

# Pregnant, dead, and on a ventilator: A few thoughts in response to Prof. McQuoid-Mason

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Advances made by medical science are able to extend human life, sometimes by highly technical means such as life-support systems. Often these procedures prove life-saving, and the patient recovers fully; at other times, however, life-extending treatment is futile, such as when the patient is declared brain dead. Advances in reproductive technologies, similarly, have been able bring hope by treating and curing infertility. This article responds to an article by Professor McQuoid-Mason entitled 'Terminating the pregnancy of a brain-dead mother: Does a fetus have a right to life?' He examines the law in South Africa and the legal implications of the *Munoz* case, which concerned an application for a court order to have a brain-dead pregnant woman removed from a ventilator. Departing from Prof. McQuoid-Mason's discussion, this article highlights a few of the ethical and legal implications of new technologies that enable pregnancy to be extended beyond the pregnant woman's life. This article questions the ethical and legal appropriateness of the use of new technologies, especially in situations where such use is contrary to the pregnant woman's express wishes. In this context, the article deliberates on whether the dead may be considered to be the bearers of rights that must be respected.

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Does one have to be alive to be pregnant? The answer to this question would have been a very definite 'yes' – and would have elicited scant controversy – in the earlier parts of the previous century. In the year 2014, however, answers to this question are less straightforward. Advances in reproductive technologies have made it possible not only to treat infertility, but to make imaginable what before had belonged to the realm of science fiction (for example, Aldous Huxley's *Brave New World* (1932) anticipated the possible consequences of the development of new reproductive technologies, while the idea of a 'womb for hire' was fictionalised in Margaret Atwood's *The Handmaid's Tale* (1985)). New reproductive technologies, now standard practice, are artificial insemination and reproduction, the cryopreservation of sperm, oocytes and embryos, embryo transfer, and preimplantation genetic diagnosis and manipulation, to name but a few. Yet more new technologies, previously inconceivable, such as same-sex procreation, which will make it possible for gay and lesbian couples to have biological children without the help of a donor sperm or ovum, are currently being developed.<sup>[1]</sup>

Better healthcare, including drug development and advances in technology, such as cardiopulmonary resuscitation and life-support systems, have made it possible to treat previously fatal conditions and so extend human life. It has become possible to drastically extend the fertility of women a long time after menopause. Similarly, in the past, when a pregnant woman died or was declared brain dead, that would have been that, and no thought would have been given to keeping the fetus she was carrying alive. Before, upon the death of a pregnant woman doctors had two choices: either to deliver the fetus by caesarean section if it was viable, or to let the fetus die with the pregnant woman. This situation has changed dramatically with the development of new technologies able to artificially ventilate and sustain brain-dead human beings.

I read Prof. McQuoid-Mason's article entitled 'Terminating the pregnancy of a brain-dead mother: Does a fetus have a right to life?'<sup>[2]</sup> with great interest, and started pondering some of the ethical implications of the court case he discusses. The *Munoz*<sup>[3]</sup> case, in my view, highlights some of the very important ethical and legal implications of new technologies that enable pregnancy to be extended beyond the pregnant woman's life. While not wishing to detract from Prof. McQuoid-Mason's insightful analysis of the law in South Africa (SA) relating to the legal status of the fetus, I would like to shift the focus to an analysis of the 'rights' of the pregnant cadaver and the ethical and legal appropriateness of artificially ventilating the cadaver in an attempt to save the fetus.

I begin with a short summary of the facts of the *Munoz* case,<sup>[3]</sup> after which I differentiate between pregnant women who are brain dead and those who are in a persistent vegetative state (PVS), as this distinction is germane to my argument. My discussion of brain death brings me to a discussion in the next section of some of the ethical concerns raised by the *Munoz* case. This is followed by an analysis of whether the rights to equality, dignity, privacy and bodily integrity may find application in the situation of artificially ventilating a brain-dead pregnant woman so that she may give birth to a live fetus. I conclude the article with a few words of caution regarding the ethical desirability of new technologies that enable pregnancy to be extended beyond the pregnant woman's life.

## The *Munoz* case

Although the facts of the case are summarised in Prof. McQuoid-Mason's article, I provide a brief summary here for ease of reference. Marlise Munoz, a 33-year-old paramedic, was declared brain dead in November 2013 by the physicians at John Peter Smith Hospital in Fort Worth, Texas, USA.<sup>[4]</sup> Marlise Munoz was 14 weeks pregnant with her

second child when she got out of bed one night to prepare a bottle for her young son.<sup>[5]</sup> She was found unconscious and not breathing on the kitchen floor an hour later by her husband. It is suspected that she had suffered a pulmonary embolism.<sup>[6]</sup> Her husband (also a paramedic) immediately started cardiopulmonary resuscitation, after which Marlise was rushed to the hospital. Tests revealed that her brain had been without oxygen for an hour, and the consequences had been fatal, prompting a diagnosis of brain death.<sup>[7]</sup>

The court case, in essence, concerned an application by Marlise Munoz's husband, Erick, for a court order compelling the hospital to take Marlise off a ventilator so that she could 'die' and her body be delivered to him and her parents to be buried.<sup>[8]</sup> Marlise Munoz had indicated earlier to her husband and parents that she did not want to be kept alive by artificial means.<sup>[9]</sup> The hospital refused to take her off ventilation, citing the Texas Health and Safety Code, proscribing the removal of 'life-sustaining treatment' from a 'pregnant patient'.

The statute in question, however, only proscribed the withdrawal of life-sustaining treatment from patients in a PVS, and not from patients who were brain dead. The accepted legal position in the USA is that a patient is dead when 'according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function. Death occurs when the relevant functions cease.'<sup>[10]</sup> I will refer to this definition later in the article. Erick Munoz also wanted the Texas Health and Safety Code declared unconstitutional as it violated his deceased wife's right to make decisions regarding her treatment, and because it violated her right to equality as the statute treated pregnant women differently from other (non-pregnant and male) patients.<sup>[11]</sup>

When the case was eventually heard 2 months later (by which time the cadaver that had been Marlise was 22 weeks pregnant),<sup>[6]</sup> the Tarrant County District Court held that the Texas Health and Safety Code did not apply to Marlise Munoz as she was dead, and ordered that she be removed from life support.<sup>[3]</sup> It did not consider the constitutional issues raised in the application.

### Brain death v. a PVS: Ethically relevant in this case?<sup>[14,15]</sup>

'Brain death' is defined in the USA by the Uniform Determination of Death Act<sup>[14,15]</sup> which determines that a person who 'has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.'<sup>[14,15]</sup> The precise methods and criteria for determining brain death vary from state to state and hospital to hospital, but the American Academy of Neurology states that three criteria must be fulfilled to confirm the diagnosis: 'coma (with a known cause), absence of brainstem reflexes, and apnoea (the cessation of breathing without artificial support)'.<sup>[16]</sup> In practice, clinicians will also look for an absence of motor responses and will rule out any other possible explanations for loss of brain function, such as drugs or hypothermia.<sup>[16]</sup> This assessment is repeated after several hours.<sup>[17]</sup>

In the UK, the National Health Service describes brain death as occurring when a person 'no longer has any activity in their brain stem and no potential for consciousness, even though a ventilator is keeping their heart beating and oxygen circulating through their blood'.<sup>[18]</sup> When brainstem function is permanently lost, the person will be confirmed dead.<sup>[18]</sup>

Similarly, in SA the National Health Act 61 of 2003 defines death as 'brain death'.<sup>[19]</sup> Here, brain death is defined as 'an irreversible and irreparable cessation of all the brainstem functions inclusive of complete cessation of the heartbeat, respiration, blood circulation and digestive functions'.<sup>[20]</sup>

There exists a clinical and legal difference between brain death and a PVS. PVS is a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness.<sup>[21]</sup> Patients lose consciousness because of a variety of reasons, most often through some serious injury or damage to a part of the brain. In this state, patients show some measure of digestive ability and some reflex activity of muscles and nerves in response to stimuli, and in some cases are able to independently maintain respiration and circulation. Nevertheless, there is no real awareness of the person's surroundings or any other higher cognitive functions. After some time of being in a vegetative state, the patient is classified as being in a PVS.<sup>[22,23]</sup> In SA, one of the most well-known definitions of PVS is as follows: 'a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflex activity of muscles and nerves for low level and primitive conditioned responses to stimuli, blood circulation, respiration and certain other biological functions but there is no behavioural evidence of either self-awareness or awareness of the surroundings in a learned manner'.<sup>[24]</sup> Someone in a PVS can show signs of wakefulness (they may open their eyes, for example), but have no response to their surroundings.<sup>[24]</sup> The vital difference between PVS and brain death is that a patient with PVS still has a functioning brainstem and therefore may have retained some form of consciousness.<sup>[21]</sup> Also, a person in a PVS can still breathe unaided and is sometimes thought to have a chance of recovering because the core or 'vegetative' functions of the brainstem are unaffected, whereas a person with brain death has no chance of recovery as the body cannot survive without artificial support. Where the brain-dead person is in a PVS, the removal of the ventilator will be legally justified if the prognosis is hopeless. When a person is kept alive artificially by means of a respirator, its eventual disconnection cannot, in law, be considered the act which causes death – it merely constitutes the termination of a fruitless attempt to avert the consequences of the fatal injury.<sup>[24]</sup>

This brings me to the question of whether the difference between the two definitions is ethically and legally relevant in the case of Marlise Munoz. I think it is: the Texas Health and Safety Code did not apply to Marlise Munoz, as she was legally dead. This is evidently the correct decision, as the alternative would be the illogical situation that physicians are compelled to administer treatment to dead people. But what if Marlise Munoz were instead in a PVS?

If Marlise Munoz had not been brain dead, but in a PVS, ethically the case would have been more problematic, as there would have been arguments that she might recover in time (however slim the chance of recovery may be). In addition, the court would not have been able to decide the case without considering the constitutional challenges brought by Munoz's husband (as she would have been a 'patient' and within the scope of the Texas Health and Safety Code). It is unlikely that Munoz's situation would have withstood such constitutional scrutiny. I return to this point below.

In the USA, as in the case of SA, patients' rights to make autonomous decisions and to refuse treatment are, on the whole, respected.<sup>[26]</sup> Marlise Munoz had clearly indicated that she did not wish to be kept alive by artificial means, and her surrogate (her husband) had insisted on her autonomous wishes being carried out. Why, then, were the hospital personnel hesitant to carry out her wishes as expressed through her surrogate? This brings me to the next section of the article, where I consider a few of the ethical issues raised by the *Munoz* case.

### Brief outline of some of the ethical concerns highlighted by *Munoz*

I suspect that John Peter Smith Hospital was hesitant to carry out Marlise Munoz's wishes as expressed through her surrogate because of a misplaced concern regarding their legal responsibilities towards the fetus she was carrying. Such a concern is not unusual, as the relationship between a pregnant woman and her unborn fetus is one of the most ethically and legally challenging in the 21st century, and not only because of the technological advances described above. The renewed interest in the abortion debate in the USA and other countries bears witness to this complexity.<sup>[26-28]</sup>

Central to the *Munoz's* case is the ethical and legal question: Is human consciousness necessary for pregnancy? Put differently, does one have to be 'alive' and conscious to be pregnant? Must the pregnant woman be a person with an identity, capable of making autonomous decisions? Or can she merely be an unconscious body, existing to gestate the fetus and be discarded after 'giving birth'? Can the pregnant body be medically managed separate from a consciousness that wills the pregnancy to continue?<sup>[29]</sup>

I would like the answer to these questions to be that human consciousness is indeed necessary for a pregnancy. The choice to be pregnant is one of women's most treasured human rights, hard won in the USA in *Roe v Wade*,<sup>[30]</sup> and legislated in SA in the Choice on Termination of Pregnancy Act<sup>[31]</sup> and confirmed in the case of *Christian Lawyers Association v Minister of Health*.<sup>[32]</sup> A woman may not deliberately choose to become pregnant (the pregnancy may be the consequence of rape, or be the result of some failure in a contraceptive device or the oral contraceptive pill), but her continued pregnancy, certainly, is a conscious decision for women in societies where their right to have an abortion is acknowledged in law.

In the case of Marlise Munoz, certainly, she indicated that she did not want to be kept alive artificially. The circumstances of the Munoz case indicate that this choice or advanced directive was less valued in the eyes of the law because she was pregnant. If that indeed is the case, and it does seem so, can we deduce that women in pregnancy lose their ability to make autonomous, informed decisions regarding reproduction? Such an outcome, at the very least, would be considered absurd: women's rights to equality, human dignity, bodily integrity and privacy do not alter when they become pregnant. This is supported by the fact that, in many jurisdictions pregnancy is a prohibited ground for discrimination. For example, in SA: 'The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, *pregnancy* [my italics], marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.'<sup>[33]</sup> In Marlise Munoz's case, the refusal of the hospital to turn off the machines that were ventilating her

cadaver not only denied her (through her surrogate) the right to make decisions regarding her medical treatment, but reminds one of the worst of consequentialist philosophies (such as some forms of utilitarianism which would regard the violation of the dead woman's wishes acceptable if the outcome is the birth of a live baby).

However, it should be remembered that, at the time the court action was brought, Marlise Munoz was brain dead. Even if it is true that women's constitutional rights do not alter when they become pregnant, Marlise Munoz was not only pregnant, she was also dead. This, then, brings me to the next section of the article where I briefly examine whether the rights to privacy, equality, dignity and bodily integrity may find application in the case of a pregnant, brain-dead cadaver.

### Equality, dignity, privacy and bodily integrity: Also applicable in death?

It is clear from the statute that gave rise to the Marlise Munoz case that exceptions are made for pregnant women – their advance directions are taken less seriously by the law than those of men, and those of women who are not pregnant. On the face of it, this clearly treats pregnant women unequally, potentially violating their right to equality. But do dead pregnant women have a right to equality?

I agree fully with Prof. McQuoid-Mason that cadavers are not the bearers or holders of either civil law rights or human rights.<sup>[2]</sup> In addition, there is no doubt that he is correct when he argues that the fetus, equally, has no rights in terms of the SA Bill of Rights until it is born alive.<sup>[2]</sup> Consequently, I do not want to argue that cadavers are indeed bearers of human rights, or, in the case of Marlise Munoz, that her cadaver indeed had a 'right' to equality and so forth.

The fact that cadavers are not protected under the Constitution and possess no rights<sup>[32]</sup> apart from those highlighted by Prof. McQuoid-Mason regarding the desecration of a corpse and so forth, does not necessarily imply that the living can make no provisions that will be honoured upon death, or that society may do whatever it pleases with the body of the deceased, as is done by the hospital in the case under discussion. There are countless situations where the living make decisions on how their future dead bodies will be treated and where those decisions are indeed being honoured and respected. Society respects a dead person's wish regarding how and when they wish to be buried, or whether, instead, they prefer to be cremated. The law respects the living's wishes regarding whether they want to donate their organs upon their death or whether or not they want to donate their cadavers for medical research. In addition, an entire field of law has developed around giving effect to the will of the deceased regarding the disposal of their property after their death.

Over many centuries philosophers have grappled with questions as to whose interests are being respected in the examples mentioned above, and whose wishes are being carried out. Some argue that it is the living person's wishes or interests, in events that occur after their deaths that are being respected. Others argue that the dead, themselves, have a limited range of ongoing interests.<sup>[35]</sup> Ronald Dworkin<sup>[36]</sup> maintains the latter, which he calls 'critical interests' – the interests of the living in what will become of their cadavers. Wilkinson<sup>[37]</sup> stresses the importance of these critical interests to the human personality: what happens 'after death can (depending on the particular person's own idea of self-development) complete the

development of the self'. Based on these views it is indeed possible to say, at the very least, that some interests of the cadaver are being protected by the law; even if these are not 'rights' in the classic sense of the term.<sup>[38]</sup>

Marlise Munoz indicated to her relatives that she did not want to be kept alive by artificial means. The hospital was made fully aware of her wishes by her proxy, her husband. Whether we can call these wishes regarding what happens after her death merely 'interests' or whether they are 'rights', it is clear that they were not given effect to, until a court order was obtained compelling the hospital to do this. In addition, it is evident that the hospital would have acted differently had Marlise Munoz not been 14 weeks pregnant. She lost her 'interest' in what happens after her death to her cadaver because she was pregnant. Her pregnant dead body, therefore, had been disowned by the hospital, and her interests in it had been disclaimed.

## Conclusion

A woman's autonomous choice regarding her end-of-life care should be inviolable, unaffected by whether or not she may be pregnant. This is supported by the Ethics Committee of the American College of Obstetricians and Gynecologists: 'pregnant women's autonomous (end-of-life) decisions should be respected, and concerns about the impact of those decisions on fetal well-being should be ... understood within the context of the women's values.'<sup>[39]</sup>

The SA legal system has not yet had to consider the complex ethical and legal questions that beset new technologies that enable the artificial ventilation and support of brain-dead pregnant cadavers such as Marlise Munoz. It is in the best interests of our society that these questions be addressed carefully and thoughtfully. And when they are, perhaps the wisest answer might simply be to accept the course of nature: a woman's capacity to nurture a life, any life, ceases with her death.

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