note 77, at 385.

is not without criticism; it is neither a "systematic investigation to establish facts, principles or generalizable knowledge" nor an "activity designed to test a hypothesis, permit conclusions to be drawn and thereby to develop or contribute to generalizable knowledge."[109] Interpreting the practice of such procedures on the newly dead as research when it clearly is not typical research strengthens the conclusion that practicing on dead bodies without consent is illegal.[110] Because practicing such procedures does not contribute to generalizable knowledge or benefit the recently dead, consent should be required. In sum, a legal analysis based on general common law principles of consent, statutes that deal with consent, statutes that discuss the treatment of the corpse, and rules concerning human subject research, leads to the same result: obtaining consent for practicing on the newly dead is a legal requirement.

B. The Sufficiency of Implied or Presumed Consent

Consent can be express or implied.[111] Once a person has died, consent is obtained either by directive or by the pre-death signing of a consent form.[112] Implied consent is less clear and can be inferred from circumstances.[113] For example, consent may be implied or presumed in a situation where the medical procedure is performed unless the patient or next-of-kin objects ("opt-out").[114] Another situation where consent is presumed or implied involves situations where a patient gives express consent to a procedure and the provider infers consent to perform any procedures that may become necessary during the course of the main procedure.[115] Finally, one can imply consent through application of the reasonable person test.[116] Under this test, the question of whether the patient would have consented to the medical treatment is answered by setting forth a hypothetical scenario in

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109. BELMONT REPORT: ETHICAL PRINCIPLES & GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH, DEP'T. OF HEALTH, EDUC., & WELFARE, OFFICE OF THE SEC'Y, PROTECTION OF HUMAN SUBJECTS REPORT OF THE NATIONAL COMMISSION FOR THE PROTECTION FO HUMAN SUBJECTS OF BIOMEDICAL & BEHAVIOR RESEARCH 15 (1979).

110. NELSON, *supra* note 77, at 120-25, 129-56.

111. *Id.* at 113.

112. *Id.*

113. *Id. See* O'Brian v. Cunard Steamship Co., 28 N.E. 266 (Mass. 1891). *See also* Reynen v. Antonenko [1975] 20 C.C.C. (2d) 342 (Can.).

114. This form of consent is particularly common in Europe, especially in the context of organ transplantation. Samatha A. Wilcox, *Presumed Consent Organ Donation in Pennsylvania: One Small Step for Pennsylvania, One Giant Leap for Organ Donation*, 107 PENN. STATE L. REV. 935, 938 (2003).

115. *See, e.g.*, Villeneuve v. Sisters of St. Joseph of Diocese of Sault Ste. Marie, [1971] 2 O.R. 593, *revised* [1972] 2 O.R. 119 (Can.)

116. NELSON, *supra* note 77, at 114.

which the court asks whether a reasonable person in the circumstances of the patient would have consented to the treatment. The court used such a test to determine whether a blood donor, who was not told that samples of his blood would be stored or tested for HIV antibodies, would have consented to have his blood tested for HIV.[117]

Although implied consent may express the patient's wishes, express consent is preferable for two reasons: (1) implied consent leaves the patient out of the process and therefore runs counter to the philosophy underlying the law with respect to consent; and (2) express consent provides better evidence (as opposed to reliance on implied consent) that the patient has given permission for the proposed treatment.[118] Indeed, when relying on implied consent it is essential that the circumstances from which the consent is inferred be clearly documented. The circumstances under which resuscitation procedures are performed—for example, in the intensive care unit, minutes after death, with the medical team surrounding the patient—are less than ideal circumstances under which to ask for documentation.

Besides the doubtful base upon which presumed consent rests, there are several reasons to ask for explicit consent. Traditionally, situations involving resuscitation procedures on the newly dead do not fall into the category of either implied or presumed consent. It is unreasonable to believe that patients and their families will be aware of the practice of using the recently deceased for teaching purposes. Also, the number of patients who die sudden and unexpected deaths in emergency rooms and intensive care units makes it difficult to interpret the silent behavior of the next-of-kin as consent to these procedures. Further, there are many people who, because of ideological, religious,[119] or personal beliefs, strongly oppose any use or interference with their body after death. One cannot fully respect their convictions by only presuming or implying their consent.

Moreover, the law regards the notion of consent not as a mere contract between the patient and the physician but as a *process* aiming to ensure that no treatment is performed without the agreement of the patient.[120] The procedural character of the consent requirement has led courts to recognize the patient's right to withdraw treatment at any time or stage of the treatment after an initial consent was given.[121] Accordingly, consent is not determined by the doctor-patient relationship that ends with the patient's death. Rather, it has a deeper origin that rests in respect to the patient.

117. Canadian AIDS Soc'y v. Ontario, [1995], 25 O.R. (3d) 388 (Gen.Div.).
118. NELSON, *supra* note 77, at 114
119. *See* Kerns, *supra* note 68, at 609-10 (discussing religious convictions).
120. NELSON, *supra* note 77, at 114.
121. Ciarlariello v. Schacter, [1993] 2 S.C.R. 119, 136 (Can.).

C. Giving Consent

When a patient's consent cannot be obtained, treatment should proceed unless the patient's proxy decision-maker consents.[122] In Canada, although family members often make decisions regarding the treatment of their deceased,[123] under the common law and in the absence of legislative authority stating otherwise[124] the only person who has the legal right to consent or to refuse treatment on behalf of a patient (who lacks the capacity to do so) is the patient's court-appointed guardian or the court itself.

An alternative to asking for consent from family members is to "judicialize" the proposed medical process.[125] The court's involvement can be useful when there is irresolvable conflict within the patient's family. However, "it may be superfluous when it is used merely to formalize a decision which has already been made and which no one has challenged and which involves no real dispute, controversy, or conflict."[126] In the case of practicing on the newly dead, there will probably be fewer controversial cases within the family than, for example, in cases of passive euthanasia where the question is whether to withdraw life-sustaining treatment. When there is little controversy, it is better that the decision to perform the medical procedure, and thus the consent for it, be obtained from the family. The court should only be used as a last resort.

It is possible to appease all parties—medical providers, family members, judicial officers—on the issue of consent. Empirical studies show that consent is more often obtained when requests are sensitively made and are framed in terms of the importance of enabling physicians to save other lives.[127] Thus, it is possible to cooperate and to develop a discourse that will yield a result that satisfies all parties involved.

Performing resuscitation procedures without consent can have legal ramifications. The various causes of action in both criminal and civil law that may be available will be examined and strengths and weaknesses of each argument will be highlighted in the following section.

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122. McNamara et al., *supra* note 55, at 311 (stating that the spouse was generally more willing to give consent (seventy-seven percen of the time) than the children (only fifty percent of the time).

123. 64 CIVIL CODE OF QUEBEC 15 (1991).

124. Healthcare Consent Act, ch. 2, § 20 (1996). *See* 64 CIVIL CODE OF QUEBEC 15 (1991).

125. *See* PROTECTION OF LIFE: EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT 64 (Law Reform Comm'n of Canada, Working Paper No. 28, 1982).

126. *Id.*

127. Orlowski et al., *supra* note 17, at 203.

1. Criminal Offense

Practicing on the newly dead without consent can constitute an offense in Canada and in some states in the United States. The Criminal Code of Canada states that "every-one who . . . (b) improperly or indecently interferes with or offers any indignity to a dead human body or human remains, whether buried or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years." [128]

However, protection of the human corpse through criminal law is not unique to Canada. Some states in the United States make it a crime to mutilate or mistreat a corpse. The California Health and Safety Code, for example, states that "every person who willfully mutilates, disinters, or removes from the place of interment any human remains, without authority of law, is guilty of a felony."[129] In Massachusetts, whoever "willfully digs up, disinters, removes or conveys away a human body . . . or knowingly aids in such disinterment, removal or conveying away" is subject to jail time and monetary penalties.[130] Ohio has similar provisions.[131]

2. Civil Liability

Practicing resuscitation procedures on the recently dead can also result in civil liability. Almost every province in Canada has specific statutes that deal with the treatment of dead bodies.[132] These statutes include certain

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128. Canadian Criminal Code, R.S.C. ch. C-46 (1985) (Can.).

129. CAL. HEALTH & SAFETY CODE § 7052 (West 2003). This section, however, does not apply to any person who, under authority of law, removes the remains for reinterment, or performs a cremation.

130. MASS. GEN. LAWS ANN. ch. 252, § 71 (West 1982).

131. OHIO REV. CODE ANN. § 2927.01 (West 2003). The statute provides that:

> (A) No person, except as authorized by law, shall treat a human corpse in a way that the person knows would outrage reasonable family sensibilities.
>
> (B) No person, except as authorized by law, shall treat a human corpse in a way that would outrage reasonable community sensibilities.
>
> (C) Whoever violates division (A) of this section is guilty of abuse of a corpse, a misdemeanor of the second degree. Whoever violates division (B) of this section is guilty of gross abuse of a corpse, a felony of the fifth degree.

132. *See e.g.*, Human Tissue Gift Act, R.S.A. ch. H-15 (2000) (Can.) (stating that, in Alberta, "[e]very person who knowingly contravenes this Act is guilty of an offence and is liable to a fine of not more than $1000 or to imprisonment for a term of not more than 6 months, or to both"). *See also* Human Tissue Gift Act, R.S.B.C. ch. 211 (1996) (Can.); Trillium Gift of Life Network Act, R.S.O. ch. H-20 (1990) (Can.). The Trillium Gift of Life Network Act states that a defense to such a liability is given to a:

> [M]ember of the medical or other staff of a designated facility or any other person employed in a designated facility for any act done or performed in good faith in the performance or intended performance of any duty or function or in the exercise or intended exercise of any power or authority under this Act or for any neglect, default or omission in the performance or execution in good faith of any

provisions that make the consent requirement mandatory in circumstances that can be interpreted to encompass situations involving the practice of resuscitation procedures on the "newly-dead." Acting without consent is a direct violation of these provisions and may result in prison time and fines.[133] Violation of specific provisions, in this regard, is not unique to Canada; the UAGA[134] also provides for the imposition of civil liability. In addition, there are several bodies of law, including tort law, contract law, trust law, constitutional law, and property law that provide support for imposing civil liability in addition to criminal sanctions upon those who practice resuscitation procedures without obtaining informed consent.[135]

a. Battery

While violation of specific legislative provisions can result in civil liability, violation of tort law principles can similarly result in civil liability. Typically, treatment of any kind without the consent of the person being treated results in a battery (the unauthorized physical interference with a person) whether or not interference causes physical injury, and even if the patient benefited from the treatment.[136] As set forth in *Malette*, "[a]ny non-consensual touching which is harmful or offensive to a person's reasonable sense of dignity is actionable" as a battery.[137] Thus, is arguable that the practice on dead bodies without obtaining consent can result in a successful claim of battery under the principles set forth in *Malette*.

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duty, function, power or authority under this Act.

133. *See supra* note 133.

134. *See generally* UNIFORM ANATOMICAL GIFT ACT, NAT'L CONFERENCE OF COMM'RS ON UNIFORM STATE LAWS (1987), *available at* http://www.law.upenn.edu/bll/ulc/fnact99/usaga87.htm (stating under what conditions organ donation is allowed).

135. *See e.g.*, RESTATEMENT (SECOND) OF TORTS § 868 (1979). The Restatements of Torts specifically identifies a claim for interference with dead bodies. It states that "[o]ne 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." *See* Constance F. Fain, *Civil Liability of Hospital for Negligent Handling, Transportation, and Disposition of Corpse*, 86 A.L.R. 5th 693 (2001) (stating that courts have noted that the Restatement approach represents a minority view whereas the traditional majority rule requires wanton, malicious, or intentional interference with a dead body and does not extend to negligent misconduct). For one of the first judicial opinions finding liability for the unlawful mutilation of the body of the recently deceased see Larson v. Chase, 50 N.W. 238 (Mass. 1891).

136. LEWIS KLAR, TORT LAW 41 (2d ed. 1996); Malette v. Shulman, [1990] 72 O.R. 417 (Can.).

137. Malette v. Shulman, [1990] 72 O.R. 417 (Can.).

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b. Invasion of Privacy

An invasion of privacy claim is another potential tort claim that can be brought when resuscitation procedures are performed without first obtaining consent. There are two questions that arise with regard to a claim for invasion of privacy. First, does the dead patient have a constitutional right to privacy? Second, assuming that the answer is affirmative, does violation of the right to privacy result in civil liability?

The right to privacy, as originally conceived, is the right to be left alone and includes one's interest in personal dignity and self-respect.[138] The right to privacy is widely recognized by the international human rights law,[139] although it is not explicitly mentioned in the Canadian Constitution. However, there is consensus that this right is protected by certain provisions of the Constitution, specifically in Articles 7 and 8 of the Canadian Charter of Rights and Freedoms which accords "the right to life, liberty and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice . . . and to be secure against unreasonable search or seizure."[140] In the dissenting opinion of the *Rodriquez* court, Justices McLachlin and Cory stated that Article 7 of the Charter, which emphasizes the innate dignity of human existence, protects the dying since it is viewed as an integral part of living. [141] Applying this reasoning, one could argue that the person in the intensive care unit, minutes after being pronounced dead, is still under going the process of dying and cannot, and should not, be disrupted by the pronouncement of death itself let alone a resuscitation procedure.

Assuming that the issue at stake involves a violation of the right to privacy, the question then becomes whether this violation results in civil liability. There is no consistent approach to liability for the invasion of

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138. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 195 (1890).

139. *See* Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. GAOR, 3rd Sess., U.N. Doc A/810 at 71 (1948), *available at* http://www.un.org/Overview/rights.html (recognizing basic human rights). *See also* The International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *available at* http://www.unhchr.ch/html/menu3/b/a_ccpr.htm (recognizing rights derive from the inherent dignity of being human); Council of Europe, The European Convention on Human Rights, art. 8(1) (1950), *available at* http://www.hri.org/docs/ECHR50.html (recognizing basic human rights).

140. Canadian Charter of Rights & Freedoms, Part I of the Canadian Constitution Act, Art 11 (stating that the rights guaranteed in the Charter are subject only to such reasonable limits prescribed by law "as can be demonstrably justified in a free and democratic society"). Interestingly, in Article 7, the constitutional rights holder is defined by the word "everyone" as opposed to "person," (ART. 6) or "individual" (ART. 15). This serves as a strong response to the claim that the dead patient, who is no longer a person, does not have right to privacy.

141. Rodriguez v. British Columbia (Attorney General), [1993] 3 S.C.R. 519, at 630.

privacy in Canada. While courts have tended not to recognize a tort action for invasion of privacy *per se*,[142] over the past few decades there have been indications of a nascent common law tort for breach of privacy.[143] Moreover, in four provinces, British Columbia,[144] Manitoba,[145] Saskatchewan,[146] and Newfoundland,[147] Privacy Acts have created a statutory tort. Section 2 of the Saskatchewan Act, which serves as a model for the other privacy acts, declares that it is a tort to violate, willfully and without claim of right, the privacy of another.[148] The tort is actionable *without proof of damage*.[149] Section 3 of the Act describes conduct that, in the absence of consent, is prima facie evidence of a violation of privacy.[150] The Act authorizes a broad range of remedies, including damages, an injunction, an accounting for profits that have accrued as a consequence of the violation of privacy, and orders for the surrender of articles or documents that have been secured through a violation of privacy.[151] Accordingly, practicing on the newly dead without consent can constitute a violation of privacy by virtue of either Section 2 or Section 3.

c. Negligent Practice on the Dead Without Consent

Of all of the potential tort claims, a claim for negligence is perhaps one of the more obvious. In order to sue a physician for negligently practicing on the recently dead without first obtaining consent, the plaintiff must satisfy the basic elements of a negligence claim: (1) the existence of a duty of care; (2) breach of that duty; (3) a causal link between the defendant's negligence and the plaintiff's injury, and (4) damages.

Thus, the initial question is whether the healthcare provider owes a duty to the recently deceased. The obvious problem is that upon the patient's

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142. *See, e.g.*, Bingo Ent. Ltd. v. Plaxton, [1986] 26 D.L.R. 604, 608 (Can.) ("It would appear that at common law the tort of violation of privacy in regard to disclosure of private information has not been recognized in Canada").

143. *See, e.g.*, Saccone v. Orr, [1981] 34 O.R.2d 317; Capan v. Capan, [1980] 4 O.R.3d 740; Roth et al. v. Roth et al., [1991] 4 O.R.3d 740. Despite the movement toward a common law breach of privacy tort, in a recent case, an Ontario court refused to apply such an action *per se* to the circumstances of that case. *See* Weingeral v. Seo, [2003] O.J. 4277.

144. British Columbia Privacy Act, R.S.B.C. ch. 373 (1996). As evidence of the enforcement of this tort of invasion of privacy in British Columbia see Lee v. Jacobson, [1992] 87 D.L.R. 401 (Can.).

145. Manitoba Privacy Act, R.S.M., ch. P125 (1987).

146. Saskatchewan Privacy Act, R.S.S., ch. P-24 (1978).

147. Newfoundland Privacy Act, R.S.N., ch. P-22 (1990).

148. R.S.S., ch. P-24, § 2 (emphasis added).

149. R.S.S., ch. P-24, § 2.

150. R.S.S., ch. P-24, § 3 (1978).

151. R.S.S., ch. P-24, § 7 (1978).

death the doctor-patient relationship, traditionally the source for such a duty, ceases to exist. Is it possible to argue that the healthcare provider owes a duty of care to the dead patient based on the former's representations of a willingness to render assistance if needed and the latter's reliance on this representation? This might be a more reasonable assertion then the assertion that there is no continuing relationship between the dead patient and the provider. However, this assertion is problematic, raising several new questions. What is the scope of the assistance that the healthcare provider represented? Didn't the duty cease once the patient (and his reliance) die?[152]

Despite these questions, a Missouri Court of Appeal recently held that such a duty can be established under the UAGA.[153] In *Schembre v. Mid-America*, the family of a deceased patient brought a negligence suit against a transplant association and a hospital for removing the deceased's corneas, bone, and tissue.[154] Although an issue of first impression in Missouri, the court looked to other jurisdictions to address the issue.[155] Specifically, the court looked to Florida, which had adopted a standard requiring a finding of acting "without negligence and in good faith" in order for a party to be immune from civil liability under the UAGA. After setting forth the facts, the Missouri court stated that while there was "no dispute that MTS [Mid-America Transplant Services] ha[d] a duty to follow the requirements set forth under the UAGA in order to compete a valid organ donation,"[156] MTS followed those requirements.[157] Thus, the court held that MTS was not negligent when removing the decedent's corneas, bones, and tissue.[158] Although the plaintiffs were unsuccessful in their suit, the case is important because the court recognized that a healthcare provider does have a duty to the recently deceased under the UAGA. It remains to be seen, however, how courts will find such a duty when the medical procedure is not covered under the UAGA.

Accordingly, it is difficult to infer a duty of care premised on the special relationship between the patient and the provider. A possible solution from the next-of-kin's perspective is to assert a claim against the provider for breach of the duty of care owed to the family or relatives of the dead

152. *See* Kenneth V. Iserson, *Using a Cadaver to Practice and Teach*, 16 HASTINGS CTR. REP. 28, 29 (1986).

153. Schembre v. Mid-America Transplant Ass'n, 2003 WL 21692986 (Mo. App. E.D. 2003).

154. *Id.* at *1.

155. *Id.* at *3.

156. *Id.* at *4.

157. *Id.*

158. *Id.*

patient.[159] Assuming that the doctor does have a duty to the family, what is the standard of care? Generally, a doctor is required to exercise the same degree of skill and care that could reasonably be expected of a practitioner of the same experience and standing.[160] According to the "approved practice" concept, a doctor is not negligent if she is shown to have acted in accordance with accepted medical practice.[161] The rationale is that in a malpractice suit a judge or a jury does not have the medical expertise or knowledge of those who testify or argue at trial. Although a bad practice, performing resuscitation procedures on the "newly-dead" without consent is, unfortunately, an accepted practice. Despite this, arguing that it is an "approved practice" is a weak argument since the justification for the negligence standard—the lack of medical expertise between the judge or the jury—may not apply here. The question at stake is not *what* is being practiced and trained, rather *how* these procedures are performed. Such a practice, when done without consent, is contrary to the professional association guidelines previously discussed and should not be considered "acceptable."

In negligence cases, the plaintiff bears the burden of proving that the doctor's negligence was the cause of the plaintiff's injury.[162] Negligence is actionable only with a proof of damages. Can the dead be harmed or is the practice of resuscitation procedures more a "wrong" rather than a "harm" to the dead?[163] If one accepts the proposition that a person can commit a dignified wrong to a dead body, one must accept the causative relation between the resuscitation procedure and the wrong committed.

Perhaps infringing on the dignity of the dead may suffice for bringing an action in tort, but as a matter of public policy, is this sufficient to establish an action in negligence? Again, the legal implications of the resuscitation procedures, as related to the next-of-kin rather than the dead, may make any

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159. Another possible way of inferring a duty of care to the dead was established in the Supreme Court decision *Reibl v. Hughes*, [1980] 112 D.L.R. (3d), 1 S.C.C. (Can.). In *Reibl*, the Supreme Court located the duty to obtain informed consent primarily within the realm of negligence. *Id.* Although the court held that the battery claim is appropriate in situations where no consent was obtained at all (as compared to situations where consent was obtained but on the basis of incorrect information), the fact that the court found a duty of care with regard to acts that were not in the strict scope of the initial consent may perhaps support the view that the court is gradually willing to import also the law of negligence to the concept of consent. *Id.*

160. Crits v. Sylvester, [1956] S.C.R. 991; Poole v. Morgan, [1987] 50 Alta. L.R.2d 1203 (Can.).

161. Weingeral v. Seo, [2003] O.J. 4277.

162. Snell v. Farrell, [1990] 72 D.L.R. 289 (Can.).

163. *See generally* Callahan, *supra* note 5 (discussing whether the dead can be harmed). *See also* FEINBERG, *supra* note 5, at 83-84 (arguing for a posthumous harm made to the surviving interests of the deceased).

discussion about the sufficiency of an action in tort stronger because of the mental anguish and the emotional suffering experienced by the next-of-kin upon learning about the procedures.

In sum, because the patient is deceased, difficulties may arise with respect to each element of the negligence claim if based upon the doctor-patient relationship. However, a negligence claim may be possible when brought by the next-of-kin and premised on the lack of informed consent argument.

d. Hospital Liability for Negligent Handling of a Corpse

Since most resuscitation procedures are performed in teaching hospitals, the hospital's responsibility for the negligence of physicians and residents employed by the hospital is also an issue. As in any malpractice suit, the plaintiff will have to prove the existence of a duty of care, the breach of that duty, a casual link between the defendant's negligence and the plaintiff's injury, and damages. In this context, a hospital can be both vicariously liable and directly liable.

As a general rule, employers are vicariously liable for torts of their employees committed in the course of employment.[164] Hence, if a doctor is found liable for an action performed at a hospital, the hospital is automatically liable. However, although the practice of resuscitation procedures on the recently deceased takes place in medical schools affiliated with hospitals, the vicarious liability formula is not that simple. Doctors in Canada are independent contractors with the hospitals rather than employees and,[165] as such, the hospital is not vicariously responsible for their negligence.[166] However, interns and residents who are the main "beneficiaries" of the resuscitation are regarded as employees of the hospital.[167] Thus, the hospital may be found liable for the latter's actions and not for the former's.

In addition to vicarious liability, the hospital can be directly liable for the patient's care and treatment. The hospital has a duty to its patients to select and maintain competent and ethical staff and to provide proper instruction and supervision for the staff.[168] In terms of research conducted at a

164. B. (K.L.) v. British Columbia, [2003] S.C.C. 51 (Can.).

165. Doctors are granted hospital privileges, but they are not paid by the hospital. In the healthcare system in Canada doctors bill the provincial health plan for their services to the patient.

166. Yepremian v. Scarborough Gen. Hosp., [1980] 110 D.L.R. 513 (Can.).

167. ELLEN I. PICARD & GERALD B. ROBERTSON, LEGAL LIABILITY OF DOCTORS AND HOSPITALS IN CANADA 384 (3d ed. 1996).

168. Ellen Picard, *The Liability of Hospitals in Common Law Canada*, 26 MCGILL L.J. 997, 1007 (1981).

hospital, a hospital may have a direct duty of care to research participants, derived, again, from the duty to select a competent and ethical staff of researchers.[169] The duty of care of a hospital-defendant with regard to practicing on dead bodies without consent should be based on the standard of care that is reasonably expected of someone dealing with corpses.[170]

As in negligence cases brought against the provider, proof of damage to the corpse and causation can be troublesome. A solution to the problem of proof of damage could be a claim by a family member against the hospital for negligent handling of a corpse.

In sum, attempting to hold a hospital liable for practicing resuscitation procedures raises some difficulties. Whereas hospitals can be held vicariously liable for medical procedures performed by residents or interns, a hospital may not be liable for actions performed by physicians. Moreover, finding a hospital directly liable for negligence is also questionable because of the impediments which arise in trying to prove a casual relation between the negligent performance of the hospital and actual damage to the deceased.

e. Infliction of Emotional Distress

A family exposed to unnecessary distress at a time of profound grief may be able to bring a claim for infliction of emotional distress. In *Lacy v. Cooper Hospital*, the plaintiffs alleged intentional infliction of emotional distress against a hospital doctor for performing a resuscitation procedure on their recently deceased child, immediately after the child had been pronounced dead.[171] The court analyzed both intentional infliction of emotional distress and negligent infliction of emotional distress.[172] The court set forth four elements necessary to succeed on a claim for intentional infliction of emotional distress: (1) the plaintiff has to show that the defendant acted intentionally or recklessly; (2) that such conduct must be so outrageous as to be "utterly intolerable in a civilized community"; (3) that such conduct is the proximate cause of the emotional distress; and (4) that the emotional distress is unbearably severe for a reasonable person to withstand.[173] In comparison, negligent infliction of emotional distress requires that the plaintiff show that the defendant owed a duty to the

169. NELSON, *supra* note 77, at 494.

170. *See generally* Fain, *supra* note 135 (discussing standard of care).

171. Lacy v. Cooper Hosp., 745 F. Supp. 1029, 1032 (D.N.J. 1990) ("The nurse testified that '[a]fter the man was pronounced dead, Dr. Dunst proceeded to perform a thoracentesis even after I told him that it was unacceptable to practice on patients. He told me he was not practicing and was going to do it anyway!!'").

172. *Id.* at 1033.

173. *Id.* at 1034-35.

plaintiff, that the defendant breached the duty, and that the plaintiff was injured as a result of this breach.[174]

In terms of intentional infliction of emotional distress, while it is clear that the healthcare provider acts intentionally when performing resuscitation procedures on the dead, the healthcare provider probably does not intend to cause emotional distress. In this scenario, the doctor's conduct could be defined as reckless, rather than intentional, in order to satisfy the first element of the claim. However, it would be difficult to argue that the conduct is reckless, as studies suggest the doctors, nurses, and interns are very worried when they do not ask for consent.[175] Thus, while on one hand, there is no intention, on the other hand, it seems inappropriate to call the health provider's behavior " reckless" based on the obvious concern these professionals voice when not first obtaining consent.

In addition, it is doubtful that the practice of resuscitation procedures on the "newly-dead" could satisfy the second element—that the conduct be so outrageous as to be "utterly intolerable in a civilized community"—especially given the social benefits, particularly, the deeper professional knowledge and skill of health practitioners who have practiced such procedures. It would also be difficult to prove the proximate cause of the emotional distress. Arguably, the next-of-kin could assert that the emotional distress caused by the death is exacerbated by the performance of resuscitation procedures without consent. However, given the fact that emotional distress is subjective in nature, it would be difficult for the plaintiffs to convince the judge or the jury that their personal reactions were unbearably severe, especially when asked to do so in light of the "reasonable person" standard.[176]

f. Breach of Contract

The doctor-patient relationship, particularly in a fee-for-service system, is a contractual one.[177] One of the implied terms of the contract is that the doctor will exercise reasonable care in treating the patient.[178] Reasonable care includes asking for the patient's consent (or the consent of the next-of-

174. *Id.* at 1035.

175. McNamara et al., *supra* note 55, at 312.

176. *See, e.g.*, Strickland v. Madden, 448 S.E.2d 581 (S.C. Ct. App. 1994) (representing a more radical situation where the court did not find that the physician's conduct in informing patient's daughter that her father had died when he was in fact still alive rose to the level of outrageous). Even the fact that the physician was allegedly under the influence of alcohol, in violation of statute, was not evidence of recklessness. *Id.* at 585.

177. GERALD ROBERTSON, NEGLIGENCE AND MALPRACTICE, *in* 91 CANADIAN HEALTH LAW & POLICY 105 (Jocelyn. Downie et al. eds., 2d ed. 2002).

178. *Id.*

kin when the patient is incapable of providing consent).[179] Another implied contractual term is that the doctor will treat the patient with respect.[180]

The advantage of a breach of contract claim over a tort claim such as negligence is that it enables the plaintiff to avoid having to argue that the doctor owes a duty of care to the deceased. Furthermore, by bringing a claim under contract law, the plaintiff does not have to make the even more difficult argument that the deceased was harmed by the performance of resuscitation procedures.

However, a claim based on the contractual relationship of the doctor and the patient is not without problems. One such problem is that traditionally, once the patient is dead and fees are no longer paid for any service, the contractual relationship between the patient and the doctor is considered over.[181] Another problem is that even if such a contract (or merely the physician's contractual obligation) exists despite the patient's death, it is a mistake to imply that the parties intended for the implied terms of reasonable treatment and respect to still be applicable. Additionally, the next-of-kin may not be able to establish privity of contract between themselves and the doctor; thus, they will be precluded from bringing a breach of contract claim since there was no contract between the next-of-kin and the doctor.

g. Breach of Fiduciary Duty

In addition to being contractual, the doctor-patient relationship is also fiduciary in nature and requires that the doctor act in good faith and care for the patient's best interests.[182] More importantly, the nature of the relationship requires that doctors must not let their own interests (such as the interest in progress and further development of medical knowledge) conflict with those of their patients (such as the interest to be respectfully treated and to be free from unwanted medical intervention). Here again there might be a problem concerning the nature of the relationship in terms of bringing suit. Does a fiduciary relationship end with the patient's death? Or is it a different type of relationship than, for example, that in a contractual relationship, or the relationship that serves as a foundation for a duty of care claim? These are questions that remain unresolved.

179. *Id.*

180. *Id.*

181. The patient's stay at the hospital can nevertheless be covered by an insurance company. If this is the case, then, in the author's opinion, the contractual relationship between the patient and the doctor continues even after the patient's death.

182. *See* J.R.I.G. v. Tyhurst, [2001] B.C.S.C. 441 (showing a doctor who did not act in his patient's best interests).

h. Due Process

The next-of-kin may also be able to bring a claim for violation of the deceased's due process rights. Article 7 of the Charter encompasses the concept of Due Process protection and allows for protection of life, liberty, and security of person.[183] A claim for violating the newly deceased's due process rights is likely to be successful. Cornea removal cases provide a good analogy for comparison.

Although there are no cases on point in Canada, plaintiffs in the United States have brought successful due process claims under the United States Constitution in cases where the deceased's body was violated. However, the American courts did not always recognize the constitutional rights of the next-of-kin in the body of the deceased. In fact, the first cases rejected the notion that the next-of-kin had any rights in the body at all.

The Supreme Court of Florida first confronted the due process issue in *State v. Powell*,[184] where the petitioner challenged a law authorizing cornea removal by medical examiners without first consulting the next-of-kin. In *Powell*, the next-of-kin advanced two arguments. First, they argued that the law constituted an impermissible taking of private property.[185] The court examined at length the "property right" of the next-of-kin in a dead body and rejected the argument that there was an impermissible taking, concluding that cadavers are not constitutionally protected private property.[186] The plaintiff then argued that the actions of the medical examiner deprived the next-of-kin of the fundamental liberty right to dispose of the decedent's remains. In rejecting this argument, the court declined to apply strict scrutiny and found that the right of the next-of-kin to a tort claim for interference with burial did not rise to the constitutional dimension of a fundamental right traditionally protected under either the United States or Florida Constitution.[187] Instead, the court relied on rational basis review and upheld the law, finding that it was rationally related to the legitimate purpose of restoring sight to the blind.[188]

Following the holding in *Powell*, the Supreme Court of Georgia similarly held that there was no constitutionally protected right in a decedent's body. In *Georgia Lions Eye Bank v. Lavant*, the mother of an infant who had died of sudden infant death syndrome brought suit against a hospital and an eye

183. Canadian Charter of Rights & Freedoms, Part I of the Canadian Constitution Act, Art. 7 (1982).

184. State v. Powell, 490 So. 2d 1188 (Fla. 1986).

185. *Id.* at 1191.

186. *Id.* at 1192.

187. *Id.* at 1193.

188. *Id.* at 1193-94.

bank for the wrongful removal of corneal tissue of infant pursuant to Georgia statute authorizing removal for transplant of corneal tissue of decedents.[189] Although the lower court held that the statute violated due process, the Supreme Court of Georgia reversed, ruling that there was no constitutionally protected right in a decedent's body. Moreover, the court ruled that the statute authorizing removal for transplant of corneal tissue of decedents was constitutional if no objection was made by the decedent in his life or by his next-of-kin after death.

Over the years, however, despite the *Powell* and *George Eye Bank* decisions, the jurisprudence began to gravitate toward finding a constitutional right in the decedent's body. In *Brotherton v. Cleveland*, the court recognized a property claim to a dead body.[190] Mr. Brotherton was dead upon arrival to an Ohio hospital and the hospital asked the plaintiff, the widow of the deceased, to consent to donating her husband's organs, or in the language of the statute and court, make an "anatomical gift" of her husband's organs.[191] Based on the deceased's aversion to such a procedure, the plaintiff refused to give her permission. Because of the suspicious nature of Mr. Brotherton's death (suicide was suspected), an autopsy was performed.[192] Despite the widow-plaintiff's lack of consent, the coroner permitted the removal of the deceased's corneas.[193] The plaintiff did not learn about it until she read the autopsy report.[194] On behalf of herself and children, the widow filed suit, alleging that her husband's corneas were removed without due process of law and in violation of the equal protection clause.[195] Using an analysis similar to that suggested by the plaintiffs in *Powell*, the court found that such a claim was entitled to due process protection and thus invalidated an Ohio provision which was analogous to the Florida law upheld by the court in *Powell*.[196] The court implicitly acknowledged that allowing rights in dead bodies to rise to constitutional status, though equitable here, would be disastrous in other contexts.[197] Although the court recognized the difficulty in calling the claim a "property" claim, it maintained that the next-of-kin had a "legitimate claim of entitlement" which rose to the level of constitutional protection.[198]

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189. Ga. Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d 127 (Ga. 1985).
190. Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991).
191. *Id.*
192. *Id.*
193. *Id.*
194. *Id.*
195. *Id.* at 478-79.
196. *Brotherton*, 923 F.2d at 483.
197. *Id.* at 482.
198. *Id.* at 480-82.

A stronger move toward construing a dead body as private property was made in *Newman v. Sathyavaglswaran*,[199] a recent Ninth Circuit case. Parents of deceased children brought action against a coroner, alleging deprivation of property without due process of law, premised on the removal of the children's corneas without notice or consent.[200] After analyzing the rules with respect to the possession and protection of dead bodies, and rejecting former decisions finding there were no rights with respect to dead bodies, the court held:

> [S]erving a duty to protect the dignity of the human body in its final disposition that is deeply rooted in our legal history and social traditions, the parents had exclusive and legitimate claims of entitlement to possess, control, dispose and prevent the violation of the corneas and other parts of the bodies of their deceased children.[201]

The court, thus, concluded that the parents had property interests in the corneas of their deceased children protected by the Due Process Clause of the Fourteenth Amendment.[202]

By coming to this conclusion, the court followed a similar holding in *Brotherton* and reaffirmed the rejection of the *Powell* decision. There has been a shift in jurisprudential thinking from the position that the next-of-kin have quasi-property rights in the body of the recently deceased, limited to possession of the body for the purposes of burial with no protection under the Due Process, to a broader view acknowledging the next-of-kin's property rights in the body of the recently deceased to possess, control, dispose, and prevent the violation of the body. Such a broad view offers increased protection of a dead body under the Due Process clause when the "taking of the property" is done without consent. Although there are no Canadian cases in this area, such a move by the American courts can be a guide for both Canadian courts and Canadian plaintiffs to bring successful due process claims under Article 7 of the Charter with regard to practicing resuscitation procedures on the newly dead without obtaining consent.

i. Disciplinary Action

Another possible legal consequence for practicing resuscitation procedures on the newly dead without consent is for professional associations to take disciplinary action against health providers for failure to meet professional standards set forth by the associations. Such a move

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199. Newman v. Sathyavaglswaran, 287 F.3d 786, 786 (9th Cir. 2002).
200. *Id.* at 788.
201. *Id.* at 796.
202. *Id.* at 796-97.

has proven successful in France where no specific guidelines exist on this issue.[203] There, a prominent anesthesiologist was suspended from his hospital responsibilities by the French Minister of Health after carrying out a series of experiments in which a potentially lethal dose of nitrous oxide was administered to a brain-dead patient.[204]

As mentioned above, the AMA has concluded that performing resuscitation procedures on the dead without consent from the family "runs counter to an evolving norm of our society and threatens to erode further the trust of the community in the medical profession suggestion in the literature."[205] The standard set forth in the AMA's new guidelines can (and should) apply to other countries as well, specifically Canada, and may serve as a foundation for potential disciplinary action against providers.

D. Precautionary Measures

How can these unpleasant potential legal consequences be prevented? Practicing on the recently deceased could be legal without requiring consent immediately after the death of the patient. For example, some commentators have suggested that a state law could require those who receive driver's licenses to indicate whether the license holder authorizes the use of his corpse for medical purposes.[206] Others have argued for enactment of a state law offering financial compensation for allowing medical techniques on the newly dead.[207] Additional solutions include incorporating permission for resuscitative techniques practice into the autopsy permission form[208] or enacting legislation to permit the use of corpses for nondisfiguring training procedures accompanied by open disclosure.[209] Under the latter suggestion, patients would have the opportunity to refuse the procedure by advanced directive and families would be aware that, in absence of such refusal, the procedure would be performed.[210] Another suggestion involves including a consent form to perform resuscitation procedures upon death and admission to a teaching

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203. David Dickson, *Human Experiment Roils French Medicine*, 239 SCIENCE 1370, 1370 (1988).

204. *Id.* (stating that the experiments were made to support techniques, developed by the anesthesiologist himself to maintain organs for potential transplants).

205. CEJA ETHICS OPINION E-8.181, *supra* note 2.

206. *See* Goldblatt, *supra* note 44, at 89 (questioning the legal right of the next-of-kin to veto this authorization).

207. *Id.*

208. Orlowski et al., *supra* note 17, at 204. *See also* Benfield et al., *supra* note 6, at 2363 (showing this has already been done in some institutions).

209. Orlowski et al., *supra* note 17, at 204.

210. *Id.*

hospital.[211]

Each of these suggestions requires enacting legislation that focuses on the specific use of the "newly-dead" and would give an actionable force to the families whenever violated. Performance of resuscitation procedures is too serious an issue to be subject to interpretation. On the other hand, enforcing a requirement that these procedures be done legally cannot be effective if violation of it does not result in prosecution. Due to the nature of these procedures and to the fact that many of the families are not aware of such practices, enforcement of a criminal provision in this context will be more difficult than one which relates to other criminal provisions against providers, for example, euthanasia or assisted suicide. Accordingly, solutions outside the criminal context such as professional discipline should be seriously evaluated and acted upon.

V. CONCLUSION

Practicing resuscitation techniques on the recently deceased without consent is illegal. It is contrary to common law principles of consent and it violates statutes that deal with consent and treatment of dead bodies. Although the practice of resuscitation procedures is arguably a type of a research, it is not in accordance with any rules concerning research on human beings. Consent, in this context, cannot be satisfied by implication or presumption. It must be explicit. It should be obtained from the substitute decision-maker, the next-of-kin, or the family and it can be achieved more easily by mutual respect and understanding. Failure to obtain consent before acting could arguably be a criminal offense. It can also result in civil liability. Civil liability can be based on various claims such as violation of specific statutes (where applicable), battery, invasion of privacy, negligence, infliction of emotional distress, breach of contract, breach of fiduciary duty, negligent handling of a corpse, violation of due process rights, and unprofessional action. It is an ethical obligation to strongly oppose such practices when performed without consent, increase the public awareness of such practices, and when necessary use the effective tools that the law has to offer.

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211. *See* Kerns, *supra* note 68, at 600-01 (showing that this proposal is criticized as underinclusive as it does not account for patients who enter the hospital as an emergency case, or who experience sudden changes, turning a routine condition into a critical, life-threatening one.