IN CONVERSATION

RUTH MACKLIN, ALISON REIHELD, ROBYN BLUHM, SIDNEY CALLAHAN, AND FRANCES KISSLING DISCUSS THE MARLISE MUÑOZ CASE, ADVANCE DIRECTIVES, AND PREGNANT WOMEN

Keywords: Marlise Muñoz, Samantha Burton, Texas advance directives, life support and pregnant women, fetal containers

Ruth Macklin

On January 8, 2014, a front-page story in the *New York Times* reported the case of Marlise Muñoz, a pregnant, brain-dead woman in Texas who was being kept on life supports (Fernandez and Eckholm 2014). Despite the patient's stated wish not to be left on life supports, the hospital invoked a Texas law that prohibits doctors from removing them from pregnant patients. In contrast to other cases in which family members of patients on life supports have insisted on continuation of medical treatment despite the futility of such treatment, in this case the parents and husband of the brain-dead patient sought the removal of life supports.

As does every state in the United States, Texas has a law on advance directives: wishes expressed by persons with decisional capacity regarding what they want by way of medical treatment if they lost capacity and became incompetent. That law defines "life-sustaining treatment" as "treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die" (Health and Safety Code, Sec. 166.002, Definitions). But

Ms. Muñoz was already dead, so it is reasonable to question whether the statute even applied to this case. The Texas law also contains the provision that prohibits removing life supports from a pregnant patient: "A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient" (Health and Safety Code, Sec.166.049, Pregnant Patients). In addition, in the absence of a written advance directive, the law provides for the spouse, along with the attending physician, to make the decision to withdraw treatment of an incompetent patient. However, if the attending physician "refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient," the case must then be reviewed by an ethics committee, followed by a series of procedural steps (Sec. 166.046). In the case of Ms. Muñoz, the physician told the family that the hospital would not comply with the request to remove life supports based on the Texas law that prohibits removal of life supports from pregnant patients.

In a judicial determination, district court judge R. H. Wallace Jr. ordered the hospital to remove the patient's life supports, contending that the law did not apply to her because she was dead. The hospital's lawyer argued that although Ms. Muñoz met the clinical criteria for brain death, the law still did apply to her. Meanwhile, the hospital admitted that the fetus was not viable, and medical records obtained by the family's lawyer showed that the fetus was abnormal. The hospital complied with the court order and removed the life supports from Ms. Muñoz.

According to the accepted scientific definition of brain death, Marlise Muñoz was dead. One viewpoint holds that dead persons no longer have any interests. Indeed, it is questionable even to use the word *person* in discussing dead bodies. If one accepts that viewpoint, Marlise Muñoz had no interests in whether her body was used as a "human incubator" that would carry her fetus to term. On the other hand, the legal concept that the state has an "interest" in life might be used to defend the Texas statute. So if the state does have such interests but the dead Marlise Muñoz had no interests, why should the attempt of Texas to uphold its statute not prevail?

Alison Reiheld

There are at least two considerations here. One relates to the application of the statute to living patients, and the other relates to what the statute expresses.

One reason it should not prevail is that the statute itself arguably—and in the finding of the court that led to life support finally being withdrawn—did not apply to Ms. Muñoz. It would, however, apply to living patients. Suppose Ms. Muñoz were not brain dead but rather in a vegetative state or judged to be minimally conscious. These are precisely the sorts of occasions in which patients wish to exert their prospective autonomy through advance directives and conversations with surrogate decision makers. The prospective autonomy of any woman of child-bearing age is thus constrained by the law.

Now, one could indeed argue that the state has obligations to fetuses—has an interest in preserving the lives of these potential citizens. That is precisely what *Roe v. Wade* (1973) both asserted and limited: that the state's interest in the well-being of the fetus exists but does not become compelling until the point of viability, which is to say the point at which the fetus has a reasonable chance of survival outside of the pregnant woman's body. Until that point, a pregnant female citizen's rights over her own body and reproduction allow her to choose an abortion. Of course, as technology improves, the point of viability is pushed ever earlier during pregnancy. Legally, a pregnant woman's right to an abortion is thus already contingent on medical technology. But abortion represents an instance when, as framed by the courts, the state's interest in preserving the fetus is in tension with a pregnant woman's autonomy; it is simply that the balance between them shifts at the point of viability and perhaps especially once the pregnant woman has voluntarily chosen to continue to term.

The application of the Texas statute to living patients, even if we grant that it did not apply properly to the deceased Ms. Muñoz, is part of a larger trend that is exceedingly damaging to the autonomy rights of pregnant women, and to the possibility that they have value above and beyond that of "fetal container." As a legal doctrine, the Texas statute is legally and morally problematic. The fact that, instance by instance, such laws are overturned on appeal is of limited consolation.

This ties into the second reason that the state of Texas's attempt should not prevail: whether or not the statute is upheld, it expresses a devaluation of pregnant women, and of the autonomy of women who might become pregnant, by presenting exceptions to their advance directives that simply do not apply to men and will never apply to women who cannot become pregnant. That pregnant women will be treated to any degree as "fetal containers" is morally

troubling on any number of standards of morality. Kantian ethics, for instance, prohibits the reduction of persons to "merely a means to an end."

Ruth Macklin

But obstetricians typically consider the fetus a "second patient." How does that fit into this picture?

Alison Reiheld

Of course, in a wanted pregnancy, the fetus is a second patient. Its welfare should matter to obstetricians. But the autonomy and well-being of the pregnant woman who carries it should not cease to matter. In Judith Jarvis Thomson's words, the pregnant woman may house the fetus, but we must not forget that she is a person who houses it (Thomson 1971).

Sidney Callahan

I think dead human beings retain certain relevant interests after death. Thus, Marlise Muñoz has interests. Like other dead humans, she has interests in not having her body abused or mutilated, her legal will annulled, her reputation defamed, or her family members persecuted. I would argue that individual living human beings in every stage of development and health have interests, as do group entities, communities, collectives, families, and the state. *Interest* is an ambiguously defined word, but minimally it can refer to a stake in preserving and pursuing valuable and advantageous outcomes in time.

Women who can become pregnant and are deciding on their treatment directives should consider whether they should be changed if they are pregnant. Women are known to go to great lengths in using technology to enable their fetus to be born. Even a dying woman could view sustaining her child's life as a final altruistic and loving act. The value of kinship ties is important to surviving families. Maternal altruism is now recognized as an evolutionary constant in primates, much less in our altruistic, future-conscious, kinship-valuing cultures. One of the problematic aspects in the Muñoz case is whether Marlise knew she was pregnant when she expressed her wishes not to be kept on life support.

Robyn Bluhm

I also agree with Alison's comments, but I want to approach the question from a different angle. Let's grant, for the sake of the argument, both that the dead have no interests and that the state has an interest in life. If we take these ideas both seriously and consistently, then there is no reason to restrict the use of a brain-dead body to that of gestating a fetus. Organ donation would be compulsory, for one thing. And we could take things even further, in the interest of preserving life. I wrote in my blog post (Bluhm 2014) about Willard Gaylin's idea of "neomorts," brain-dead individuals kept in hospital-like "bioemporia" and used, among other things, as a source of donor organs and tissues and a manufacturing system for hormones and antitoxins. The use of such neomorts would also clearly promote the state's interest in life.

But we don't do this. Even jurisdictions that have presumed consent for organ donation allow people to opt out. Moreover, in a nonmedical context, we have laws that limit what can be done with human remains, and some jurisdictions have separate charges for murderers who also desecrate the body of their victim.

Ruth Macklin

Is this an isolated case of putting the interests of the fetus above the interests of the pregnant woman (even though the woman in this case was already dead)?

Alison Reiheld

I'd like to say that people who argue that the Texas statute is part of a slippery slope to treating women as merely fetal containers are committing a fallacy. Alas, this is not a lone case but part of a pattern that takes women's own preferences less and less into account. As I argued in my *IJFAB Blog* entry "Not All Objectification Is Sexual: The Return of the Fetal Container" (Reiheld 2013), these constraints on pregnant women's autonomy have been building for decades. Howard Minkoff and Anne Drapkin Lyerly (2010) make just such a point in their *Hastings Center Report* essay "Samantha Burton and the Rights of Pregnant Women Twenty Years after In re. A.C." Examples found throughout their essay and in my blog entry include forcing pregnant women to attend inpatient drug rehab even in the absence of current drug use in order to protect the fetus from possible relapse, using police power to compel pregnant women

to undertake bed rest even after they have attempted to refuse it against medical advice (the case of Samantha Burton), compelling pregnant women to undergo preterm C-sections even after they have refused them (the case of Angela Carder and many others), refusing to permit a trial of labor after C-sections and thus requiring delivery by repeat C-section, and prosecuting for murder pregnant women who attempted suicide while pregnant.

Pregnant women's own preferences are indeed being overridden, and it's not even as nice as the classic grounds for overriding patient autonomy: the patient's own benefit. When overriding the pregnant woman's autonomy rights in favor of the best interests of the fetus, her benefit is simply out of the picture. We see this clearly in cases in which invasive surgical procedures that might hasten death (Angela Carder) or present higher risks of complications are imposed against the pregnant woman's will and for the alleged benefit of the fetus.

Sidney Callahan

Preserving the fetus's interests in the Muñoz case may also not be possible in the present state of technology. Moreover, the fact that an unviable fetus would not be protected from abortion by *Roe v. Wade* supports the decision to withdraw life support. One can disagree with the morality of *Roe* but see a value in obeying the law as the present law. Yet laws change as science and moral insight progress as in granting women equality.

Ruth Macklin

Alison and Sidney referred earlier to advance directives. Can someone please elaborate on that issue and how it might apply to this case?

Alison Reiheld

To get a little more fine-grained with respect to advance care planning, it is worth noting that Linda Emanuel et al. (1995), in their well-known piece "Advance Care Planning as a Process," argue that patients should run through scenarios with their physicians. It may be that, for some pregnant women, this conflict between their prospective autonomy and the Texas statute would be avoided if one of the scenarios discussed is whether their treatment wishes would change if they were pregnant at the time they became nondecisional. (I wish to thank several of my undergraduate medical ethics students for making

this nuanced point during fall 2013 and spring 2014 discussions of this case.) If women say they would not want life support withdrawn while pregnant, then there will be no conflict with the statute. However, the conflict will remain if they wish to have life support withdrawn even while pregnant.

Whether or not the law will override a pregnant woman's medical autonomy merely because she is a pregnant woman is clearly contingent on her happening to agree with it. That sort of justification isn't good enough with paternalism—respect the patient's autonomous preferences if and only if they agree with the provider's—and it is not good enough here.

Ruth Macklin

As Alison pointed out earlier, there are two issues regarding the Texas statute: "One relates to the application of the statute to living patients, and the other relates to what the statute expresses." Can someone elaborate a bit more on the state's interest in life?

Frances Kissling

It's worth noting that state interest can be expressed throughout pregnancy, through things like not paying for abortions, counseling designed to discourage abortion, and various pronatal policies.

Sidney Callahan

The state of Texas has an interest in protecting all of its population, born and unborn, from harm. Laws are one means the state uses to preserve the interests of all parties. Texas laws protect the interests of the dying, like Marlise Muñoz, by giving power to their advance directives about life support, and to their families in making these decisions. The state also, in my opinion, validly protects the interests of the unborn fetus who will certainly die when life support and the life-giving power of its mother are withdrawn. Thus, the challenge is to resolve and reconcile the interests of all the parties in a complex case.

Robyn Bluhm

The state's interest in life really seems to be an issue only when the life in question is that of a fetus. We don't compel parents to give up a kidney, or even

blood, to save their child's life. And in the United States, at least, the state's interest in life doesn't extend to ensuring that children receive life-saving medical treatment, and certainly not to ensuring that adults do. It seems that, as Sue Sherwin (2001) has put it, our society is pronatalist but doesn't seem to care as much about children once they've been born.

So there is something about the case of pregnant women, in particular, that makes it seem reasonable to some to use their bodies as incubators if they are declared brain-dead during pregnancy. As I said above, I agree with Alison that we already tend to objectify pregnant women. We also tend to romanticize motherhood, thinking that women will (or should) do anything for their child: being left on life support until the child can be born is just something that a good mother would want to do (if, of course, she were able to say so). As Alison and Sidney have pointed out, some women might indeed want to do this—and it would be a good idea to address the possibility in advance care planning. But note that even doing this much is granting that women's wishes, even when they're pregnant, carry moral weight.

Alison Reiheld

The seeming alignment of a woman's choice to continue the pregnancy to term with the state's interest in the well-being of the fetus has been used in legal justifications to limit the autonomy of pregnant women with respect to their conduct during pregnancy and childbirth. Minkoff and Lyerly (2010) note that a common argument against the rights of pregnant women to medical autonomy is that "the value and 'humanity' of a fetus must be championed regardless of costs to pregnant women, even in the context of a desired pregnancy . . . . [E]ven with legal precedent consistently on their side, pregnant women have nevertheless had their right to refuse surgery, their right to be treated like other citizens when prosecuted for drug possession, their right to information and voluntariness needed for informed consent, and even their right to die challenged" (14). That does not, as Robyn so nicely put it, "grant that women's wishes carry weight."

Sidney Callahan

The use of language in these difficult ethical dilemmas is significant. Oddly enough, the only place I encounter degrading descriptions of pregnant

women such as "human incubator," "fetal container," "house," et cetera is in feminist discourse describing what their opponents are thinking. But in pro-life literature, I see talk of mothers and babies, families, and maternal nurturing of new life. Yet this language also gets derided as romanticizing motherhood. Many feminists, like myself as a member of Feminists for Life, see pregnancy as an exercise of life-giving creative power and rescue that only the woman can fulfill. The value of medical autonomy is important but should not override the equal human value and interests of a new human life.

Frances Kissling

Is it the descriptions that are degrading, or is it the treatment described that is degrading of women? I don't doubt that the intent of those who support the pregnancy exclusion provisions in advance directive laws, from the Catholic bishops to various state right-to-life groups, is to save fetal life, but there does seem to be an assumption that women, left to their own devices—or their families who would act in their interests when they cannot decide—would not care about the loss of the pregnancy.

Also, there seems to me a lacuna in the language of mothers, babies, families, and maternal nurturing related to the Muñoz situation. I was deeply moved by the family's experience of their daughter and wife, dead but on life support for two months. This is how her husband, Erick Muñoz, described their pain in an affidavit: "When I bend down to kiss her forehead, her usual scent is gone, replaced instead with what I can only describe as the smell of death. As a paramedic, I am very familiar with this smell, and I now recognize it when I kiss my wife. In addition, Marlise's hands no longer naturally grip mine for an embrace. Her limbs have become so stiff and rigid due to her deteriorating condition that now, when I move her hands, her bones crack, and her legs are nothing more than dead weight" (Muñoz 2014).

Robyn Bluhm

Sidney, I think your point about the use of language is striking. I think that Frances is right, though, that the treatment these terms describe is degrading to women. Talking about mothers and babies seems to ignore the point that, in this case, Marlise Muñoz would never get to be a mother to her baby or,

more broadly, that not all women who are pregnant want to be mothers to the children they carry.

Frances Kissling

Marlise Muñoz's case was exceptional in that she was dead when the Texas statute was applied to her, and we also had no way of knowing, as Sidney points out, what her wishes would have been had she known she was pregnant. Unfortunately, even when we do know what pregnant women would want if they faced a situation similar to Muñoz's, in thirty states, they don't get to decide that they would not want to be kept alive. According to Katherine Taylor and Lynn Paltrow (2014), "A majority of these laws prohibit life support from being withdrawn from a woman even if she retains some consciousness and is suffering extreme pain." Taylor and Paltrow further note that most of these states do not include information regarding the pregnancy exclusions in government materials on living wills and advance directives. Even the most rudimentary right to information and thus informed consent is denied to women.

Legally, it does not matter what a pregnant woman wants. Even if she wishes to stay on life support and give her fetus the best chance for a healthy life, the state, not she, decides whether that will happen; the state, not she, could decide to save money and deliver the fetus at twenty-eight weeks and withdraw life support.

The assumption that a state interest in fetal life would result in what is best for unborn children is flawed. As others here have said, the state—and notably states such as Texas—has shown little interest in what is best for born children. These laws are not in anyone's interest. They serve a political purpose and do harm to women's health, security, and rights.

Ruth Macklin

Frances makes a good point in saying that such laws serve a political purpose. One would not say that about child protection laws, since there is wide societal consensus that children require protection from abusive or neglectful parents and other caregivers. Such societal consensus does not exist with regard to fetal protection laws.

As we draw our conversation to a close, it is evident that we are all in agreement that this case, because of its context in wider debates of fetal welfare

and pregnant women's autonomy, raises serious issues about advance care planning, informed consent, and refusal for pregnant women.

Robyn Bluhm and Alison Reiheld

We, in particular, agree that it is counterproductive to focus solely on questions about fetal welfare and fetal rights, as has too often been the way that discussions of abortion have been framed in bioethics. The issues raised are far too nuanced, and the values far too pluralistic, for such simplicity. At the same time, the autonomy of pregnant women must be respected and valued; laws and policies should encourage women to make difficult decisions about the circumstances under which a pregnancy should be maintained (should they later become unable to express their wishes) and should also respect those choices when they are known.

Ruth Macklin

Good points and a helpful way to end our conversation. Now, if only our elected officials would be prepared to follow our good advice!

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