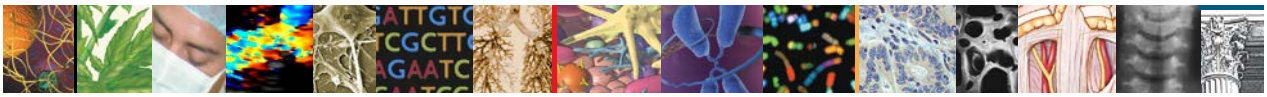

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Perspective

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Death in Pregnancy — An American Tragedy

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Marlise Muñoz was 33 years old and the mother of a 15-month-old when she collapsed on November 26, 2013, from what was later determined to be a massive pulmonary embolism. Initially described as apneic but alive, she was brought to the county hospital where her family was soon told that she was brain dead. Ms. Muñoz and her husband, both emergency medical technicians (EMTs), had discussed their feelings about such situations. So Erik Muñoz felt confident in asserting that his wife would not want continued support. Her other family members agreed, and they requested withdrawal of ventilation and other measures sustaining her body's function.

In most circumstances, this tragic case would have ended there, but Marlise was 14 weeks pregnant and lived in Fort Worth, Texas. Texas law states that a "person may not withhold cardiopulmonary resuscitation or certain other life-sustaining treatment designated . . . under this subchapter (the Texas advance directive law) . . . from a person known . . . to be pregnant."[1] The hospital caring for Ms. Muñoz interpreted this exception as compelling them to provide continued support and declined the family's request to end such interventions. The attorney representing the hospital indicated 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." After weeks of discussion and media attention with the hospital remaining intransigent, Mr. Muñoz sued in state court to have his wife's and family's wishes respected.

Because the loss of a pregnancy in utero together with a mother may be doubly mourned, clinicians, with a family's assent, have occasionally continued critical support in brain-dead parturients in order to advance gestation and potentially reach a point where a healthy neonatal outcome could be obtained. After all, brain-dead persons who are willing to donate organs are supported, albeit for much shorter periods, until tissues can be harvested. Some, but by no means all, such efforts have reportedly led to apparently healthy neonatal outcomes.[2] The ultimate result in such cases depends on the nature of the initial event, the duration of hypoxemia or circulatory compromise, and ongoing condition and complications

while function is supported (though it's odd to consider further complications in someone who is already brain dead). Indeed, by the time of the court hearing in January, the Muñoz family disclosed that ultrasound exams had revealed significant fetal abnormalities. But just as Texas law makes no provision for a mother's wishes, neither does it include an expectation for reasonable neonatal outcome in its mandate.

Texas is not unique in constraining pregnant women's end-of-life care and decision making. More than half of U.S. states have some such restrictions. Kentucky's attorney general, for example, advises that "the effectiveness of a Living Will is suspended during pregnancy." From the start of the Muñoz case, however, many experts argued that the law was misapplied, noting that the concept of life support for someone who was brain dead was an oxymoron. In this regard and in concordance with Texas law,[3] the hospital, appropriately, did not appear to distinguish brain death from any other definition of death. Many observers had a hard time escaping the conclusion that Texas was using this woman's dead body as the ultimate incubator, treating her as a means to an end rather than an end in herself. The family's attorney suggested in her arguments that if the hospital's approach were taken to its utilitarian conclusion, paramedics arriving at accident scenes would need to do on-site pregnancy tests to know which bodies to ventilate. Such arguments prevailed, and when it finally heard the case 2 months after support had been initiated (by which time Ms. Muñoz was 22 weeks pregnant), the court agreed with Mr. Muñoz, finding that that the law was not meant to apply to anyone who had been declared dead. On January 26, support was withdrawn, and the family was allowed to cremate Marlise and her undelivered fetus.

Separate from any parsing of legislation, actions like those undertaken in Ms. Muñoz's case seem a wrongful usurpation of the rights of individuals — in this case, one particular class of individuals: women. Although the moral status of a fetus is a matter of impassioned debate, the moral standing of women is not in question.

The court declined, however, to rule on the larger question of whether limiting end-of-life decision making in pregnancy is constitutional, and we must wonder what it would have decided had the facts been different. What if the patient had been not brain dead but in a persistent vegetative state? What if the appeal had been made after the usually accepted 24-week threshold of fetal viability? What if the patient were alive, competent, and coherent but declining treatment for a cancer that would surely and swiftly take her life? Though it's easy to get lost in hypotheticals, such questions point to the larger ethical issues that this case and such laws raise.

Separate from any parsing of legislation, actions like those undertaken in Ms. Muñoz's case seem a wrongful usurpation of the rights of individuals — in this case, one particular class of individuals: women. Although the moral status of and respect properly afforded a fetus is a matter of impassioned debate — discussion limited and too often confounded by abortion politics — the moral standing of women is not in question. As individuals — and just like fathers and men — mothers and women deserve to have their wishes regarding their liberty, including decisions about health, respected and followed. Their right to determine the course of their end-of-life care should be inviolate, unaffected by whether or not they may be pregnant. The Ethics Committee of the American College of Obstetricians and Gynecologists, for example, supports the position that "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."[4] Moreover, in its 1987 landmark ruling on *In re A.C.*, a federal appeals court determined that the right of a woman to decline care (in that case, a cesarean section before a cancer-associated death at 26 weeks of gestation) was not abridged by pregnancy.[5] It's important to emphasize, however,

that respect for pregnant women's autonomy is not limited to end-of-life choices. Decisions that are left to patients, surrogates, and families outside of pregnancy should remain theirs during pregnancy as well.

Practically speaking, what is a clinician to do when what a hospital's attorney says must be done seems different from what should be done? As Martin Luther King, Jr., famously wrote, "One has a moral responsibility to disobey unjust laws." If asked to violate a pregnant woman's wishes regarding her end-of-life care, physicians could appropriately choose to support the patient by declaring a conscientious objection. Though conscientious objection should arguably have limits, particularly in reproductive medicine and especially in emergency situations, those limits relate to clinicians unwilling to provide requested and accepted care such as emergency contraception. In contrast, in cases like this Texas tragedy, conscientious objection would be aligned with the patient's and family's wishes and against a state's interference with those wishes. It would seem both wrong and difficult for the state to compel a provider to participate in a patient's care against her and her family's wishes. Yet for some physicians, the consequences of seeming to break the law (real or imagined risks of losing hospital privileges or one's state license) may weigh too heavily to allow them to disobey. Such physicians may object by making their moral distress clear to their patients and the public and advocating for changes in the law.

Marlise Muñoz was dead for 2 months before she could be cremated. This event calls into question the moral appropriateness of laws limiting pregnant women's right to have their end-of-life wishes honored. Although, fortunately, the need to make end-of-life decisions is rare in obstetrics, the prevalence of statutes constraining women's autonomy argues that similar conflict and distress will arise again. Using a dead woman's body as an incubator against her wishes (as interpreted by her family) should be of grave concern to everyone who cares for and about both women and our nation's moral health.

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Accepting Brain Death

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Two cases in which patients have been determined to be dead according to neurologic criteria ("brain death") have recently garnered national headlines. In Oakland, California, Jahi McMath's death was determined by means of multiple independent neurologic examinations, including one ordered by a court. Her family refused to accept that she had died and went to court to prevent physicians at Children's Hospital and Research Center in Oakland from discontinuing ventilator support. Per a court-supervised agreement, the body was given to the family 3 weeks after the initial determination. The family's attorney stated that ventilatory support was continued and nutritional support added at an undisclosed location.

In Fort Worth, Texas, Marlise Muñoz's body was maintained on mechanical ventilation for 8 weeks after the medical and legal criteria for death were met, in an attempt to "rescue" her fetus. Muñoz was 14 weeks pregnant when she died from pulmonary embolism. Her family asserted that continuing ventilatory support was contrary to what the patient would have wanted, but John Peter Smith Hospital cited a state law requiring that support not be terminated if a patient is pregnant. A judge ultimately ordered that the hospi-