FROM THE DEAD TO THE UNBORN: IS THERE AN ETHICAL DUTY TO SAVE LIFE?*
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Abstract: In this paper I examine the question whether physicians have a legal and ethical duty to sustain pregnancies of women who die during the first or second trimester by the delivery of their fetuses. One ground for such a duty, on which I am focusing, is the duty of “special relationship” between the mother and the fetus. In my paper, I claim that the special relations the pregnant woman and the fetus have do provide such a moral duty. This moral duty derives from the special and intimate relationship between the mother and the fetus, which has two considerations that support it: the uniqueness of the fetus, and the mother’s understanding and acknowledgement of such uniqueness. However, I argue that when the mother is dead, the nature of the relationship changes, as she is no more aware of her fetus and her relationship with it. Thus, the ethical duty of the mother to save her fetus’ life should be declined upon the end of the relationship between the mother and her fetus with the mother’s death. I support my argument by analyzing the special relationship between the mother and the fetus from four related ethical theories: ethics of relationships, responsibilities to society, ethics of families, and the ethics of care. By discussing these ethical theories, I show how responsibility to society in general, and to social entities, like families, in particular, constitute a moral duty towards the fetus, which, as aforesaid, no longer exists upon the pregnant woman’s death.

In addition to being social entities I further show how the intrinsic values of families play an important role in forming such a moral duty. Nevertheless, I argue that such an instrumental duty that enables the establishment of families no more exists as the pregnant woman is no more socially and morally part of the family she belonged to while alive.

* The material in this article will appear in chapter 7 of my “Management of Post-Mortem Pregnancy: Legal and Philosophical Aspects” (Ashgate Publishing) forthcoming in 2005. I am grateful to the Editors of “Medicine and Law” for permission to use this material.

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I strengthen my argument by applying ethics of care, and by analyzing the practical conclusion I arrived at from a religious perspective.

**Keywords**: Pregnancy; fetus; maternal-fetal relationship; brain-death; death; ethics of care; ethics of relationship; society; duty; ethics for families; ethical.

A pregnancy is generally understood to last 40 weeks. The longer the fetus is \textit{en ventre de sa mere}, in terms of gestational age, the greater its chances of survival if the fetus is to be delivered before arriving at full term. When a pregnant woman is struck by brain-death,\(^1\) the fetus’ chances of survival are seriously and immediately threatened. Until recently, there were two choices in such a situation: letting the mother (and the fetus) naturally die without further medical intervention, or delivering the fetus through a Cesarean section when the death of the fetus would be a tragic but an expected result.

However, recent advances in medical technology have provided physicians with the control over the time and manner of death in ways that were never previously considered by their patients. A new option has thus become available: maintaining the brain-dead pregnant woman on “life-support” by the successful delivery of the fetus.

In her article on “The Architect and The Bee: Some Reflections on Postmortem Pregnancy”,\(^2\) Hilde Nelson raises the question whether physicians have a legal

\(^1\) By brain death, I mean “the irreversible loss of capacity for consciousness combined with the irreversible loss of all brainstem functions including the capacity to breathe”. See Marc-Andre Beaulieu, Shashikant Seshia, Jeanne Teitelbaum and Bryan Young, “Guidelines for the Diagnosis of Brain Death” (1999) 26 Can. J. Neurol. Sci. 64; Eelco Wijdicks, “Brain Death World Wide: Accepted Fact But No Global Consensus in Diagnostic Criteria” (2002) 58(1) Neurology 20. For the development of the brain-death criterion see Sam D. Shemie, Christopher Doig and Philip Belitsky, “Advancing Toward a Modern Death: the Path from Severe Brain Injury to Neurological Determination of Death” (2003) 168 CMAJ 8. From an ethical and legal perspectives we should distinguish between three different situations: 1) reversible loss of capacity caused from cerebral injury 2) irreversible loss of capacity from cerebral injury and 3) brain-death. In situations 1, 2 decisions regarding medical treatment are usually made with the obtaining of consent from the patient’s surrogate decision makers or her next-of-kin or through an objective test involving an assessment of the patient’s best interests. In this article, I will only deal with the third situation. For a report of a pregnancy in which the fetus survived maternal persistent vegetative state see B. T. Ayorinde, I. Scudamore and D. J. Buggy, “Anaesthetic Management of a Pregnant Patient in a Persistent Vegetative State” (2000) 85 (3) Br J Anaesthesia 479.

\(^2\) (1994) 8 (3) Bioethics 247 [“Nelson”].
duty to sustain pregnancies of women who die during the first or second trimester. In order to answer this question, Nelson assumes four different grounds on which such a legal duty might rest. The duty might be a matter of respecting the woman’s wishes, there may be a duty to the State to save the life of the fetus, a duty might be generally based on beneficence to the fetus, or one might find a duty of “special relationship” between the mother and the fetus. With regard to the latter, Nelson’s conclusion is that it is not clear at all how a relationship between “such shadowy figures could breed special duties”.  

More general, her conclusion is that there is no basis for a legal duty to continue a pregnancy after the woman is dead.

In this article, I will look at the dilemma evoked by post-mortem pregnancy from the standpoint of the pregnant woman. I will do so by focusing on the fourth ground Nelson proposed as a base for the duty to sustain pregnancy of a dead woman. In contrast to Nelson, I would claim that the special relations the woman and the fetus have (to which Nelson herself strongly argues) do provide such a moral duty. However, like Nelson, I would argue that this duty should diminish upon the end of the relationship between the mother and her fetus with the mother’s death. I will support my argument by analyzing the special relationship between the mother and the fetus from four related ethical theories: ethics of relationships, responsibilities to society, ethics of families, and ethics of care. In addition, I will also bring a religious perspective that would support my practical conclusion.

**The Nature of the Maternal-Fetal Relationship**

A legal duty to sustain pregnancy implies that there are two separate (legal) entities involved: the brain-dead pregnant woman on the one hand and her fetus on the other hand. The idea of separateness between the mother and the fetus touches upon the delicate problem of maternal-fetal conflict. This conflict raises the following questions: what is the relationship between the mother and the fetus? How does this relationship impact on the moral and legal status of the fetus? I will try to answer these questions by looking into the nature of the relationship between the mother and her fetus, and by asking about the moral and (perhaps) legal implications that such a relationship creates.


To understand the nature of the maternal-fetal relationship it will be useful to bring here the fascinating description about pregnancy written by Hilde Nelson in her article. By rejecting Marx’s famous distinction between the architect and the bee, according to which the woman’s activity of being pregnant is thought to follow its own preordained patterns, Nelson writes:

“In important ways, the pregnant woman more nearly resembles the architect than the bee. As is typical for her species, she both obeys the laws of nature and improves upon them, ordering and shaping what she finds in the natural world through her own intentional, creative activity. She transforms natural processes by valuing them or by imbuing them with meaning; out of the ordinary phenomenon of hunger, for example, she creates a dinner party. That is, she turns the need for food into an occasion for expressing friendship, or possibly furthering social ambition. Like the architect’s, her edifices can be and often are purposeful and deliberate…once having conceived the purposiveness continues: the woman creates a relationship with her fetus. It begins as an act of the woman’s imagination, as soon as she knows or suspects she is pregnant. At that point she may be at odds with her own body, or she may be in a special harmony with it, as the newly formed fetus both is and is not a part of her own self. If she feels it as an intrusion she may figuratively push it away, distancing herself from it and perhaps aborting it or, after birth, neglecting it or giving it up for adoption. Or she may embrace it lovingly from the beginning, imagining its future and setting it within an existing web of relationships in which it will have a valuable place. Throughout the course of the pregnancy it becomes less and less her self and more and more its own. From the beginning it has a value independent of the meaning-system she weaves around it, but what she weaves also has value – the value of painting or a song, and not just the value of the honeycomb…”

Nelson’s strong words go together with the feminist writings of Cynthia Willett and Mary Shanely.6 What follows from these writings is that the mother and the fetus are one entity or alternatively two creatures in a special relationship

5. Ibid., at 262-263.

characterized far beyond the mere biological. This relationship has, in my view, a strong ethical implication. It creates a special obligation to the fetus. The moral obligation to the fetus derives neither from the fetus’ separate moral or legal status nor from the legal claims of the fetus as a potential right holder. It is also not deduced from the mother’s traditional right to privacy, autonomy, or the like. Instead, the moral duty to the fetus is founded on the unique relationship between the mother and the fetus while in the process of pregnancy.

I will turn now to justify the argument regarding the ethical duty to the fetus owed by the pregnant mother applying four different, though related ethical theories: ethics of relationships, responsibilities to society, ethics of families, and ethics of care. Before doing so, a clarification needs to be made. In this article, I am asking whether the mother owes a duty to the fetus so that it would be ethically justified to maintain her on “life-support”. My query does not focus on the consequences of the proposed act. In this article, I am not dealing with the position that an action is morally right or wrong according to its consequences. I do not need here to take account of what can reasonably be expected to produce the greatest balance of good or least balance of harm, in order to assess the best utilitarian outcome. My only examination is that of the ethical obligation of the mother’s response (and her physician’s following this obligation) to sustain her pregnancy by artificial means of life-support until the fetus can be delivered successfully.

In this article I will follow Immanuel Kant’s belief that an act is morally praiseworthy only if done neither for self-interested reasons nor as a result of a natural disposition, but rather from a duty. That is, the person’s motive for acting ethically must be recognition of the act resting on duty. I will therefore focus on the centrality of the duty in forming the ethical judgement. More specifically, I will ask for the source of such a duty, while discussing duties that derive from relations between the mother and the fetus.

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8. “In ethics the concept of duty will lead to ends and will have to establish maxims with respect to ends we ought to set ourselves, grounding them in accordance with moral principles”, Immanuel Kant, *The Metaphysics of Morals*, ed. and trans. Gregor, Mary. (Cambridge: Cambridge University Press: 1996), p. 147 [Kant].

9. My inspiration for this analysis comes from W. D. Ross’ theory on prima facie duties. Ross’ main argument is that duties like fidelity, reparation, gratitude, beneficence, non-maleficence, justice and self-improvement are based in significant relations.
Ethics of Relationship

The idea that duties can be derived from relationships between different creatures implies that moral responsibilities are neither corollaries of moral principles (like the principle of beneficence or autonomy) nor are they structured intuitively as “rules of thumb” for determining sound deliberative conclusions. Under the relational feminist theory represented in the writings of Willett and Shanely, moral responsibilities are a product of the multiplicity of relationships with particular persons that make up our lives. It is through the specific, concrete experience of engaging with persons in different settings of circumstances, or the affiliations shaped in these ways, and the recognizing the intrinsic and unique value of persons involved that a relationship is formed such that responsibilities can be recognized.

Relationships between people and the responsibilities accompanying them depend on the potentialities and possibilities that exist in the concrete circumstances within people’s lives. In addition, relationships are believed to have a temporal dimension: they progress over time, sometimes growing, or just changing, sometimes declining, and sometimes ceasing to exist altogether.

The concept of a duty based on a special relationship assumes that some people have a duty to undergo more than minimal risk on behalf of others because they have willingly consented to put themselves in a special relationship with those persons. The idea of special relationship is best shown in so-called “fiduciary relationships”. One obvious example of a duty derived from a fiduciary relationship is the duty of physicians to treat their patients even where there is a risk of life-threatening infection to the provider herself. Another example would be the duty of firefighters and lifeguards to rescue and protect others even at the risk of endangering their own lives. But there are simpler examples and less sacrificing of “trust duties” such as a lawyer owes toward her client. The assumption under this category of duties is that the moral duty derives from the willingness to undertake it and from the nature of the relationship that enables the fulfillment of this willingness.

Another possibility from which a duty can be derived within a certain form of special relationship is causality. Under this heading, a person is responsible for putting someone else at serious risk of harm, even unintentionally. A classic example would be the duty of a person who abandoned an open refrigerator in a vacant lot where the door became jammed shut over a trespasser. Some claim that a parent’s duties to care for their children are of this nature as
In Immanuel Kant’s view, it is the act of procreation that initiates this moral duty correlating with the child’s “original innate (not acquired) right” to the care of her parents. In Kant’s own words,

From a practical point of view it is a quite correct and even necessary idea to regard the act of procreation as one by which we have brought a person into the world without his consent and on our own initiative, for which deed the parents incur an obligation to make the child content with his condition so far as they can. They cannot destroy their child as if he were something they had made (since a being endowed with freedom cannot be a product of this kind) or as if he were their property, nor can they even just abandon him to chance, since they have brought not merely a worldly being but a citizen of the world into a condition which cannot now be indifferent to them even just according to concepts of rights [emphasis is original].

Pregnancy satisfies these two forms of duties discussed above. The mother has willingly put herself in this special relationship with the fetus, and she also has put her fetus to be in a causal risk of harm under the process of pregnancy. The risk of harm is, of course, derived from the biological dependence of the fetus on its mother during pregnancy.

All of us suppose that we have a set of more or less well-defined specific moral responsibilities with respect to various particular persons with whom we are interrelated. Reflection on such relationships draws our attention to the importance of responding and behaving in ways appropriate to particular human beings generally and to members of a social community specifically.

People have intimate and non-intimate interconnections. In the intimate context, there are many moral duties which we owe one another. Love, fidelity and solidarity are all examples of qualities grounded in the fine-grained particulars

10. An Israeli case declared such a duty and found that the breach of that duty constitutes negligence under the private law. See 1966/64 The Attorney General v. Mordechai Bash (The Supreme Court of Israel) 18 (4) 568 from 15 December 1964.


12. Kant, supra note 8 at 64.

13. “Women, unlike other animals, often are pregnant for a reason: they may conceive and carry a fetus because they want a special relationship that will last over time, or because they want an existing child to have a sibling, or because without children they would feel less firmly rooted in the world, or because they hope the baby’s bone marrow will be a lifesaving match for a dying family member”. Nelson, supra note 2 at 263.
of lives lived in common. Reciprocity is ideally desired in these contexts but is not a necessary characterization of them. The mother-fetus relation is the best example of such intimate relations. In fact, it could be easily claimed that it is the most intimate relation one could have. On the other hand, in non-intimate contexts such as business, school or work, we can claim the same kind of moral respect that anyone else gets; we can expect that our moral interests will be honored and our dignity observed in a way and to the extent we respect others’.

Christopher Gowans argues for two kinds of considerations in which our responsibilities in intimate contexts are rooted. The first is the idea that each person involved in these relationships has intrinsic and unique value. The idea that individuals are regarded as valuable in themselves implies that they are valued not only as a means to some further valued end, or that they are valued not only by being a part of some valued whole. The second consideration is the recognition that some connection or another obtains between oneself and these intimates. Thus, for example, it is because Frances regards Tom as intrinsically and uniquely valuable, and because she knows he is her son and the person she has brought up for the past few years, that she understands herself to have special responsibilities towards him.

The idea of value derived from connection within a relationship is associated with what Joel Feinberg calls “other regarding” interest. Feinberg argues that a person can invest a desire so strong, durable and stable in other’s well-being, that she comes to have an independent personal stake (interest) in it herself. It is a case of disinterested “love” that is the basis for what Feinberg this “other-regarding” interest. In Erich Fromm’s words, a person is loved for what she is, or more accurately, because she is. Domestic relations such as the love of a parent for her child or one’s love of a spouse are usually the type of connections which can provide this sort of interest.

Immanuel Kant’s ethical theory regards respect for persons as ends in themselves as a manifestation of respect for the moral law dictated by pure practical reasoning. Kant’s universal principle of right is ‘to act externally that the free


use of your choice can coexist with the freedom of everyone in accordance with a universal law'. In his view, what makes persons ends in themselves is a property shared equally by all: rationality and freedom. Since only this property is morally fundamental, nothing about persons that distinguishes them from one another is of deep moral relevance. Persons are intrinsically valuable, but are equal in being so.

In the Utilitarian tradition, persons are neither intrinsically valuable nor uniquely valuable. The Utilitarian view seeks to calculate and weigh the welfare of our actions, while each actor’s actions are counted separately and in isolation relative to their interconnection to the others. According to this view what ethically matters is the consequences of the act rather than its circumstances or the deontological status of its doers.

In both Kantian and Utilitarian traditions, whatever may be unique about individual persons cannot be of basic moral significance. In contrast to these two ethical theories, on the “responsibilities to person” account we do not regard intimate parties as intrinsically valuable by application of an a priori moral law, but through the experience of concrete interactions. It is the context of our particular relations with other persons that matters to our morals. On this view, a person is not only intrinsically valuable in isolation from her surroundings. Instead, a person has an intrinsic value, which is different from that of everyone else, but only by the fact that she comes to fully interact with others is her intrinsic value as a human being appreciated.

The uniqueness of persons can play different roles in deliberation. In the intimate relations context, for example in relations between family members or spouses, the specific ways in which a particular person is unique are primarily important.

17. Kant, supra note 8 at 24.
18. For a different view see Thomas Mappes & David DeGrazia (eds.), Biomedical Ethics, 5th ed. (Boston: McGraw-Hill: 2001) at 16. Although not distinguishing between intimate relations and non-intimate relations, Mappes and DeGrazia claim that duties that derive from relations are consistent with Rule-Utilitarianism: “Rule-Utilitarianism also seems to accord reasonably well with our experience of particular morally significant relationships. We commonly perceive ourselves as having special obligations arising out of our various morally significant relationships, and we think of these obligations as incompatible with functioning in the manner of an act-utilitarian. For example, parents have a special obligation to care for their children; physicians have a special obligation to act in the interests of their patients, and so forth. Such special obligations can be understood as having a rule-utilitarian foundation, as deriving from rules that, if generally followed, would maximize utility”.


In these contexts, we attempt to respond to what is uniquely valuable in these persons. As we move away from the paradigm of intimate relations, we are in less of a position to understand or appreciate much of what is uniquely valuable in a person. In extreme cases, where there is no proximity in those relations, we can hardly respond to anything specific about the person or her value at all.

Being intrinsically and uniquely valuable creates the potentiality for responsibility. It establishes the assertion that there is a (specific and valuable) being for which one can have moral responsibilities. It does not by itself establish that someone, indeed that anyone, has responsibilities. These only arise when some connection is established between persons, for example, through family relation, friendship, love, but also through common characteristics of people such as nationality, ethnicity or other shared background. The relationship can be innate or natural and involve no “choice” with regard to at least one of the parties, or it can be “artificial”, though consented to, by a way of agreement or actual behaviour.

On the basis of one or more of these various forms of connections, and typically the mutual recognition of the unique and intrinsic value of one another, a relationship between persons may be formed. Attached to such relationships is the understanding and appreciation of some form of responsibility by each person for the well being of the other. The nature and scope of the responsibilities, as well as the extent of their application to the parties involved and the degree to which they are well defined, varies with the nature of the relationship.\footnote{It is important to stress here two points: first, there is a great deal of diversity in the ways in which connections among us take place. This diversity results from the fact that our relationships depend upon social institutions that are both complex and variable across history and cultures. The different possibilities of our particular social world determine how we can come to be related to other persons. The implication of such diversity is a considerable variety among the moral responsibilities that arise from these relationships. Second, relationships typically arise through a combination of choice and unchosen circumstances. In some case, for example in responsibilities children have towards their parents, there is no element of choice at all. In most cases, relationships come about through choice in the context of circumstances that are unchosen and contingent, such as the choice of our spouse, the choice of our workplace (where we have relations with other workers), etc’.

Applying the theory of responsibility in relationships to the relation between the mother and her fetus is highly appealing. Although the fetus is in an early stage of development, it has uniqueness. It was created in special context (time, place, emotional state, etc’), and it carries with it the special meaning of bringing
a child into the world in the unique way of the process of pregnancy, which I described above. As long as the mother is aware of this uniqueness, and as long as she acknowledges the value of her fetus, and of her relationship with the fetus, she is responsible for its well being. Thus, she cannot abort him out of her own discretion, and to the extent she can do so, she has a duty to refrain from smoking, drinking excessive amounts of alcohol, or taking recreational drugs. The moment she becomes brain-dead, she loses her ability to appreciate and understand that she has such a special relationship (and hence responsibilities) to her fetus. The second and perhaps the most important component of the source for her responsibility for the fetus no longer exists.

Responsibilities to Society

The duty of the mother to her fetus can also be justified by the ethics of responsibilities to society in general. Human flourishing requires more than individual relationships. It requires participation in collective forms of human activity. Moreover, many relationships between individual persons are possible and dependent upon some form of a collective. This elementary fact establishes the idea that we have responsibilities not only to individual persons, but also to social entities, which consist of persons brought together by a way of common interest, purpose, belief, or aspiration, but which nonetheless differ radically from persons. Hence, there may be responsibilities to one’s family (as a social entity), community, nation, religious institution, political party, and so on.

Social entities last longer than the persons who make them up. Often, they are concerned with matters that transcend the needs of any specific individuals comprising them, for example the general commitment of a social institution like a university to promote general values such as education and research. The obligation to advance these ends does not depend upon the participation of specific individuals although it cannot do without them. This is why our relationships with social institutions and groups and our responsibilities and duties owed to them are not reducible to our relationships with and responsibilities to persons that form these institutions or groups. Responsibilities to a social entity thus should be thought of as something which consists of persons united with some common human interest.

A given relationship implies an understanding of the nature of the responsibilities that are part of it. Many factors affect these qualities. Some of them are the nature of the persons comprising the social entities involved, the nature of the relationship between these persons, and the specific circumstances of these
persons’ lives (history, health, financial state, etc.). Other factors relate to broader circles of relationships these persons have, and the possibilities that exist for these persons involved within the specific social institution or group.

One such an important social entity is the family. The fetus, although not born, is part of the mother’s family (new or existing one). From the mere fact of its existence in utero, the fetus constructs this social entity, shapes it and gives it a new meaning, power-relation, and form. Being part of it, on the one hand, and activating it on the other hand, the fetus’ well-being is instrumental to the establishment of this new and developing social entity. The mother, as a moral agent, owes a societal duty to enhance this social entity and to provide it by, *inter alia*, being responsible for her fetus. In this view, the duty towards the fetus serves as a means to enhance the new social entity (the family).

However, families have intrinsic values in themselves and they differ from any other social institution. Families should be ethically respected not only because they are social entities like other entities. They are special. They represent a combination of the ideas I discussed above, that is they are unique social entities exemplified by the intimate relations within their members. Thus, they create special ethical obligations about which I shall now elaborate.

**Ethics of Families**

What is so special in families? More than any other social entity families are characterized by the particular individuals that form them. The personal characterization of families makes this social institution irreplaceable by similarly (or even better) qualified people. Families function to foster the liberty and growth of their individual members, not as contributors to external ends, but mainly for the members themselves. Moreover, family members are “stuck” with each other. We do not choose familial relations, nor can we replace family members with others. For this reason, we cannot tear apart our familial bonds.

From biological and historical perspectives, occupying family roles involves a variety of considerations we regard as morally significant. As mentioned above, families are social entities that consist of strong and unchangable intimate relations. These relations provide a rich set of vulnerable situations and expectations, that when unfulfilled result in deep disappointment and sometimes severe damage. Finally, families serve as our first and perhaps most fundamental guidance for our moral capacities, and they are also central to the evolution of a child’s conscience and sense of self. It is within families that children learn
how to morally interact with others and to be ready for the “real” life in which the successful development of social capacities is crucial for one’s own survival.

Like traditional ethics in general, traditional medical ethics in particular is concerned with individuals. Under this view, it is morally wrong (if relevant at all) to take broader communal concerns into account while making treatment decisions for patients. Nevertheless, it seems that medicine is not ethically devoted to all individuals. Only those people who have a doctor-patient relationship are the subject of special moral concern. Medical ethics is, therefore, a contractual ethics in which all special duties flow from a relationship freely entered into by willing participants.

However, as Nelson and Nelson rightly claim, medical ethics, unlike general ethics, is grounded in a social practice, that is, the culture-specific traditions of the profession. This view is supported by contemporary calls for providers to regard their patients as active decision-makers, who can (and should) often determine their medical interests for themselves, and who will not always opt for actions the physician suggests. Nelson and Nelson further argue that these calls are accompanied by the huge rise in medical-practice lawsuits that seems to have made a continuing threat to the professional careers of physicians.

Indeed, recent developments in the profession of medicine show that the ethics of families have been well incorporated within medical ethics. It is believed that this process took place due to some important changes in the role of physicians on the one hand, and in the centrality of families and communal needs, on the other. The most profound example for such a view is the fact that questions of justice in the allocation of medical resources (like organ transplantation) become very compelling. By dealing with such questions,

20. Some, however, may argue that in addition to considering communal interests physicians have an obligation to save resources for society – an obligation that sometimes can compete with their own obligation to their patient. This makes them “double agents”. See the excellent piece of Marcia Angell, “The Doctor As Double Agent” (1993) 3(3) Kennedy Inst Ethics J 279.

21. A stronger argument which I will not develop here would be that not only is medical ethics not individualistic and impartial, but it tends to favor those who are powerful enough to enter into the doctor-patient relationship. Thus, it tends to favor those with more rather than less money, education, social standing, etc’. Hilde Lindemann Nelson & James Lindemann Nelson, The Patient in The Family (New York; Routledge; 1995) at 57 [Nelson & Nelson].

22. Ibid. at 57-59.

23. Ibid. at 59.
providers are expected to make a balance of “fairness” between the interests of their patients and the interests of society at large.

The implications of health care decisions are far beyond the patients themselves. As Eva Kittay beautifully writes when she discusses Communitarianism and its effect on bioethics:

“We frequently speak as if the obligation to provide care to a particular person belonged to a given individual or, perhaps, to a family. But an individual in need of care is like a stone cast in the water. Those feel the impact most immediately who are in closest proximity, but the effects come in wider and wider ripples. Even though the well-being of an individual may be the immediate duty of those who are closest, it is the obligation of the larger society to assure that care can be and is provided.”

Along with this new trend in medical ethics are the centrality of the family and the increased role of the family in shaping the patients’ attitude and decision-making. As the focus in the clinical area has extended from the patient to other family members (spouse, partner, parents), health-care providers face an inherent need to discuss their patient’s health problems with people other than the patient herself.

The situation of a pregnant brain-dead woman is a classic example of such a complexity, as it always involves other family members as well. Sometimes, the attitudes of a patient’s family members can vary among themselves. The case of Ellen Higgis that Jeffrey Spike brings in his article on...

24. Eva F. Kittay, “A Feminist Public Ethic of Care Meets the New Communitarian Family Policy” (2001) 111 Ethics 523 at 535. Some argue that health care decision making is not only a (neutral) matter of the society or the community in general, but that it is also and mainly influenced by our own culture, ideology, discourse and tradition: “If we think of medical developments as simply putting difficult but discrete moral choices before us – how to best use this or that technology, whether to turn off a respirator, or whether to engage in a fetal therapy – we have already failed to see the presence of a still deeper question. That is really a twofold question: first, to what extent has the culture engendered by medicine already constrained our choice (forcing us, for instance, to consider the use of a respirator whether we want such a choice or not)? and second, what kind of culture well we be engendering by the pattern of private decisions that eventually emerges from the need to make decisions?”. Daniel Callahan, “Bioethics: Private Choice and Common Good” (1994) 24(3) Hastings Center Report 28 at 31

25. Sometimes, sharing the patient’s health problems with other family members can cause ethical dilemma. For example, when the physician discovers a new genetic disease, a question arises whether the physician has a duty to contact other family members that may also be sick where the patient herself objects to tell her family.
maternal brain-death is an example of a real life situation in which the mother opposed to maintaining Ellen “alive” while her father and his second wife asked the medical team to perform this procedure.26

**Ethics of Care**

Another theory that can justify the argument on familial obligation to the fetus comes from ethics of care. The theory of ethics of care focuses on a set of character traits that are valued in close personal relationships. These qualities include sympathy, compassion, fidelity, love, friendship, etc.27 Caring and compassion are also emphasized — though not exclusively — by virtue-ethics approaches.28 An ethics of care places greater emphasis on health-care providers' communication skills and emotional sensitivity as well as on the effects ethical issues have on relationships. It does so by adhering to five major principles of moral attention, sympathetic understanding, relationship awareness, accommodation and response.29 Consequently, ethics emphasizing caring for others encourages the settlement of moral problems that give greater power to family members in health-care decision making.

The Royal Commission on New Reproductive Technologies in Canada adopted the guidelines of ethics of care and regarded this theory as the most suitable in maternal-fetal conflicts. In its report, the commission concluded that:

“In line with the ethics of care, we believe that the best approach is to seek ways to ensure that the needs of both the woman and the fetus are met... the ethics of care offers a means of avoiding the conflicts inherent in judicial intervention by promoting two fundamental values: respect for the rights and autonomy of the pregnant women and concern for the health and well-being of the fetus. The best way to accomplish this is not by compelling pregnant woman to behave in certain ways, but by providing a supportive and caring environment in which they can make

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27. Interesting to note here that the Latin word for cure is cura, which also means care.


informed decisions and choose from among realistic options before and during pregnancy.”

Hence, taking family seriously as an important social entity or for its intrinsic special values is also in accordance with the ethics of care. As I showed above, ethics of families (as social entities and as special entities with intrinsic values), and ethics of care can support the claim on the mother’s duty to the fetus. However, with the mother’s death, the mother does no longer take part in the familial obligations owed to the fetus like she did while alive. Her moral agency in this regard is over now, and she has no more obligations of care to her fetus. This practical conclusion will eventually be supported by religious ethics, especially Catholic ethics.

**Religion and Bioethics**

Religious ethical discussion is often conducted by reference to moral rules prohibiting or mandating the performance of certain types of actions. Much religious moral thought assesses actions in terms of the *intentions* embedded in them rather than in terms of what is done or what results. As this article turns aside from examining the consequences of the proposed action of whether to maintain the brain-dead pregnant woman on life-support or not, religious moral thought is appealing to the discussion on the mother’s moral duties toward her fetus. According to moral religious thought, the intention embedded in the action can substantially determine the moral permissibility of the action. The idea of intent, for example, can lead to a different result when interpreting an act as “letting die” rather than “kill”.

Examining our case through the lens of “intent” leads to the conclusion that letting the mother (and her fetus) die peacefully does not amount to killing the


32. One of the objections to Utilitarianism derives from this distinction and from the absence of components such as intention and responsibility. As Arras and Steinbock writes: “For nonconsequentialists, it can be very significant whether an outcome occurs because of something I did, whereas for consequentialists all that matters ultimately is what happens. This has led some consequentialists to reject a time-honored distinction in medicine between ‘killing’ and ‘letting die’.” See John D. Arras & Bonnie Steinbock eds., *Ethical Issues in Modern Medicine*, 5th ed. (Mountain View, Calif.: Mayfield Publication Co.: 2000) 11.
fetus. By using the principle of “double effect” it is possible to argue that the death of the fetus can be regarded as best a foreseen but unintended result. Of course, this is different from (actively) performing an abortion on a living pregnant woman. In addition to the act of killing itself, this living woman continues to owe her fetus all the moral duties discussed above, so that performing abortion is also morally wrong from the mother’s perspective, that is from her moral obligations toward her fetus.

Respecting the secular principle of “autonomy” can derive in religious ethics from the concept of fidelity. Much religious moral thought draws upon theological conceptions to develop an ideal view of human relations. One such ideal is covenental fidelity. According to this ideal, God and his people have entered into a covenant of fidelity, which mandates faithfulness to each other, so individuals entering into special relations with each other are bound by the requirements implied in this treaty of fidelity or faithfulness.

In the context of maternal brain death, it is however difficult to speak of the pregnant woman’s duty of fidelity to her fetus. Nevertheless, derived from the duty of fidelity is the physician’s duty to respect the patient’s wishes and be faithful to her, notwithstanding that she holds the right to autonomy (and hence according to the traditional view, as soon as she dies, she no longer enjoys this “right”). The woman’s wishes should be respected and considered mainly because the physician has a duty of faithfulness towards her. This duty does not end while she is still a patient, lying in the intensive care unit, though brain-dead. Acting not in accordance with her prior wishes (including the situation in which she did not explicitly leave any directives regarding her pregnancy upon her death) violates the ideal of fidelity.

In addition to the notion of fidelity, there are other specific values that are

33. In this article, I did not focus on the principle of autonomy. A major reason for many of the problems identified with the autonomy ideal, especially in regard to dead people is that the notion of autonomy is commonly understood to represent freedom of action for agents who are paradigmatically regarded as independent, self-interested, and self-sufficient. As such, it is easy to categorize dead people as not being autonomous or as people who are not entitled to autonomy (due to their death). The familiar critique by Relational Feminists to this liberal approach to autonomy is that it takes atomistic individuals as the basic units of a political and legal theory, and, thus, fails to recognize the inherently social nature of human beings. For the application of a relational feminist theory on the case of a brain-dead pregnant woman see chapter 6 to my Management of Post-Mortem Pregnancy, supra.

34. Baruch Brody, supra note 31 at 45.
fundamental to Catholic bioethics from which one can support the practical conclusion not to maintain a brain-dead pregnant on life-support. One important value is the belief in the sanctity of life. The value of a human life as a creation of God is beyond human evaluation and authority. According to this view, only God maintains dominion over this value. As Markwell and Brown explain, following from this view is the idea that “we are stewards, not owners of our own bodies and are accountable to God for the life that has been given to us”. Prolonging “life” after a person is dead is “playing God” perhaps in the extremest way. Moreover, according to the Catholic view, a person is a composite of body and soul, and as long as there is a living body (even with reduced mental capacities or with brain-death), there is still a person present. Hence, it seems that the Catholic tradition would hesitate to recognize, in the first place, that the brain dead pregnant woman is dead.

Indeed, as Markwell and Brown argue, the process of maintaining a brain-dead pregnant woman on life support for the delivery of her fetus, especially when the fetus is at the very early stage of development constitutes extraordinary means, and therefore, is from a religious perspective wrong. There seems to be no moral obligation to sustain the woman’s body for the sake of her unborn child flowing from such an analysis.

CONCLUSION

In this article, I examined whether a pregnant mother owes a duty to save the life of her fetus and to provide its well being. Such a moral duty has been shown to derive from the special and intimate relationship between the mother and the fetus. Two considerations support this duty based on the maternal-fetal relationship: the uniqueness of the fetus, and the mother’s understanding and acknowledgement of such uniqueness. However, as argued in this article, when the mother is dead, the nature of the relationship changes, as she is no more aware of her fetus nor does she appreciate her relationship with it. Also shown in this article is how responsibility to society in general, and to social

35. This is not exclusive to the Catholic tradition. In fact, all of the monotheistic religions (Judaism, Islam and Christianity) maintain that we have a duty to protect the life given to us by God.


37. Ibid., at 191-92.
entities like families in particular, constitutes a moral duty towards the fetus.

In addition to being social entities it was further demonstrated how the intrinsic values of families play an important role in forming the moral duty to the fetus. Nevertheless, it was argued that such a an instrumental duty that enables the establishment of families no more exists as the pregnant woman is no more socially and morally part of the family to which she had obligations while alive. This argument was strengthened by applying ethics of care, and by analyzing this practical conclusion from a religious perspective.

In sum, analyzing maternal brain-death through the above ethical theories leads to the conclusion that a brain-dead pregnant woman has no moral duty to keep her fetus alive after her death, and that without any other prior intentions on her behalf, it would be impermissible to maintain her on life-support for this purpose.