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DO PREGNANT WOMEN HAVE (LIVING) WILL?*

DANIEL SPERLING**

Living wills are documents that instruct health care providers about particular kinds of medical care that an individual would or would not want to have if rendered incompetent.¹ Under the American legal system, pregnant women are not typically allowed to express their will merely due to the fact they are pregnant. In other cases, their will is much weaker than those of other women, not to mention those of other men. In Canada, however, the law is silent on this matter: in contrast to the American legal system, no special provision relates to the state of pregnancy. From this silence one can infer two possible conclusions. According to the first, Canada has a gap in its living will legislation concerning pregnant women. This gap could be attributed to legislators who were not fully aware of the possibility that incompetency may also occur during pregnancy. According to the second potential conclusion, Canada considered the American model and decided to reject it due to legal and cultural differences between the two nations. Of course, choosing one interpretation over the other has far-reaching practical implications. But, what do we have to choose?

It is believed that advance directives in general, and living wills in particular, have three important purposes.² First, by issuing an advance directive, an individual is exercising her control over health care decisions concerning her body and state of health. Validating an advance directive is giving respect to the patient's prior wishes and to her right to self-determination, which does not extinguish should the signor of the advance directive become incompetent.³ However, advance directives also have an important procedural role: they prevent the need to go to court whenever a problem occurs as to what the patient would have decided in the relevant case had she had the opportunity to do so. Just as

* This Article is an excerpt from chapter 3 of my book, *MANAGEMENT OF POST-MORTEM PREGNANCY: LEGAL AND PHILOSOPHICAL ASPECTS*, forthcoming with Ashgate in 2005.

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1. The degree of incompetency under which an advance directive should operate is debatable. Originally, advance directives apply when the patient is alive but incapacitated, and unable to make reasonable, or indeed, any decision concerning his or her health matters. However, it seems plausible to argue that advance directives can also apply when the patient becomes dead. Under these circumstances, an advance directive functions like a donor card or a will, providing for treatment of the body after death. Ed Newman, *Ethical Issues in Terminal Health Care, Part Four: Patients Have Rights, but Doctors Have Rights, Too* (1992), <http://www.cp.duluth.mn.us/~ennyman/DAS-4.html> (last visited May 18, 2005).

2. ALAN MEISEL, *THE RIGHT TO DIE* 6 (2d ed. 1995).

3. *Id.*

important, they provide physicians with immunity from civil and criminal liability by offering solutions that reside with the patient, even when incompetent.⁴

Legislation usually regulates advance directives. Advance directive statutes allow individuals to make decisions about the kind of care they want, if they are unable to make decisions on their own, and to appoint another person to make those decisions for them. They provide a mechanism that advances the ethical principles of individual autonomy, self-determination, and bodily integrity. The legislation provides the form of the document, the procedure to create it, and the scope of its effect. Living will legislation actually reflects the recognition by the state that the incompetent adult has the right, if the expression of intent is made, to have medical treatment discontinued or otherwise prescribed, and, thus, that courts should uphold the individual's living will.

A. CANADA

In Canada, advance directive legislation exists over almost all the country.⁵ Such legislation covers the provinces of Alberta,⁶ British Columbia,⁷ Manitoba,⁸ New Brunswick,⁹ Newfoundland,¹⁰ Nova Scotia,¹¹ Ontario,¹² Quebec,¹³ Saskatchewan,¹⁴ Prince Edward Island,¹⁵ and Yukon Territory.¹⁶ Although legislation varies among these provinces and territories, *none* of these extensive

4. *Id.* at 7.

5. For a discussion of the legal status of living wills in Canada see UNIV. OF TORONTO JOINT CENTRE FOR BIOETHICS, LIVING WILLS, http://www.utoronto.ca/jcb/outreach/living_wills_download.htm (last visited May 18, 2005). See generally *Quality of End-of-Life Care: The Right of Every Canadian: Subcomm. To update "Of Life and Death" of the Standing Senate Comm. on Social Affairs, Science and Technology*, (2000), <http://www.parl.gc.ca/36/2/parlbus/commbus/senate/Com-e/upda-e/rep-e/repfinjun00-e.htm> (last visited May 18, 2005) (providing a detailed explanation of the legislation).

6. Personal Directives Act, S.A., ch. P-4.03 (1996) (Can.), *repealed by* R.S.A., ch. S-19, § 7 (2000) (Can.).

7. Representation Agreement Act, R.S.B.C., ch. 405 (1996) (Can.), http://www.qp.gov.bc.ca/statreg/stat/R/96405_01.htm (last visited May 18, 2005).

8. The Health Care Directives and Consequential Amendments Act, S.M., ch. 33 (1992) (Can.).

9. Infirm Persons Act, R.S.N.B. 1973, ch. I-8. (1973), amended by ch. 45, 2000 S.N.B. 1 (Can.).

10. Advance Health Care Directives Act, S.NFLD., ch. A-4.1 (1995) (Can.), <http://www.gov.nf.ca/hoa/sr> (last visited May 18, 2005).

11. Medical Consent Act, R.S.N.S., ch. 279, § 1 (1989) (Can.), <http://www.canlii.org/ns/laws/sta/r1989c.279/20041103/whole.html> (last visited May 18, 2005).

12. Substitute Decisions Act, S.O., ch. 30 (1992) (Can.).

13. Civil Code of Quebec, S.Q., ch. 64, § I (1991) (Can.).

14. Health Care Directive and Substitute Health Care Decision Makers Act, S.S., ch. H-0.001 (1997) (Can.).

15. Consent to Treatment and Health Care Directives Act, R.S.P.E.I., ch. 10 (1996), amended by ch. 5, 2000 R.S.P.E.I. (Can.).

16. Enduring Power of Attorney Act, R.S.Y.T., ch. 73 (2002) (Can.), <http://www.canlii.org/yk/sta/pdf/ch73.pdf> (last visited May 18, 2005).

legislative frameworks has a specific provision from which one can infer that the legal effect of an advance directive is influenced by whether the patient, who issued the living will, is pregnant or not. Thus, it seems that without any specific regulations for pregnant women deemed incompetent, Canadian law treats the incompetent pregnant woman who issued an advance directive while competent the same way as it treats other incompetent patients, that is, it respects the patient's right to control his or her care.

B. UNITED STATES

1. Regulation of Pregnancy Clauses

The legal structure of living will legislation regarding incompetent pregnant women is different in the United States than in Canada. Generally, in the United States, living will legislation of states differs from the Canadian legislation in that they allow the use of a living will only when a patient is terminally ill, or after a prognosis showing that the patient would not recover. While all the states have enacted some form of advance directive legislation, only 35 contemplate the validity of the advance directive when a woman is pregnant.¹⁷ Each of these statutes has specific guidelines as to the applicability of an advance directive when a woman who makes the advance directive is pregnant. While these guidelines reflect a practical balance between the constitutional rights of an incompetent

17. These states are: Alabama, ALA. CODE § 22-8A (1997 & Supp. 2004); Alaska, ALASKA STAT. § 13.52.055 (Michie 2004); Arizona, ARIZ. REV. STAT. ANN. § 36-3262 (West 2003 & Supp. 2004); Arkansas, ARK. CODE ANN. § 20-17-206 (Michie 2000 & Supp. 2003); California, CAL. PROB. CODE § 4670-8 (West 1991 & Supp. 2005); Colorado, COLO. REV. STAT. ANN. § 15-18-104 (West 1997 & Supp. 2004); Connecticut, CONN. GEN. STAT. ANN. § 19a-574 (West 2003); Delaware, DEL. CODE ANN. tit. 16, § 2503(j) (2003); Florida, FLA. STAT. ANN. § 765.113 (West 1997 & Supp. 2005); Georgia, GA. CODE ANN. § 31-32-8(a)(1) (2001); Hawaii, HAW. REV. STAT. ANN. § 327E-3 (West 2004) (repealed 1999); Idaho, IDAHO CODE § 39-4504(4) (Michie 1996); Illinois, 755 ILL. COMP. STAT. ANN. 35/3(c) (West 1992 & Supp. 2004); Indiana, IND. CODE ANN. § 16-36-4-8(d) (Michie 1993); Kansas, KAN. STAT. ANN. § 65-28, 103 (2002); Kentucky, KY. REV. STAT. ANN. § 311.631 (Banks-Baldwin 2004); Minnesota, MINN. STAT. ANN. § 145B.13 (West 1996 & Supp. 2005); Missouri, MO. ANN. STAT. § 459.025 (West 1992); Montana, MONT. CODE ANN. § 50-9-106 (2003); Nebraska, NEB. REV. STAT. ANN. § 20-408 (Michie 1997); Nevada, NEV. REV. STAT. ANN. § 449.624 (Michie 2000); New Hampshire, N.H. REV. STAT. ANN. § 137-H:14 (1996); North Dakota, N.D. CENT. CODE § 23-06.4-03 (2002); Ohio, OHIO REV. CODE ANN. §§ 1337.13, 1337.15, 1337.17, 2133.06, 2133.08 (Anderson 2002 & Supp. 2003); Oklahoma, OKLA. STAT. ANN. tit. 63, §§ 3101.4, 3101.8 (West 2004 & Supp. 2005); Pennsylvania, 20 PA. CONS. STAT. ANN. § 5414 (West Supp. 2004); Rhode Island, R.I. GEN. LAWS § 23-4.11-6 (1996); South Carolina, S.C. CODE ANN. § 62-5-504 (Law. Co-op. 1986 & Supp. 2004); South Dakota, S.D. CODIFIED LAWS § 34-12D-10 (Michie 1994); Texas, TEX. HEALTH & SAFETY CODE ANN. § 166.049 (Vernon 2001 & Supp. 2004); Utah, UTAH CODE ANN. § 75-2-1109 (1993); Washington, WASH. REV. CODE ANN. § 70.122.030(1)(d) (West 2002 & Supp. 2005); Wisconsin, WIS. STAT. ANN. § 154.03 (West 1997 & Supp. 2004); Wyoming, WYO. STAT. ANN. § 35-22-102(b) (Michie 2003). See generally, Amy Lynn Jerdee, Note, *Breaking Through the Silence: Minnesota's Pregnancy Presumption and the Right to Refuse Medical Treatment*, 84 MINN. L. REV. 971 (2000) (discussing refusal of medical treatment by pregnant women).

pregnant woman and the interests of the state in protecting potential life (or, even further, the interests of a fetus), the requirements represented in each of the statutes differ from one state to another. Nevertheless, they can be roughly divided into the following six categories:

1. Total Disregard of An Advance Directive During the Entire Pregnancy.

This category is the most frequent, appearing in 17 states.¹⁸ Statutes under this category declare that an advance directive of a person who becomes pregnant has no effect during pregnancy.

2. Possibility, Probability, or Medical Certainty that the Fetus Will Develop to Live Birth.

Some states have legislation that does not give effect to an advance directive if it is probable,¹⁹ possible,²⁰ or supported by medical certainty²¹ that the fetus will develop to live birth.

18. Alabama, ALA. CODE § 22-8A (1997 & Supp. 2004); California, CAL. PROB. CODE § 4670-8 (West 1991 & Supp. 2005); Connecticut, CONN. GEN. STAT. ANN. § 19a-574 (West 2003); Hawaii, HAW. REV. STAT. ANN. § 327E-3 (West 2004) (repealed 1999); Idaho, IDAHO CODE § 39-4504(4) (Michie 1996); Indiana, IND. CODE ANN. § 16-36-4-8(d) (Michie 1993); Kansas, KAN. STAT. ANN. § 65-28,103(a) (2002); Missouri, MO. ANN. STAT. § 459.025 (West 1992); New Hampshire, N.H. REV. STAT. ANN. § 137-H:14 (1996); Ohio, OHIO REV. CODE ANN. § 2133.06(B) (Anderson 2002); Oklahoma, OKLA. STAT. ANN. tit. 63, §3101.4, 3101.8 (West 2004 & Supp. 2005); South Carolina, S.C. CODE ANN. § 44-77-70 (Law Co-op. 1986 & Supp. 2004); Texas, TEX. HEALTH & SAFETY CODE ANN. § 166.049 (Vernon 2001 & Supp. 2004-05); Utah, UTAH CODE ANN. § 75-2-1109 (1993); Washington, WASH. REV. CODE ANN. §70.122.030(1)(d) (West 2002 & Supp. 2005); Wisconsin, WIS. STAT. ANN. § 154.03 (West 1997 & Supp. 2004); Wyoming, WYO. STAT. ANN. § 35-22-102(b) (Michie 2003). It is interesting to note here that Oregon law lists abortion as one of the limitations for which the durable power of attorney is not authorized to consent. OR. REV. STAT. § 127.540 (2003).

19. ALASKA STAT. § 18.12.040 (Michie 2004); DEL. CODE ANN. tit.16, § 2503(j) (2003); MONT. CODE ANN. § 50-9-106(6) (2003); NEB. REV. STAT. § 20-408(3) (1997); NEV. REV. STAT. ANN. § 449.624(4) (Michie 2000); R.I. GEN. LAWS § 23-4.11-6(c) (1996). This language can also be found in the Uniform Rights of the Terminally Ill Act, which reads: "Life sustaining treatment must not be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment." NAT'L CONFERENCE OF COMM'RS ON UNIF. STATE LAWS, Uniform Rights of the Terminally Ill Act § 6(c), (1989), available at <http://www.law.upenn.edu/bl/ulc/fnact99/1980s/urtia89.pdf> (last visited May 18, 2005).

20. ARIZ. REV. STAT. ANN. § 36-3262(3) (West 2003 & Supp. 2004); ARK. CODE ANN. § 20-17-206(c) (Michie 2000 & Supp. 2003); 755 ILL. COMP. STAT. ANN. 35/3(c) (West 1992 & Supp. 2004); MINN. STAT. ANN. § 145B.13(3) (West 1998 & Supp. 2005).

21. KY. REV. STAT. ANN. § 311-629(4) (Banks-Baldwin 2004); N.D. CENT. CODE § 23-06.4-07(3) (2002).

3. *Viability of the Fetus.*

Two states mention the viability criterion as a limit on the effect of the advance directive. Colorado requires fetal viability before voiding an advance care directive.²² Georgia requires that the fetus be non-viable for the discontinuation of medical treatment.²³

4. *Physical Harm or Pain to the Pregnant Woman.*

In addition to the requirement of reasonable medical certainty that the fetus will develop to live birth, Pennsylvania and South Dakota require the assurance that physical harm or pain to the woman can be alleviated.²⁴

5. *Rebuttable Presumption of Continuation of Treatment.*

The Minnesota advance directive law offers a unique approach. In 1998, the Minnesota legislature fundamentally revised their existing advance directive law.²⁵ Prior to 1998, Minnesota's pregnancy provision provided that:

In the case of a living will of a patient that the attending physician knows is pregnant, the living will must not be given effect as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.²⁶

With the 1998 amendment, the current pregnancy provision states that: When a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is real possibility that if health care to sustain her life and the life of the fetus is provided the fetus could survive to the point of live birth, *the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant. This presumption is negated by health care directive provisions . . . or . . . in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary.*²⁷

22. COLO. REV. STAT. ANN. §15-18-104 (West 1997 & Supp. 2004).

23. GA. CODE ANN. § 31-32-8 (2001).

24. 20 PA. CONS. STAT. § 5414 (West 1975 & Supp. 2004); S.D. CODIFIED LAWS § 34-12D-10 (Michie 1994).

25. MINN. STAT. ANN. § 145C (West 1998 & Supp. 2004).

26. *Id.* § 145B.13(3).

27. *Id.* § 145C.10(g) (emphasis added). For a general discussion on the new law in Minnesota see Barbara J. Blumer, *Minnesota's New Health Care Directive*, 81 MINN. MED. 1 (1998) (emphasis added), <http://www.mnmed.org/publications/MnMed1998/September/blumer.cfm> (last visited May 18, 2005).

Hence, the new approach acknowledges the interest of the state in potential fetal life, while still preserving the pregnant patient's right to withdraw treatment. It also encourages health professionals to discuss the issue with women who are or could become pregnant. This view goes beyond simply making the living will void with pregnancy. It attempts to balance the woman's rights with those of the state interest in protecting the life of the fetus.

6. Probability that the Fetus Would Not Be Born Alive.

In Ohio, life-sustaining treatment can be withheld or withdrawn, if "the declarant's attending physician and one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive."²⁸

The various legislative forms of restricting the woman's right to control her care on the basis that she is pregnant are troubling. Not only are women deprived of their right to determine their own treatment when incompetent, in some states this deprivation occurs regardless of the stage of the incompetent woman's pregnancy and heedless of whether the fetus is viable. This seems illogical: if the woman were competent, she could abort her child without hesitation, at least during her first trimester. But if she becomes incompetent during the first trimester, she cannot ask to withdraw life-sustaining treatment, and is thus compelled to save her pre-viable fetus's life.

2. Constitutionality of Pregnancy Clauses

More disturbing than the fact that pregnancy clauses exist is the fact that they were not found to be unconstitutional under United States jurisprudence. While the issue of constitutionality of pregnancy clauses has been raised in three judicial opinions, none of these cases involved substantial debate over the constitutional questions pregnancy clauses raise, nor about the serious implications they have on women in general.

In *University Health Services v. Piazzi*, the Supreme Court of Georgia implied that it would follow the pregnancy clause of Georgia, notwithstanding the objections of the patient's family.²⁹ The court granted a hospital petition to continue life-support procedures on a brain-dead pregnant woman, *contrary to the request of the patient's husband and family*. The woman's wishes were *unknown*, and there was no living will. The court held that, according to the law of Georgia,

28. OHIO REV. CODE ANN. § 2133.06(B) (Anderson 2002).

29. Molly C. Dyke, Note, *A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes*, 70 B.U. L. REV. 867, 871 (citing *Univ. Health Servs., Inc. v. Piazzi*, No. CV86-RCCV-464 (Ga. Super. Ct. Aug. 4, 1986)).

the woman was dead and therefore had no protectable privacy interest. In addition, the court ruled that because the pregnancy clause of the Georgia legislation determined that the living will would be ineffective during pregnancy, the woman's wishes regarding the living will were irrelevant. The *Piazza* ruling has led commentators to assume that the court's reliance upon the living will statute indicates that it might reject the claim that the pregnancy clause is unconstitutional.³⁰ The court, nevertheless, did not state that it was unconstitutional.³¹

Donna Piazza did not leave any directive. Still, the court based its ruling on the Georgia pregnancy clause. Perhaps the reason that the court relied on the pregnancy clause is that the woman was dead under Georgia law. It is not clear whether the court would have mentioned the pregnancy clause, let alone indirectly validated its constitutional content, had she been legally alive. But if Donna did not have any interests at all – a proposition for which the court did not provide any authority – what additional weight did mentioning the pregnancy clause have in the overall ruling? It seems to be none.

Another case in which the constitutionality of pregnancy clauses has been raised is *DiNino v. State ex. rel. Gorton*.³² In *DiNino*, the plaintiff executed a living will, adding a sentence declaring that the directive was the final expression of her “legal right to consent to termination of any pregnancy,” and that contrary to the Washington Natural Death Act, it would “still have full force and effect during the course of [her] pregnancy”.³³ DiNino and her physician, who feared including her directive in her medical file, sought a judgment declaring that her directive was valid, and that no physician would be liable for obeying it. DiNino argued that her constitutional right to privacy was infringed under the Act in two respects. First, the provision directly inhibited her right to choose to have an abortion and second, it directly infringed upon her right to choose to forego medical treatment.³⁴

The Superior Court of King County, Washington, granted DiNino partial summary judgment, declaring the pregnancy provision of the Natural Death Act unconstitutional because, as drafted, the subsection inhibited a woman's right to exercise control over her reproductive decisions; therefore, the provision violated DiNino's fundamental right of privacy. The Superior Court, however, denied the declaration of validity of a woman's directive because this directive attempted to exercise full control over DiNino's reproductive decisions *beyond the point where*

30. *Id.* at 871.

31. *Id.*

32. 684 P.2d 1297, 1299 (Wash. 1984).

33. *Id.*

34. It is interesting to note that the state conceded that an individual could draft an advance directive that contains a properly worded abortion provision, or alternatively, delete the pregnancy provision of the model directive. *Id.* at 1300.

the State has a legitimate interest in such decisions. Hence, both DiNino and the state appealed to the Supreme Court of Washington.

On appeal, Justice Brachtenbach, writing for the majority, held that the controversy was not “justiciable” under the meaning of the Uniform Declaratory Judgments Act, under which DiNino and her physician brought the suit against the state of Washington. Because the plaintiff was neither pregnant nor terminally ill, her arguments concerning the unconstitutionality of the Natural Death Act pregnancy provision were “purely hypothetical and speculative.” The only issue in controversy was whether Ms. DiNino could draft a declaration that differed in its terms from that provided in the Natural Death Act. Since the state was willing to concede that the form could differ or be absent from the pregnancy provision, a fact which undermines the state’s objective in enacting the pregnancy provision in the first place, the court concluded that “in the abstract, the NDA itself does not *directly* infringe any constitutional rights as claimed by the respondents.”³⁵

Although the court admitted that the constitutional rights allegedly infringed upon are important, it did not find the case to be one of “broad overriding public import.” Hence, the court did not think an advisory opinion on the constitutionality of the Washington living will provision would be “beneficial to the public or to other branches of government.” However, despite the fact that the court refused to express any opinion regarding the validity of DiNino’s directive and the constitutionality of the Washington pregnancy provision, it implied that in a real controversy, DiNino’s advance directive would have been effective. The court said:

We express no opinion as to the validity of DiNino’s directive as drafted, for this must await a factual controversy. However, under the facts presented, the respondents, as well as this court, can only speculate as to the possible impact of the NDA on an individual who is pregnant and is in a terminal condition.³⁶

In his dissenting opinion, Justice Dimmik explained why it is logically wrong to hold, as the majority did, that there is no justiciability at the time a woman drafts a directive under the Natural Death Act. In his words:

By the majority’s reasoning, a woman must be pregnant and terminally ill before the issue is ripe for determination. Whatever the impact of the [Natural Death Act] in that circumstance, the woman whose directive will then be ‘justiciable’ will never benefit from a ruling on the matter. In fact, the case would run a very real danger of being declared moot before a judicial decision could be made. And if, in its discretion, the court chooses to address the issues on mooted facts, would that

35. *Id.* at 1300 (emphasis added).

36. *Id.*

determination be based on any less speculation than a determination under the circumstances now before us?³⁷

Justice Dimmik's hypothesis was realized six years later when the Court of Appeals for the District of Columbia, in one of the leading decisions in the United States, acknowledged the right of a pregnant woman to refuse a cesarean section that was needed to save the life of her twenty-three-week-old fetus.³⁸ The woman could not benefit from the court's decision because she (and her fetus) died two days after the forced medical treatment. As a result of this outcome, one has to seriously ask whether moot cases are an appropriate forum in which courts should decide these life-and-death issues.

Yet, courts continue to hold off on determining the constitutionality of these pregnancy provisions. In *Gabrynowicz v. Heitkamp*,³⁹ the plaintiffs challenged the Uniform Rights of the Terminally Ill Act of North Dakota that invalidated an advance directive at pregnancy.⁴⁰ The plaintiffs were husband and wife. The woman sought to execute a living will and durable power of attorney (for her husband) with the hope that it would have the same effect whether she was pregnant or not. The plaintiffs argued that North Dakota's pregnancy clauses are unconstitutional because they: 1) impose undue burdens on the right to terminate pregnancy and make medical decisions under the First, Fourth, Ninth, and Fourteenth Amendments; 2) deprive women of liberty (bodily integrity) without due process, violating the Fourteenth Amendment; 3) discriminate on the basis of gender, violating the equal protection guarantee of the Fourteenth Amendment; 4) require an expression of adherence to the state's policy of protecting fetal life, violating the right to make and decline to make an expression of belief under the First and Fourteenth Amendments; and, 5) violate the right to free exercise of religion under the First and Fourteenth Amendments.

However, like the majority opinion in *DiNino*, the U.S. District Court for the District of North Dakota chose not to discuss the constitutional questions and dismissed the plaintiffs' motion for the technical reasons of standing and ripeness. The court held that at the time of the claim, Ms. Gabrynowicz was neither pregnant nor incompetent. Hence, the court did not see any "realistic danger" that the statute in question would directly injure the plaintiffs. The court acknowledged that section 23-06.4-07(3) of the statute authorizes medical treatment of a pregnant

37. *Id.* at 1301.

38. *In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990).

39. 904 F. Supp. 1061, 1062-63 (D. N.D. 1995).

40. N.D. CENT. CODE § 23-06.4-07(3) (2002). The statute provides: "Notwithstanding a declaration executed under this chapter, medical treatment must be provided to a pregnant patient with a terminal condition unless . . . such medical treatment will not maintain the patient in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful or unreasonably painful to the patient or will prolong severe pain that cannot be alleviated by medication." *Id.*

patient without distinguishing on the basis of fetal viability, and so admitted that at least some of the rights alleged by Ms. Gabrynowicz could be implicated. Nevertheless, the court still considered these questions to be abstract and non-justiciable.⁴¹

Indeed, at the time of the trial, Ms. Gabrynowicz had not issued an advance directive and in that sense her case was less ripe than DiNino's. However, both women were fertile: they were ready to become pregnant and fully aware of the consequences of their proposed (present or future) directives. It is unclear why the courts avoided substantial discussion of their directives under the premise that the issues were not yet ready for review. Is a state of loss of competency in which the woman's wishes cannot be directly examined, a better model than a state of full competency to use in evaluating her constitutional rights? Alternatively, did DiNino or Gabrynowicz have to actually become pregnant to have their claims heard? What if the validity of their advance directives is an important factor in their decision of whether to conceive? Can the courts avoid these women's basic rights as competent healthy persons to make choices concerning their health, body, and reproduction?

Importantly, in *DiNino*, the court stated that Ms. DiNino or her physician had to make a better effort to look for another physician who would be willing to place the directive in her file. The court thus concluded that the real controversy was between DiNino and her physician. But is the question before the court really about who gets to file the directive? Does DiNino's physician have a duty to look for another physician who will agree to file her directive? Will the latter be immune from any possible liability? These questions show that the courts' rulings on these matters may create, rather than resolve, inconsistencies in the law.

C. UNITED KINGDOM AND IRELAND

Advanced directives are valid under English law provided they are made freely, without undue influence. It is also necessary for the person who issued an advance directive to be competent and informed about the directive's legal consequences. If a pregnant woman temporarily loses capacity, an advance directive would be effective only if it *specifically addressed the possibility of pregnancy*. In case of doubt, some scholars have argued that a directive refusing all of the recommended forms of medical treatment is unlikely to be respected, because the courts may assume that "the woman had not addressed her mind to the circumstances which have arisen."⁴² This also seems to be the case in Ireland. Due to the well-recognized constitutional rights of the unborn, scholars have

41. *Gabrynowicz*, 904 F. Supp. at 1064.

42. Nicola S. Peart et al., *Maintaining a Pregnancy Following Loss of Capacity*, 8 MED. L. REV. 275, 279 (2000).

recognized that courts in Ireland will tend to ignore any advance directive issued and will protect the life of the unborn child, "unless there existed a grave, real and substantial risk to the life of the [incompetent] mother."⁴³

However, this claim is not supported in legislation, nor in English case law. Moreover, in its "Report on Mental Incapacity," the English Law Commission *disagreed* with the United States' approach of suspending the effectiveness of living wills during pregnancies.⁴⁴ The Commission recommended that women of childbearing capacity should address the possibility of a pregnancy when executing advance directives. In section 5.25 of the report, the Law Commission said:

We do not . . . accept that a woman's right to determine the sorts of bodily interference which she will tolerate somehow evaporates as soon as she becomes pregnant. There can, on the other hand, be no objection to acknowledging that many women do in fact alter their views as to the interventions they find acceptable as a direct result of the fact that they are carrying a child.⁴⁵

The Law Commission view is in accordance with ethical guidelines on this matter. In a supplement to its previous report, the Royal College of Obstetrics and Gynecologists stated that if an incompetent pregnant woman, who was fully informed, refused treatment during pregnancy in advance, her wishes should be respected *even at the expense of the fetus*.⁴⁶ However, if the woman referred in her advance directive to some forms of treatment but had no opportunity to discuss treatment during pregnancy, and if pregnancy is not mentioned in the directive, "the directive could be declared invalid because the circumstances at the critical time of decision were not clearly envisaged when the directive was made".⁴⁷

Hence, although academic writing in the United Kingdom and Ireland may support the view that a woman's advance directive should be invalidated during pregnancy, such an approach is contradictory to ethical guidelines concerning a pregnant woman's right to determine the fate of her care, and to the Law Commission's 1995 report on mental incapacity that explicitly discussed this issue.

43. Asim A. Sheikh & Denis A. Cusack, *Maternal Brain Death, Pregnancy and the Foetus: The Medico-Legal Implications*, 7 MEDICO-LEGAL J. IR. 75, 83 (2001).

44. LAW COMMISSION, MENTAL INCAPACITY, 1995, Cm. 231, § 5.25.

45. *Id.*

46. ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, COURT-AUTHORISED OBSTETRIC INTERVENTION: A CONSIDERATION OF THE LAW AND ETHICS, §§ 3.4.2, 4.2, (1996) <http://www.rcog.org.uk/print.asp?PageID=109&Type=guidelines&GuidelineID=33> (last visited May 18, 2005).

47. *Id.* § 3.4.2.

CONCLUSION

A woman's decision to issue an advance directive and to have it effectuated implicates her fundamental right to make decisions regarding procreation, family relationships and bodily integrity. These are the most intimate and personal choices a person makes in a lifetime. They are central to personal dignity and autonomy and to the "life and liberty" interests that are protected under the Canadian Constitution.

Pregnancy clauses that exist under American law should not be a model for Canadian law. Not only do they infringe on a woman's right to refuse medical treatment just because she is pregnant, and hence distinguish them from non-pregnant women on the basis of their pregnancy, but they also discriminate toward them on a gender basis and on the basis of their incompetency. In addition, Pregnancy clauses trivialize the significance of the mother's self-defining and conscientious choice by automatically overriding it. They ignore the pregnant woman's family, pretending to protect potential life without even drawing the line at the viability of the fetus. Finally, they control the woman's body, devalue it, and bring it near a state of involuntary servitude.⁴⁸ The woman's wishes are automatically ignored simply because she is pregnant.

However, it is not enough to conclude that Canada should not follow the American model of pregnancy clauses. A more active step should be taken, similar to that in the United Kingdom, so that the American model should be publicly discussed and rejected. No doubt should be left in such a significant area. It is hoped that this Article initiates the debate on this central issue and helps future pregnant women and their loving families and friends better handle these difficult circumstances of incompetency.

48. Timothy J. Burch, *Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes*, 54 MD. L. REV. 528, 555 (1995).