

# **Somatic Support for Brain-Dead Pregnant Women**

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## **Introduction**

The case of Marlise Munoz in Texas has brought to national attention the issue of providing prolonged somatic support for a brain-dead pregnant woman for the sake of the developing fetus. In fact, such cases are not new but go back several decades.

In this white paper we will examine the issue of providing somatic support for a brain-dead pregnant woman from medical, ethical, and legal perspectives. Our intent is to provide relevant information from the published literature and to promote informed, reflective discussion of this issue within the Catholic community.

## **Medical Perspective**

When a pregnant woman suffers brain death, there are three options to consider regarding the fetus:

- 1) attempt immediate delivery of the fetus (when past the age of viability), 2) continue full support of the mother's body in an attempt to prolong the pregnancy and allow the fetus to mature further, or 3) immediately discontinue mechanical ventilation and other supportive measures with the understanding that the fetus will then also die. [1]

This paper will focus on the second option.

It is established medical practice that brain dead persons may be given somatic support for the sake of harvesting their organs in good condition. However, in the case of organ procurement "the newly dead are maintained only briefly, the organs are quickly removed, and elaborate efforts are rarely needed." [2] Maintaining somatic support for brain-dead pregnant women is different in terms of the complexity of medical procedures needed and the length of time involved. [3]

A review of the medical literature between 1982 and 2010 surfaced 30 cases of brain-dead pregnant women who received extended somatic support to facilitate fetal maturation in the uterus. [4] Among these cases, 12 viable infants were born and survived the neonatal period. [5]

The mean duration of maternal support was 38.3 days (range, 2 - 107 days).  
...The mean gestational age at the time of BD [brain death] was 22 weeks (range,

1 – 40 wk). ...The mean gestational age at delivery was 29.5 weeks (range, 26 -33 wk). During extended life support, patients developed several complications, including infection, hemodynamic instability, diabetes insipidus (DI), panhypopituitarism, poikilothermia, metabolic instability, acute respiratory distress syndrome and disseminated intravascular coagulation. ...The indications for delivery in all reported cases were maternal or fetal difficulties, including maternal hemodynamic instability (seven cases), fetal distress (three cases), oligohydramnion (two cases), intrauterine growth retardation (one case) and abnormal pattern of the placental structure (one case). In two cases in which maternal BD began at week 13 of gestational age, spontaneous abortion occurred at weeks 13 and 19. In four cases, there was intrauterine death... [6]

In 12 (63%) of 19 reported cases, the prolonged somatic support led to the delivery of a viable child. We did not find any information about the fate of the fetuses in the published case series. ...The average birthweight was 1,384 g (range, 815 – 2,083 g), and the mean Apgar score was 7 and 8 at 1 and 5 minutes, respectively. Congenital defects were reported for only one infant, who was diagnosed with fetal hydantoin syndrome resulting from previous chronic phenytoin usage by the mother. Four infants required temporary mechanical ventilation because of neonatal respiratory distress syndrome of pneumonia. Fungemia was diagnosed in one infant, and he was treated with amphotericin B. However, not every infant was sufficiently followed to determine the long-term effects of prolonged maternal life support. Postnatal follow-up up to 24 months was available only for six infants. All of them developed normally and apparently had no problems related to their exceptional intrauterine circumstances. [7]

The reviewers come to the conclusion that “at present, it seems that there is no clear lower limit to the gestational age which would restrict the physician’s efforts to support the brain-dead mother and her fetus.” [8] They also present guidelines and recommendations for the medical management of brain-dead pregnant women in the areas of cardiovascular support, respiratory support, endocrine support, thermoregulation, nutritional support, infection, prophylactic anticoagulation and for monitoring the fetus. [9]

In 2013 yet another case was published from the United Arab Emirates of “maternal brain death at 16 weeks gestation with somatic support provided for 110 days and a successful neonatal outcome.” [10] This represents “the second reported case where prolonged somatic support led to the delivery of a viable child in which the fetus was about 16 weeks of gestation.” [11] Moreover, this case represents the longest duration of somatic support to date, viz. 110 days, surpassing a previous case of 107 days. [12] Thus the authors likewise conclude that “the gestational age at the time of maternal brain death is not the main consideration in deciding whether to decide somatic support or not.” [13] However, they note that “gestational age of the fetus can predict the successful delivery of the fetus.” [14]

Wood *et al.* showed that the severity of the disability correlates with how extremely children were born as preterm infants. He also showed that at 22, 23, 24, and 25 weeks of gestation, a fetus has about a 1%, 11%, 26%, and 44%

likelihood of survival with a 0.7%, 5%, 12%, and 23% chances of survival without handicap at 30 months, respectively. ...Parry *et al.* also showed that the probability of mortality increases in infants born before 32 weeks gestation. However, the improved outcome for preterm infants can be attributed to closer surveillance of the mother and preterm obstetric interventions and hence the decision of prolonged somatic support must be done on an individualized basis. [15]

Although there have been reported successes with bringing fetuses to a healthy birth through prolonged somatic support of their brain-dead mothers, cautions have been offered about interpreting and extrapolating the published literature on this phenomenon:

...the number of reported cases is too small to define the rate at which intensive care support of the brain-dead mother can result in a healthy infant. The percentage of successful cases cannot be determined, because there are no reports describing failure of intensive maternal support from all medical centers. [16]

Despite these reported favorable outcomes, it must be said that no firm conclusions can be drawn about the likelihood of success of prolonged somatic support of a pregnancy in a given case of maternal brain death or about the expected prevalence of favorable fetal outcomes with such support because there are little or no data on the frequency of cases of unsuccessful support or unfavorable fetal outcome. This may be due in part to the small number of cases overall, but it undoubtedly also reflects a publication bias against the cases in which extended support could not be achieved or a reluctance in many cases on the part of providers and families to even attempt such support after brain death of the mother. [17]

Several cases of unfavorable fetal outcome in spite of somatic support for the brain-dead mother have made their way into the published literature. In one case loss of fetal heartbeat occurred on the eighth day following maternal brain death. [18] In another case a spontaneous abortion occurred. [19] Indeed, “some believe that strategies used to maintain maternal somatic function are still in the experimental stage,” pointing out that “not every adverse effect of medication used on the fetus during an extended somatic support is known.” [20]

## **Ethical Perspective**

There are no official statements from the Catholic Church on the ethics of providing or forgoing prolonged somatic support for brain-dead pregnant women. Hence we present the following ethical discussion as “theological opinion.” In general, a body of ethical literature specifically on the issue of somatic support for brain-dead pregnant women remains to be developed.

In the Catholic tradition, the embryo/fetus is regarded as a human being with a right to life who entitled to medical care. As stated in *Donum Vitae*:

Thus the fruit of human generation, from the first moment of its existence, that is to say from the moment the zygote is formed, demands the unconditional respect that is morally due to the human being in his bodily and spiritual totality. The human being is to be respected and treated as a person from the moment of conception; and therefore from that same moment his rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life. This doctrinal reminder provides the fundamental criterion for the solution of the various problems posed by the development of the biomedical sciences in this field: since the embryo must be treated as a person, it must also be defended in its integrity, tended and cared for, to the extent possible, in the same way as any other human being as far as medical assistance is concerned. [21]

Thus in considering somatic support for a brain-dead pregnant woman, there are two patients to consider: the mother and the fetus.

Apart from Catholic teaching, there are those who recognize the fetus as a patient in his/her own right:

During the course of prenatal care, an obstetrician's primary obligation to the pregnant patient is to support her biologic and mental well-being both for her sake and to promote the life and health of her fetus. Increasingly, the fetus is considered a patient as well, by virtue of the fact that it is a developing human whose treatable conditions can be affected by specific medical interventions. For the individual physician, the fetus becomes a potential patient when its mother presents for prenatal care. [22]

Formerly, the physician could only treat the mother and had to assume that in maintaining her health, the health of the fetus would be enhanced. The fetus itself was largely beyond the diagnostic and therapeutic reach of the physician. The assessment of fetal condition was made by *indirect* methods. Advances in knowledge of fetal physiology and the development of new technology, however, have enabled physicians to see the fetus in a *direct* way. This has made physicians believe and act as if the fetus was their "second patient." Thus, if one of them dies, the doctor's duty to the other patient remains, and what matters is the patient's best interest. [23]

Hence if "the mother and foetus are two distinct organisms," then "maternal brain death mandates consideration of the appropriateness of continuing maternal somatic support in an attempt to attain foetal viability." [24]

In the Catholic moral tradition, using/forgoing medical treatments is governed by the following principles as articulated in the *Ethical and Religious Directives for Catholic Health Care Services*:

A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of

the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community. (no. 56)

A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community. (no. 57) [25]

Key concepts are "reasonable hope of benefit," "excessive burden," and "excessive expense."

The brain-dead pregnant woman, as dead, herself receives no benefit from continued somatic support. If, assessing the medical condition of the fetus, there is a reasonable possibility that, through continued somatic support of the brain-dead mother, the fetus can be brought to birth and in a condition in which s/he can survive, then continued somatic support of the brain-dead mother offers a "reasonable hope of benefit" to the fetus. However, if the fetus would not survive to the point of viability or would be "born dying," then there does not seem to be benefit to continuing the pregnancy through somatic support for the mother. [26]

Regarding burdens of the somatic support for the brain-dead pregnant woman, it is difficult to see how the somatic support could be burdensome *for the woman herself* since, as dead, she is incapable of having experiences. However, burdens of the somatic support have been described in terms of emotional stress for family members of the brain-dead woman and for her caregivers:

...there is a tremendous emotional stress on family members who simultaneously suffer loss of the mother during the prolonged period while awaiting delivery. [27]

And the cost of achieving that is great, emotionally even more than financially. The family will have to watch the slow deterioration of Ellen's [brain-dead pregnant woman] body. Many nurses, too, will have to watch that process and be actively involved in its prolongation, at the cost of great stress.

The family members will be put through an emotional trial every day, both by seeing Ellen and by worrying about the fetus's survival. [28]

The extensive periods needed to bring the fetus to viability (as compared with the limited transience of brain death for organ donation) may cause nurses significant moral distress. Caring for the brain-dead physical body for long periods may be frightening or distasteful. [29]

While such emotional stress is real, it is not clear that it would constitute an "excessive" burden, especially if there is a reasonable possibility that continued somatic support for the brain-dead pregnant woman will have the good outcome of the birth of a fetus that survives.

Whether continued and prolonged somatic support for the brain-dead pregnant woman imposes "excessive expense" on her family will depend on the health insurance coverage available in these sorts of cases. In the case of Marlise Munoz, it was reported that "it was unclear...who

would end up paying the hospital bill.” [30] Hospital officials indicated that “they were focused on caring for Ms. Munoz, and that it was inappropriate for them to comment on or estimate the cost of a patient’s care.” [31] It was further stated that “at the appropriate time, the finance department will pursue the customary avenues to identify payers and reimbursement.” [32]

What constitutes “excessive expense for the community” is not clearly defined in Catholic health care ethics. [33] Question has been raised about somatic support for brain-dead pregnant women on grounds of just allocation of resources:

...intensive medical care is necessary to ensure that the fetus’ needs are met, and, accordingly, considerable effort and resources must be expended. It can be argued that a just society cannot, and should not, afford to direct thousands of dollars per day, for an indefinite number of weeks or months to the care of one individual under conditions of moderately scarce medical resources. [34]

Those concerned with social justice and health care for all children might question this type of financial effort on behalf of one child. ...The cost-benefit analysis of maintaining somatic functioning in a brain-dead woman is increasingly weighed against the overall unavailability of ICU beds, the scarcity of other resources and nursing staff, and limited access to health care in general. [35]

On the other hand, as a society a decision has been made to provide expensive neonatal intensive care for the benefit of particular infants, and this can be seen as setting a precedent for caring for the fetuses of brain-dead pregnant women. Indeed, it has been pointed out that “although the economic cost of intensive somatic support is undeniably high, this must be balanced (at least when gestational age is beyond that of fetal viability) against the cost of caring for an even more severely premature infant who would require prolonged neonatal intensive care unit care if delivery were not delayed to allow the fetus to mature further in utero.” [36]

In sum, it seems that somatic support for a brain-dead pregnant woman should be provided if there is a reasonable possibility that the fetus can be brought to birth in a condition in which s/he can survive, and if the family will not incur devastating expenses from the provision of such support.

Patient autonomy is a value that is much emphasized in contemporary health care ethics. Thus we must consider the question of whether, from an ethical point of view, a woman could legitimately give a directive against the provision of somatic support if she should suffer brain death during pregnancy. In other words, suppose that a woman would not want her brain-dead body subjected to continued somatic support with the attendant deterioration of the body, but would wish immediate burial. In the name of autonomy, can her wishes completely trump the interests of the fetus if she is pregnant when suffering brain death?

Relevant to answering this question is directive 59 from the *Ethical and Religious Directives for Catholic Health Care Services*:

The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, *unless it is contrary to Catholic moral teaching*. [italics added; 37]

The point to note is that patient autonomy is limited by the principles of Catholic moral teaching. In the case at hand, the woman is obliged to take into account (1) the status of the embryo/fetus as a human being with a right to life who entitled to medical care, and (2) the ordinary/extraordinary means principle which governs decisions about using and forgoing medical treatments. As previous discussion indicates, whether somatic support for a brain-dead pregnant woman for the sake of the fetus falls into the category of “ordinary” or “extraordinary” treatment must be decided on a case-by-case basis. Thus, from an ethical point of view, a woman would not be justified in directing a *blanket refusal* of somatic support in the case of brain death during pregnancy.

Indeed, in discussing somatic support for brain-dead pregnant women, ethicist Robert Veatch cites legal precedent for requiring a pregnant woman to undergo medical treatment for the sake of the fetus when she alone might refuse it:

In rare cases, court orders for treatment can be obtained on the grounds that the continued treatment is in the interests of some party other than the patient. The most relevant precedent is the ordering of a blood transfusion for a Jehovah’s Witness woman to serve the interests of her fetus when clear precedent gave her the right to refuse if only her own welfare were at stake. [38]

Another ethical issue that might still be raised is *the respect that is due to dead human bodies* and whether prolonged somatic support of a brain-dead body in a process of deterioration violates that respect. Theologian D. Gareth Jones has commented:

[A]ll human beings are to be viewed as having an inalienable dignity, stemming from our creation by God and revealed supremely in the redemption made possible by Christ. It rests not on what human beings can accomplish in material, social or spiritual terms, but on the rock of God’s love. Consequently human dignity is always based on what individuals are in the sight of God and never on what they may be able to do for society, for mankind, or even for God. From this follows that those who are of no functional value to society still retain a dignity, since they remain important *in this sight and purposes of God*. Elements of this dignity are also to be found in those who have died, but a short time ago were one of us. [39]

The case of the “Erlanger baby” which occurred in Germany in 1992 provoked strong comments that somatic support for a brain-dead pregnant woman violates her dignity:

Hanna Wolf, spokeswoman for Women’s Affairs of the Lower House of the Federal Parliament comments in the *Bild-Zeitung*: “What is happening in this clinic is a scandal and inhuman. The mother is degraded to a nutrient fluid, disposable after use.” She told the *Berliner Morgenpost* that she was asking the

government, “if maintaining the physical functions on the grounds of pregnancy violates the human dignity guaranteed by article one of the constitution.” Other female politicians of different political parties said that the “border of what is tolerable for a civilized society has been exceeded” and that “the dignity of the dead woman...is violated in an unacceptable way.” ...Professor Andrea Abele-Brehm, Director of the Institute for Psychology at the University of Erlangen and a representative of female employees there, criticized the male composition of the committee and said, “It cannot be right that the horror-vision of a female corpse as an ‘incubator’ becomes reality without any female comment.” [40]

...it was emphasized again and again that her dignity required that the apparatus be switched off and she be allowed to die. [41]

On the other hand, it is established practice to provide somatic support for brain-dead persons to “use” them to procure organs for transplant purposes, and this is not seen as an unacceptable violation of their dignity. Further, providing somatic support for the brain-dead mother in order to bring the fetus to birth can be seen as a way of bringing something good out of a tragic situation. [42] Indeed, the question has been raised, “But why should it be more dignified to decompose at once, rather than to be used for bringing a child into existence?” [43]

## **Legal Perspective**

Thirty-one states across the country have some form of “pregnancy exclusion” clause in their advance directive laws overriding a women’s directive to forgo life-sustaining treatments if she is pregnant. [44] Legally, the issue is whether the provision to provide life-sustaining treatments to a pregnant woman extends to somatic support after her death.

A 1986 court case in the State of Georgia gave an affirmative response:

In *University Health Services v. Piazzi*, a Georgia court granted a hospital’s petition to keep a brain-dead pregnant woman on life support until the birth of her fetus over the objections of her husband and family. Donna Piazzi had not drafted a living will or other healthcare directive embodying her intentions in such a situation, and the biological father of the fetus (who was not Donna’s husband) favored continuing medical care to save the fetus. The court determined that Donna Piazzi lacked the power to terminate life-sustaining medical treatment during her pregnancy even if she executed a living will, relying upon the pregnancy restriction in the Georgia Natural Death Act, which invalidated an advance directive at pregnancy. The court also rejected the argument that Donna possessed a constitutional right to refuse treatment and to terminate pregnancy, concluding that these privacy rights extinguished when she became brain dead. Finally, the court found that public policy in Georgia requires the maintenance of life support systems for a brain-dead mother so long as there exists a reasonable possibility that the fetus can develop and survive. The court believed there was a reasonable possibility that Donna’s fetus would

develop and survive. Unfortunately, the fetus died of multiple organ failure within forty-eight hours of its delivery. [45]

However, the judicial judgment went in the opposite direction in the 2014 case of *Munoz vs. John Peter Smith Hospital* in the State of Texas. [46]

On November 26, 2013 Marlise Munoz, 33, was found unconscious by her husband, Erick, in their family home. He took her to John Peter Smith Hospital. The cause of her condition was suspected to be a pulmonary embolism. At the hospital it was also determined that Marlise was 14 weeks pregnant. She was declared brain-dead on November 28, 2013 but was kept on life support. Marlise, a paramedic like her husband, had previously told him that she would not want to be kept alive artificially. However, the hospital refused to remove life support on grounds of Texas law. [47]

Chapter 166 of the Texas *Health and Safety Code* deals with advance directives. Sec. 166.049 stipulates that “a person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient.” This stipulation is explicit in the text of the living will: “I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant.” [Sec. 166.033]

Attorneys for the Munoz family made the following arguments in support of withdrawing somatic support from Marlise Munoz:

First, they argue that when you apply one section of the code, Marlise Munoz would be considered already dead because “there is irreversible cessation of the person’s spontaneous respiratory and circulatory functions.” So JPS [John Peter Smith Hospital] would not be removing life-sustaining treatment.

The lawsuit also argues that even if JPS was to argue that the health code applies to Marlise Munoz, the Advance Directives Act does not extend the prohibition of withholding or withdrawing life-sustaining support to the unborn child.

Finally, the attorneys argue that the section of the health code that says “a person may not withdraw or withhold life-sustaining treatment from a pregnant patient” violates Marlise Munoz’s Fourteenth Amendment right to privacy with regard to making decisions about her own body and equal protection under the law. [48]

The last argument “asked the judge to declare the Texas law unconstitutional.” [49]

On the other hand, the hospital’s attorney, Larry M. Thompson, contended that Texas “lawmakers...have strongly demonstrated a commitment to protect unborn children by including in the Texas Penal Code a definition that says a human being is alive at every stage of gestation from fertilization to birth,” which means that “someone may commit murder if during the criminal offense an unborn child is killed.” [50] He also “pointed to a bill backed by Gov. Rick Perry that lawmakers passed last year that banned abortions after 20 weeks of pregnancy,

based on the theory that the fetus can feel pain at that stage.” [51] Inferences were drawn from these legislative actions:

“Given the strong interest of the Texas legislature in protecting the life of unborn children, it is unlikely the Legislature contemplated only the welfare of the mother” when it enacted the law prohibiting the withdrawal of life support for pregnant patients, Mr. Thompson wrote.

He added that it was reasonable to infer that the law was meant to “protect the unborn child against the wishes of a decision maker who would terminate the child’s life along with the mother’s.” [52]

The law “must convey legislative intent to protect the unborn child, otherwise the Legislature would have simply allowed a pregnant patient to decide to let her life, and the life of her unborn child, end,” wrote Mr. Thompson... [53]

Finally, Thompson argued that “the law is constitutional because the right of privacy is not absolute and must be balanced with the state’s interest to protect the life of an unborn child.” [54]

Judge R.H. Wallace found that

The provisions of Sec. 166.049 of the Texas HEALTH AND SAFETY CODE [pregnancy exclusion clause] do not apply to Marlise Munoz because, applying the standards used in determining death set forth in Sec. 671.001 of the Texas HEALTH AND SAFETY CODE, Mrs. Munoz is dead. [55]

Although no further explanation is provided, the stipulations of the Texas advance directive law do seem to apply to persons who are still living. The living will allows persons who are terminally ill or who have an irreversible condition to forgo or continue medical treatments [Sec. 166.033] “Terminal condition” is defined as “an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment *will produce death within six months*, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.” [Sec. 166.002; italics added] An “irreversible condition” is defined as “a condition, injury, or illness (A) that may be treated but is never cured or eliminated; (B) that leaves a person unable to care for or make decisions for the person’s own self; and (C) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.” [Sect. 166.002]

Further, Judge Wallace found that

In light of that [the first] ruling, the Court makes no rulings on the Plaintiff’s constitutional challenges to Sect. 166.049. [56]

Thus it was “ordered that *Plaintiff’s First Amended Motion to Compel Defendants to Remove Marlise Munoz from ‘Life-Sustaining’ Measures* is granted and that the Defendants are ordered to pronounce Mrs. Munoz dead and remove the ventilator and all other ‘life-sustaining’

treatment from the body of Marlise Munoz no later than 5:00 p.m., Monday, January 27<sup>th</sup>, 2014.” [57]

The Code of Iowa Chapter 144A Life-Sustaining Procedures establishes a living will for the state, known as a *Declaration Relating to Use of Life-Sustaining Procedures*. It includes the following “pregnancy exclusion” stipulation:

The declaration of a qualified patient known to the attending physician to be pregnant shall not be in effect as long as the fetus could develop to the point of live birth with continued application of life-sustaining procedures. [144A.6]

It should be noted that Iowa’s pregnancy exclusion stipulation contains a condition not found in the Texas advance directives law, namely, “as long as the fetus could develop to the point of live birth with continued application of life-sustaining procedures.”

By definition, a “qualified patient” refers to a person “who has been determined by the attending physician to be in a terminal condition” [144A.2] A “terminal condition” is defined as “an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.” [144A.2] Thus a “qualified patient” is someone who is still alive. Hence, as in the case in Texas, it is a question whether the aforementioned stipulation suspending a living will in the case of a pregnant woman applies if the woman suffers brain death. Similarly, Iowa’s pregnancy exclusion stipulation might also be subjected to challenges similar to those posed against the Texas law.

If the pregnancy exclusion stipulation of an advance directive statute is interpreted as no longer applicable upon the death of the mother, then it is theoretically possible that a case could occur in which somatic support for a brain-dead pregnant woman ought to be provided from an ethical point of view but would not be legally obligatory. Thus the following recommendation is noteworthy:

...while nowadays somatic support in the case of maternal BD [brain death] is technically possible, there is still no legal document which asks a pregnant woman about the fate of her unborn child in the event of BD. *It is highly recommended that this question be added to the advance directives of any woman of childbearing age and routinely discussed in standard prenatal interview.* [italics added; 58]

A sample addendum for an advance directive is attached which is formulated in accord with the language of the Code of Iowa Chapter 144A.

Also relevant is the pregnant woman’s status as an organ donor. It has been proposed that “if the deceased mother is an organ donor, then prolongation of her vital function is more easily justified from an ethical point of view, since the foetus would be the first to benefit from receiving the donation of the mother’s organic function.” [59] Robert Veatch has gone further in tracing out the legal implications of the pregnant woman being an organ donor:

...the problem involves the legitimacy of using the body of a newly deceased woman to serve the interests of another (her fetus). The relevant legal and ethical literature is now clear that the use of a newly dead, respiring cadaver should be governed by the provisions of the Uniform Anatomical Gift Act (UAGA). Thus, if the woman had, perchance, signed an anatomical donation card in accordance with the UAGA, physicians who had access to her could use her body as an incubator, technically even against the next of kin's permission. [60]

## NOTES

1. Antara Mallampalli and Elizabeth Guy, "Cardiac arrest in pregnancy and somatic support after brain death," *Critical Care Medicine* 33/10 (Suppl) (2005): S325-S331 at S328. See also Joao P. Souza, Antonio Oliveira-Neto, Fernanda Garanhani Surita, Jose G. Cecatti, Eliana Amaral and Joao L. Pinto e Silva, "The prolongation of somatic support in a pregnant woman with brain-death: a case report," *Reproductive Health* 3/3 (27 April 2006): 1-4 at 2.
2. Erich H. Loewy, "The pregnant brain dead and the fetus: Must we always try to wrest life from death?" *American Journal of Obstetrics and Gynecology* 157/5 (Nov. 1987): 1097-1101 at 1098.
3. Mallampalli and Guy, "Cardiac arrest in pregnancy and somatic support after brain death," S330.
4. Majid Esmailzadeh, Christine Dictus, Elham Kayvanpour, Farbod Sedaghat-Hamedani, Michael Eichbaum, Stefan Hofer, Guido Engelmann, Hamidreza Fonouni, Mohammed Golriz, Jan Schmidt, Andreas Unterberg, Arianeb Mehrabi, and Rezvan Ahmadi, "One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review," *BMC Medicine* 8/74 (2010); published on line November 28, 2010. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3002294>. See also Abuhasna Said, Al Jundi Amer, Ur Rahman Masood, Abdallah Dirar, Chedid Faris, "A brain-dead pregnant woman with prolonged somatic support and successful neonatal outcome: A grand rounds case with a detailed review of literature and ethical considerations," *International Journal of Critical Illness and Injury Science* 3/3 (Jul-Sep 2013): 220-4 at 220.
5. *Ibid.*
6. Esmailzadeh et al., "One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review," section Maternal and obstetric outcome.
7. *Ibid.*, section Fetal and neonatal outcome.
8. *Ibid.*, section Discussion.

9. *Ibid.*, section Recommendations for the management of maternal brain death. See also Anita J. Catlin and Deborah Volat, “When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model of Care in the Twenty-First Century?” *Critical Care Nursing Clinics of North America* 21 (2009): 267-76 at 270-71.
10. Said et al., “A brain-dead pregnant woman with prolonged somatic support and successful neonatal outcome,” p. 221.
11. *Ibid.*, p. 222.
12. *Ibid.*, p. 222.
13. *Ibid.*, p. 222.
14. *Ibid.*, p. 222.
15. *Ibid.*, 222.
16. Esmaeilzadeh et al., “One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review,” section Discussion.
17. Mallampalli and Guy, “Cardiac arrest in pregnancy and somatic support after brain death,” p. S329.
18. Alan Lane, Andrew Westbrook, Deirdre Grady, Rory O’Connor, Timothy J. Coughlin, Brian Marsh, John G. Laffey, “Maternal brain death: medical, ethical and legal issues,” *Intensive Care Medicine* 30 (2004): 1484-86.
19. Christoph Anstötz, “Should A Brain-Dead Pregnant Woman Carry Her Child to Full Term? The Case of the ‘Erlanger’ Baby,” *Bioethics* 7/4 (July 1993): 340-50.
20. Esmaeilzadeh et al., “One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review,” section Ethical and legal issues.
21. Congregation for the Doctrine of the Faith, *Donum Vitae – Instruction on Respect for Human Life in its Origin and On the Dignity of Procreation* (1987), I.1. Available at <http://www.vatican.va> > Roman Curia > Congregations > Doctrine of the Faith > Doctrinal Documents.
22. David R. Field, Elena A. Gates, Robert K. Creasy, Albert R. Jonsen, and Russell K. Laros, “Maternal Brain Death During Pregnancy,” *Journal of the American Medical Association* 260/6 (August 12, 1998): 816-22 at 821.
23. Daniel Sperling, “Maternal Brain Death,” *American Journal of Law & Medicine* 30 (2004): 453-500 at 492.
24. Lane et al., “Maternal brain death: medical, ethical and legal issues,” p. 1485. See also Esmaeilzadeh et al., “One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review,” section Background.

25. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009). Available at <http://www.usccb.org> .
26. Cf. Lane et al., “Maternal brain death: medical, ethical and legal issues,” p. 1486: “In the Republic of Ireland the foetus is accorded a right to life from conception. Sheikh and Cusack in considering the medicolegal implications of this protection in Ireland maintain that there is an obligation to maintain a foetus to a viable gestational age. However, if the available medical evidence suggests that the foetus could not be successfully maintained, this would be considered futile therapy and would not be permitted.”
27. David J. Powner and Ira M. Bernstein, “Extended somatic support for pregnant women after brain death,” *Critical Care Medicine* 31/4 (2003): 1241-49 at 1247.
28. Jeffrey Spike, “Brain Death, Pregnancy, and Posthumous Motherhood,” *The Journal of Clinical Ethics* 10/1 (Spring 1999): 57-65 at 60.
29. Catlin and Volat, “When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model of Care in the Twenty-First Century?”, p. 272. Staff may find themselves with conflicting feelings in providing seemingly futile support for a person who is dead and focusing on the baby in the womb as a human being. Health care facilities may need to be selective in staff able to care for a brain-dead pregnant woman.
30. Manny Fernandez, “Texas Woman Is Taken Off Life Support After Order,” *New York Times* (January 26, 2014). <http://nyti.ms/1aVxVQH>
31. *Ibid.*
32. *Ibid.*
33. Janine Marie Idziak, “Forgoing Drugs on Grounds of Cost: A Perspective from Catholic Health Care Ethics and Social Teaching,” *Marquette Elder’s Advisor* 13/1 (Fall 2011): 89-105.
34. Sperling, “Maternal Brain Death,” pp. 478-9.
35. Catlin and Volat, “When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model of Care in the Twenty-First Century?”, pp. 274.
36. Mallampalli and Guy, “Cardiac arrest in pregnancy and somatic support after brain death,” p. S330. The same point is mentioned by various authors. See Catlin and Volat, “When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model of Care in the Twenty-First Century?”, p. 273-4; Souza et al., “The prolongation of somatic support in a pregnant woman with brain-death: a case report,” p. 3; Powner and Bernstein, “Extended somatic support for pregnant women after brain death,” p. 1247; Field et al., “Maternal Brain Death During Pregnancy,” p. 821.
37. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5<sup>th</sup> ed. (2009). Available at <http://www.usccb.org>

38. Robert M. Veatch, "Maternal Brain Death: An Ethicist's Thoughts," *Journal of the American Medical Association* 248/9 (Sept. 3, 1982): 1102-3 at 1102.
39. Sperling, "Maternal Brain Death," p. 484.
40. Christoph Anstotz, "Should a Brain-Dead Pregnant Woman Carry Her Child to Full Term? The Case of the 'Erlanger Baby'," *Bioethics* 7/4 (July 1993): 340-50 at 344-5.
41. *Ibid.*, p. 346. The issue of the woman's "right to die with dignity" has also been raised in Catlin and Volat, "When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model of Care in the Twenty-First Century?," pp. 271; Lane et al., "Maternal brain death: medical, ethical and legal issues," p. 1485; L.M. Purdy, "Are pregnant women fetal containers?" *Bioethics* 4/4 (2007): 273-91.
42. Souza et al., "The prolongation of somatic support in a pregnant woman with brain-death: a case report," pp. 1, 4.
43. Anstotz, "Should a Brain-Dead Pregnant Woman Carry Her Child to Full Term?, p. 346.
44. Katherine Taylor, "State Pregnancy Exclusions are Bad Law," Munoz/McMath Symposium . <http://thebioethicsprogram.wordpress.com/category/munozmcmath-symposium> Accessed February 2014. Citation of Megan Greene and Leslie R. Wolfe, "Reproductive laws for the 21<sup>st</sup> century: Pregnancy exclusions in state living will and medical proxy Statutes" <http://www.centerwomenpolicy.org/programs/health/statepolicy/documents> .
45. Daniel Sperling, "Maternal Brain Death," *American Journal of Law & Medicine* 30(2004): 453-500 at 494-95.
46. *Erick Munoz vs. John Peter Smith Hospital* District Court Tarrant County, Texas 96<sup>th</sup> Judicial District Cause No. 096-270080-14.
47. "Death of Marlise Munoz" [http://en.wikipedia.org/wiki/Death\\_of\\_Marlise\\_Munoz](http://en.wikipedia.org/wiki/Death_of_Marlise_Munoz) Accessed March 2014.
48. Max V. Baker and Elizabeth Campbell, "Texas law didn't anticipate Munoz case, drafters say," *Star-Telegram* January 24, 2014. <http://www.star-telegram.com> Accessed February 2014.
49. Manny Fernandez, "Judge Orders Hospital to Remove Pregnant Woman From Life Support," *New York Times* January 24 2014. <http://www.nytimes.com> Accessed February 2014.
50. Max V. Baker and Elizabeth Campbell, "Texas law didn't anticipate Munoz case, drafters say," *Star-Telegram* January 24, 2014. <http://www.star-telegram.com> Accessed February 2014.
51. Manny Fernandez, "Judge Orders Hospital to Remove Pregnant Woman From Life Support," *New York Times* January 24 2014. <http://www.nytimes.com> Accessed February 2014.
52. *Ibid.*

53. Manny Fernandez, "Texas Woman Is Taken Off Life Support After Order" *New York Times* January 26, 2014. <http://www.nytimes.com> Accessed February 2014.
54. Max V. Baker and Elizabeth Campbell, "Texas law didn't anticipate Munoz case, drafters say," *Star-Telegram* January 24, 2014. <http://www.star-telegram.com> Accessed February 2014.
55. *Erick Munoz vs. John Peter Smith Hospital* District Court Tarrant County, Texas 96<sup>th</sup> Judicial District Cause No. 096-270080-14.
56. *Ibid.*
57. *Ibid.*
58. Esmaeilzadeh et al., "One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review," section Ethical and legal issues. See also Catlin and Volat, "When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model of Care in the Twenty-First Century?," p. 274; Sperling, "Maternal Brain Death," p. 499.
59. Souza et al., "The prolongation of somatic support in a pregnant woman with brain-death: a case report," p. 3. See also Esmaeilzadeh et al., "One life ends, another begins: Management of a brain-dead pregnant mother-A systematic review," section Ethical and legal issues; Lane et al., "Maternal brain death: medical, ethical and legal issues," p. 1486.
60. Veatch, "Maternal Brain Death: An Ethicist's Thoughts," p. 1103.

## **Addendum for Advance Directives for Women of Childbearing Age**

*This document may be appended to your living will and/or durable power of attorney for health care.*

I recognize the embryo/fetus as a human being with a right to life who is entitled to medical care and treatment. If I should suffer brain death while pregnant, I wish my body to be given medical support to allow the pregnancy to continue as long as there is a reasonable possibility that the child could develop to the point of live birth through such medical support of my body.

If I should suffer brain death while pregnant, continued medical support should NOT be given to my body if, to a reasonable degree of medical certainty, the child would not develop to the point of live birth through such medical support of my body. The child may be allowed to die naturally in my body.

If I should suffer brain death while pregnant and continued medical support of my body has been initiated in order to allow the pregnancy to continue, such medical support of my body should be stopped if it becomes clear, to a reasonable degree of medical certainty, that the child would not develop to the point of live birth through such medical support of my body. The child may be allowed to die naturally in my body.

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Name (printed)

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Signature

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Date

*This document should be discussed with your spouse, family members, and health care providers.*