Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Directive Statutes

Timothy J. Burch

Follow this and additional works at: http://digitalcommons.law.umaryland.edu/mlr

Part of the Health Law Commons

Recommended Citation
Available at: http://digitalcommons.law.umaryland.edu/mlr/vol54/iss2/9
INCUBATOR OR INDIVIDUAL?: THE LEGAL AND POLICY DEFICIENCIES OF PREGNANCY CLAUSES IN LIVING WILL AND ADVANCE HEALTH CARE DIRECTIVE STATUTES

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. . . . To compel any one, and especially a woman, to lay bare the body, or to submit it to the touch of a stranger, without lawful authority, is an indignity, an assault and a trespass; and no order or process, commanding such an exposure or submission, was ever known to the common law in the administration of justice between individuals. . . .

The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.2

INTRODUCTION

The right of competent individuals to forego medical treatment as an expression of their right to bodily integrity and autonomy has been consistently recognized by the United States Supreme Court for the last one-hundred years.3 Although the Court has often balanced the interests of the individual with the interests of the state to determine the extent of the right to forego medical treatment,4 the basic

3. See, e.g., Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992) (Casey I) (holding that Constitution limits a state's authority to interfere with an individual's basic decisions regarding bodily integrity); Cruzan, 497 U.S. at 278 (recognizing a right to refuse medical treatment); Washington v. Harper, 494 U.S. 210 (1990) (holding that forcible injection of medication into a nonconsenting individual infringes a liberty interest); Winston v. Lee, 470 U.S. 753 (1985) (invalidating surgical removal of bullet from murder suspect as unreasonable under the Fourth Amendment); Youngberg v. Romeo, 457 U.S. 307 (1982) (recognizing right to be free from unreasonable bodily restraints); Rochin v. California, 342 U.S. 165 (1952) (holding that involuntary stomach-pumping violates due process); Jacobson v. Massachusetts, 197 U.S. 11 (1905) (recognizing liberty interest of individual with regard to undergoing unwanted treatment); Camden & Suburban Ry. v. Stetson, 177 U.S. 172 (1900) (holding that court has no common-law power to order an individual to undergo surgical procedures).
4. See, e.g., Cruzan, 497 U.S. at 261 (holding that individual's liberty interest must be balanced against competing state interests); Washington v. Harper, 494 U.S. 210 (1990)
underlying right of competent individuals to forego medical treatment\(^5\) and to protect their right to bodily integrity and autonomy has not been questioned. State appellate courts have also upheld the right of a competent individual to forego medical treatment.\(^6\)

While upholding the rights of competent individuals to forego medical treatment in most circumstances\(^7\) has been the easy case for federal and state courts, upholding the rights of incompetent\(^8\) individ-

(holding that state's interest in administering antipsychotic drugs to violent, mentally-ill inmate outweighed the inmate's liberty interest); Jacobson v. Massachusetts, 197 U.S. 11 (1905) (recognizing that reasonable state regulations may override individual's liberty interest).

5. This Comment recognizes, as do most feminist theories, that the framing and naming of an issue is a political act. As such, this Comment does not use the morally laden terms “right-to-die,” “euthanasia,” or “suicide.” To do so would detract from the true issue involved: the right of individuals to choose what medical treatment, if any, is to be performed upon their bodies. See Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 Tenn. L. Rev. 519, 527 (1992).


7. The cases uniformly recognize that the right of an individual to forego medical treatment is not absolute, and that it can be balanced against the countervailing interests of the state in its role as *pares patriae*. These interests are: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and, (4) the maintenance of the ethical integrity of the medical profession. See, e.g., *Brophy*, 497 N.E.2d at 634; see also *Cruzan*, 497 U.S. at 279 (“[W]hether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.” (quoting Younberg v. Romeo, 457 U.S. 307, 321 (1982))); John D. Hodson, Annotation, *Judicial Power to Order Discontinuance of Life-Sustaining Treatment*, 48 A.L.R.4th 67 (1986) (analyzing state and federal cases pertaining to court orders to discontinue life support). For a good discussion of “protecting innocent third parties,” which is the interest most frequently argued by states when intervening in the decision-making process of individuals to forego medical treatment, see *In re Dubreuil*, 629 So. 2d 819 (Fla. 1993), corrected, 18 Fla. L. Wkly., S 636 (Fla. 1993).

8. What constitutes incompetency depends upon the statute in question. Generally, the term is used to describe a patient that is either brain-dead, in a persistent vegetative state, an end-stage condition or a terminal condition. It is the “[l]ack of ability, legal qualification, or fitness to discharge a required duty. A relative term to show want of physical or intellectual or moral fitness.” *Irving J. Sloan, The Right To Die: Legal & Ethical Problems* 142 (1988).

Brain-death refers to “whole brain death” where “all functions of the brain, including cortical, subcortical, and brainstem functions, are permanently lost.” *Fred Plum & Jerome B. Posner, The Diagnosis of Stupor & Coma* 9 (3d ed. 1980). Persistent vegetative state “describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the
uals to forego medical treatment has been more difficult. The seminal case involving the rights of incompetent patients to forego medical treatment was issued by the New Jersey Supreme Court in 1976. In re *Quinlan* held that an individual, whether competent or incompetent, had the right to forego medical treatment at common-law as well as under a state and federal constitutional right to privacy. Since *Quinlan*, several state appellate courts have also held that the right to forego medical treatment can be found in state and/or federal constitutional law, usually based on the right to privacy. This constitutional right to forego medical treatment has also been found to exist by several federal courts.

End-stage condition is a statutory creation which appears in the Maryland Health Care Decisions Act of 1993. The Act defines an end-stage condition as "an advanced, progressive, irreversible condition caused by injury, disease, or illness: (1) That has caused severe and permanent deterioration indicated by incompetency and complete physical dependency; and (2) For which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective." Md. Code Ann., Health-Gen. § 5-601(i) (1994). A terminal condition is defined in Maryland as "an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery." *Id.* § 5-601(q) (1994).

9. For example, there are no United States Supreme Court cases directly on point which deal with the rights of an incompetent patient to refuse medical treatment; but see *Cruzan*, 497 U.S. at 278-80.


11. *Id.* at 603.


Though *Quinlan* and its progeny of cases have recognized the right of an incompetent individual to forego medical treatment, the cases have consistently turned on the question of how this right could be exercised and protected. While state appellate courts have come up with varying answers in case law, state legislatures originally reacted by enacting living will statutes. Durable power of attorney for health care and advance health care directive statutes soon followed. By enacting such prior directive statutes, state legislatures aimed to codify the common-law right to forego medical treatment, though not recognizing constitutional right to refuse life-sustaining treatment; *Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1456 (D.D.C. 1985) (holding that competent patient has the right to order removal of life-support).


15. In 1976, California became the first state to enact a "Natural Death Act." *See* *CAL. HEALTH & SAFETY CODE* § 7185 et seq. (1976). Generally, living will statutes allow competent adults to prepare documents "authorizing or requiring the withholding or withdrawal of specified medical treatments" upon some triggering event (usually a terminal condition, a persistent vegetative state, an end-stage condition, or brain death) that has "render[ed] the declarant incompetent to make such a decision personally." *Gregory Gelfand, Living Will Statutes: The First Decade*, 1987 Wis. L. REv. 737, 740. *See supra* note 8. "The Living Will is a means for the individual to manage his death by prospective guidelines and is premised on the informed consent of the person prior to an irreversible coma or a state of being disabled or maimed." *Sloan, supra* note 8, at 31.

16. Durable power of attorney for health care statutes allow an individual (the principal) to appoint another individual (agent, surrogate, or proxy) to act as the principal's agent in the event that the principal becomes incompetent and is unable to make health care decisions. *See*, e.g., *Massachusetts Health Care Proxies Act*, *MASS. GEN. LAWS ANN.* ch. 201D, § 2 (West Supp. 1993).

Advance health care directive statutes allow individuals to state, in advance, what type of medical care they would want if they should become incompetent at a future date, or to name a surrogate or proxy to make any decision regarding health care that the individuals would have been able to make if competent. *See* *PRESIDENT'S COMMISSION, supra* note 8, at 136. *See also* *Gregory G. Sarno, Annotation, Living Wills: Validity, Construction, and Effect*, 49 A.L.R.4th 812 (1992) (analyzing state and federal cases on the validity of living wills); *James M. Jordan, Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 Ga. L. REV. 1103, 1105 n.8 (1988) (discussing advance directives). Many advance health care directive statutes also set up surrogate decision-making mechanisms whereby an individual who has not been appointed, but who is within a hierarchy established by statute, can make health care decisions for one who has become incompetent and has made no prior directive. *See*, e.g., *MD. CODE ANN., HEALTH-GEN.* § 5-605 (1994).

17. This Comment will use "prior directive" as a shorthand method of referring to living wills, durable power of attorneys for health care, and advance health care directive statutes or documents.

18. *See infra* note 57.
to limit or supersede it, and to recognize, as some courts already had, the constitutional right to forego life-sustaining treatment if one becomes incompetent. 19

As of this writing, all fifty states and the District of Columbia have enacted such statutes. 20 Of these fifty-one jurisdictions, eighteen have

19. See Gelfand, supra note 15, at 770; see also Janice MacAvoy-Snitzer, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987) ("Living will statutes provide legislatively defined mechanisms for exercising the constitutional right to bodily integrity, which encompasses the right of competent individuals to designate the course of their medical treatment.").

only living will statutes,21 four have only durable power of attorney for health care statutes,22 eighteen have integrated23 statutes,24 and


23. An integrated statute provides for both a living will and a durable power of attorney for health care. Such a statute generally allows an individual to execute one or both such prior directives, and it also generally provides for what is to occur when no prior directive exists and the patient is incompetent to make decisions regarding health care.

eleven have separate living will and durable power of attorney for health care statutes.\textsuperscript{25}

Of the eighteen jurisdictions with only living will statutes, eight forbid physicians to comply with the terms of a living will throughout the term of a patient's pregnancy,\textsuperscript{26} four forbid a physician from implementing the living will of a pregnant woman if the fetus could possibly be brought to the point of live birth with the continued use of life-sustaining treatment,\textsuperscript{27} one forbids a physician from implementing the living will of a pregnant woman if the fetus could be brought to the point of live birth and the mother would not be further harmed.
or made to suffer from being kept on life-support systems, and five do not have pregnancy clauses.

Of the four jurisdictions with only durable power of attorney for health care statutes, one forbids a physician from implementing the terms of a durable power of attorney for health care throughout the term of a patient’s pregnancy, one forbids a physician from implementing the durable power of attorney for health care of a pregnant woman if the fetus could possibly be brought to the point of live birth with the continued use of life-sustaining treatment, and two do not have a pregnancy clause.

Of the eighteen jurisdictions with integrated statutes, eight forbid physicians to comply with the terms of a prior directive throughout the term of a patient’s pregnancy, three forbid a physician from implementing the terms of the prior directive of a pregnant woman if the fetus could possibly be brought to the point of live birth with the continued use of life-sustaining treatment, one forbids a physician

28. S.D. CODED LAWS ANN. § 34-12D-10 (1994) (“Notwithstanding a declaration made pursuant to this chapter, life-sustaining treatment and artificial nutrition and hydration shall be provided to a pregnant woman unless, to a reasonable degree of medical certainty, such procedures will not maintain the woman in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication.”).


30. MICH. COMP. LAWS ANN. § 700.496(7) (c) (Supp. 1994) (“This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient’s death.”).

31. NEB. REV. STAT. § 30-3417(1)(b) (Supp. 1993) (“[A]ttorney in fact shall not have authority . . . to make any decision when the principal is known to be pregnant that will result in the death of the principal’s unborn child and it is probable that the unborn child will develop to the point of live birth with the application of health care.”).

32. MASS. GEN. LAWS ANN. ch. 201D, §§ 1-17 (West Supp. 1994); N.Y. PUB. HEALTH LAW ANN. §§ 2980-2994 (McKinney 1993).


See, e.g., CAL. HEALTH & SAFETY CODE § 7189.5(c) (West Supp. 1994) (“The declaration of a qualified patient known to the attending physician to be pregnant shall not be given effect as long as the patient is pregnant.”).

34. COLO. REV. STAT. § 15-18-104(2) (1989); FLA. STAT. ANN. § 765.113(2) (West 1986); MINN. STAT. ANN. § 145B.13(3) (Supp. 1993). See, e.g., MINN. STAT. ANN. § 145B.13(3) (West Supp. 1994) (“[I]n 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.”).
from implementing the prior directive of a pregnant woman if the fetus could be brought to the point of live birth and the mother would not be further harmed or made to suffer from being kept on life-support systems,\textsuperscript{35} and six do not have a pregnancy clause.\textsuperscript{36}

Of the eleven jurisdictions with separate living will and durable power of attorney for health care statutes, three forbid physicians to comply with the terms of a living will throughout the term of a patient’s pregnancy.\textsuperscript{37} The durable power of attorney for health care statutes in these jurisdictions, however, vary in their treatment of an incompetent pregnant woman. While Mississippi’s durable power of attorney for health care statute does not contain a pregnancy clause,\textsuperscript{38} New Hampshire’s statute states that an incompetent pregnant woman must be maintained until live birth if, to a reasonable degree of medical certainty, the unborn child could be brought to term.\textsuperscript{39} Wisconsin’s statute allows the surrogate to make whatever decisions the prior directive authorizes.\textsuperscript{40}

Five of the eleven jurisdictions with separate living will and durable power of attorney for health care statutes forbid a physician from implementing the living will of a pregnant woman if the fetus could possibly be brought to the point of live birth with the continued use of life-sustaining treatment.\textsuperscript{41} Yet, the durable power of attorney for health care statutes vary widely in their treatment of an incompetent pregnant woman. Georgia’s statute allows a surrogate to make the same decisions that the principle could,\textsuperscript{42} Illinois’s statute states that a living will supersedes a durable power of attorney for health care,\textsuperscript{43}

\textsuperscript{35} PA. CONS. STAT. ANN. § 5414(a) (Supp. 1993) ("Notwithstanding the existence of a declaration or direction to the contrary, life-sustaining treatment, nutrition and hydration must be provided to a pregnant woman . . . unless, to a reasonable degree of medical certainty . . . life-sustaining treatment, nutrition and hydration: (1) will not maintain the pregnant woman in such a way as to permit the continuing development and live birth of the unborn child; (2) will be physically harmful to the pregnant woman; or, (3) would cause pain to the pregnant woman which cannot be alleviated by medication.").


\textsuperscript{38} See generally MISS. CODE ANN. § 41-41-151 et seq. (1992).


\textsuperscript{40} WIS. STAT. ANN. § 155.20(6) (Supp. 1993).


\textsuperscript{43} ILL. ANN. STAT. ch. 755, para. 40/15 (Smith-Hurd 1992).
Iowa’s statute does not have a pregnancy clause, Nevada’s statute does not allow a surrogate to consent to abortion, and Rhode Island’s statute does not allow a surrogate to consent to the withholding or withdrawal of life-sustaining treatment if the declarant is pregnant as long as it is probable that the fetus could be brought to the point of live birth.

Of the eleven jurisdictions with separate living will and durable power of attorney for health care statutes, one forbids a physician from implementing the living will of a pregnant woman if the fetus could be brought to the point of live birth and the mother would not be further harmed or made to suffer from being kept on life-support systems. Under this particular durable power of attorney for health care statute, however, a surrogate may not consent to abortion. Two jurisdictions do not have pregnancy clauses in either statute.

Thus, the majority of states in this country give a woman fewer constitutional and common-law rights if she is pregnant and incompetent than if she were either (a) competent and pregnant, (b) competent and chose to have an abortion before fetal viability, or (c) incompetent and without a prior directive. The diversity of statutes

50. It should be noted that the Attorney General of Alaska has issued an informal opinion questioning the constitutional validity of that state’s pregnancy clause in light of the Supreme Court’s Griswold-Roe jurisprudence in privacy right cases. See Op. (Inf.) Att’y Gen. Alaska 523 (1986). The Attorney General of Wisconsin has also issued an opinion questioning the constitutionality of the pregnancy clause in Wisconsin’s living will statute. See Letter from Bronson C. La Follette, Wisconsin Attorney General, to Walter Kunicki, Chairperson, Special Comm’r on Bio-Ethics Legislative Council (Jan. 14, 1985).

No state or federal court has yet addressed the issue of whether pregnancy clauses can withstand constitutional scrutiny. While the Supreme Court of Washington was directly confronted with this issue in DiNino v. State, 684 P.2d 1297 (Wash. 1984), it chose not to address it. In that case, Ms. DiNino had prepared a living will stating that it was to be given effect even if she was pregnant. Ms. DiNino requested that the court resolve the constitutionality of the pregnancy clause in the statute so that she and her doctor could know what their rights and liabilities were under the Washington Natural Death Act. Id. at 1300. However, the court refused to address the issue, ruling that a non-justiciable controversy was presented. Id. Ms. DiNino was neither pregnant at the time she brought suit nor was she suffering from a terminal condition. Thus, because the court thought that it would be issuing an advisory opinion, it declined to address the issue raised. Id.

This result is unfortunate. As the dissent argued, the majority opinion “underrates the public importance of this issue,” and this is a “matter of ‘continuing and substantial public interest’ that warrants an authoritative determination for future guidance.” Id. at 1301
makes it unclear exactly what the rights of an incompetent pregnant woman are and whether she would be better off not having a prior directive and relying upon the common law and the Constitution to protect her right to bodily integrity and autonomy. This Comment will show that pregnancy clauses, as presently written, create legal and policy deficiencies that require the creation of a more caring paradigm to resolve the issue of protecting the individual rights of the incompetent pregnant woman.

Following this Introduction, Part I of this Comment argues that pregnancy clauses in prior directive statutes violate the common law. However, since legislatures can change the common law, this paper looks to the federal Constitution to defend the rights at issue from arbitrary state action. Part II argues that pregnancy clauses in prior directive statutes also violate constitutional rights of autonomy and privacy under the Equal Protection and Due Process Clauses of the Fourteenth Amendment, as well as violate Ninth and Thirteenth Amendment prohibitions on state power over the individual. Part III argues that pregnancy clauses in prior directive statutes are also deficient from a policy standpoint and that there is a more realistic and humane way to legislate. Part III concludes by proposing a legislative remedy that avoids constitutional, common law, and policy deficiencies in dealing with an incompetent pregnant woman with, or without, a prior directive.

Finally, this Comment concludes that the best way to deal with the dilemma of whether life-sustaining treatment should be withdrawn or withheld from an incompetent pregnant woman with a viable fetus, or one who has a pre-viable fetus and has not made her wishes clear in a prior directive, is to defer to the family or friends of the individual and allow them to make the decision instead of allowing the state to simply ordain what should occur. This solution, a caring substituted judgment approach, will best effectuate the interests of the individual, the state, and family and friends, by recognizing that individual decisions are rarely made in a vacuum and that we often look to family and friends to resolve difficult moral and legal issues in our life and as death approaches.

(Dimmick, J., dissenting) (citations omitted). Since pregnancy only lasts nine months and a terminally ill individual may not survive the pregnancy, or potential legal proceedings, the court should have resolved this important issue, because it is "capable of repetition, yet evading review." Southern Pac. Terminal Co. v. Interstate Commerce Comm'n, 219 U.S. 498, 515 (1911).

51. While this Comment mainly addresses the situation where a prior directive has been executed by an incompetent pregnant woman, the legislative proposal discussed infra also addresses the situation where a prior directive does not exist.
1995] COLLOQUIUM: GENDER, LAW AND HEALTH CARE 539

I. THE COMMON LAW AND PREGNANCY CLAUSES

The common law has long recognized and upheld the right of a competent or incompetent individual to forego medical treatment.\(^{52}\) This right to forego medical treatment under the common-law is based on the doctrine of informed consent,\(^{53}\) which "also encompasses a right to informed refusal."\(^{54}\) Many state courts that have addressed the issue of whether an individual has a right to forego medical treatment have avoided the constitutional issues involved and have decided these cases solely on common-law grounds.\(^{55}\) This has been the case whether the individual in question was competent to make such decisions or incompetent.\(^{56}\)

\(^{52}\) See, e.g., Schloendorf v. Society of New York Hosp., 105 N.E. 92, 99 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body") (Cardozo, J.), overruled on other grounds, Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957); Pratt v. Davis, 118 Ill. App. 161, 166 (1905), aff'd, 79 N.E. 562 (Ill. 1906) ("Under a free government, at least, the free citizen's first and greatest right, which underlies all others— the right of inviolability of his person; in other words the right to himself—is the subject of universal acquiescence"); Slater v. Baker & Stapleton, 95 Eng. Rep. 860 (K.B. 1767) (holding surgeon liable for damages for not obtaining the consent of his patient before operating); see also supra notes 3, 6 & 14.

\(^{53}\) The doctrine of informed consent "follows logically from the universally recognized rule that a physician, treating a mentally competent adult under non-emergency circumstances, cannot properly undertake to perform surgery or administer other therapy without the prior consent of his patient." Sard v. Hardy, 281 Md. 432, 438-39, 379 A.2d 1014, 1019 (1977). "The fountainhead of the doctrine . . . is the patient's right to exercise control over his own body, . . . , by deciding for himself whether or not to submit to the particular therapy." Id. at 439, 379 A.2d at 1019.


\(^{54}\) In re Conroy, 486 A.2d 1209, 1222 (N.J. 1985). See also Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 277 (1990) ("[T]he common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment."); In re Rosebush, 491 N.W.2d 633, 635 (Mich. 1992) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, the right to refuse medical treatment and procedures").

\(^{55}\) See, e.g., Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983); In re Estate of Longeway, 549 N.E.2d 292 (Ill. 1989); DeGrella v. Elston, 858 S.W.2d 698 (Ky. 1993); Mack v. Mack, 329 Md. 188, 618 A.2d 744 (1993); In re Gardner, 534 A.2d 947 (Me. 1987); In re Rosebush, 491 N.W.2d at 635; In re Peter, 529 A.2d 419 (N.J. 1987); In re Storar, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981). It is interesting to note that soon after the issuance of the Mack decision by the Maryland Court of Appeals, the Maryland General Assembly stated in the Preamble to the Maryland Health Care Decisions Act of 1993 that the "constitutional law of this nation recognizes an individual's right to personal health care decisionmaking, complementing the common-law doctrine of informed consent." 1993 Md. Laws 372.

\(^{56}\) See, e.g., supra notes 6 & 14.
While most prior directive statutes do not alter the common law, state legislatures have the power to alter or change the common law, in conformity with constitutional restrictions on legislative power, and restrict those rights that now exist if they so desire. Thus, to defend the right to forego medical treatment, this Comment looks to the federal Constitution.

II. THE CONSTITUTION AND PREGNANCY CLAUSES

A. Fourteenth Amendment Analysis

1. Right to Bodily Integrity and Privacy.—Most analyses of the constitutional right to forego medical treatment rely on the right of autonomy, better known as the right to privacy. The Supreme Court first recognized this right in Griswold v. Connecticut.

In Griswold the Court stated that there are various zones of privacy that are protected by the “penumbras” of the Bill of Rights, and that without such zones of privacy those rights explicitly expressed could not be truly enjoyed. The Court ruled that the state could not forbid married couples from using contraceptives because the marital relationship is a fundamental right protected by the Constitution under the Due Process Clause of the Fourteenth Amendment.

57. See, e.g., Ky. REV. STAT. ANN. § 311.984(5) (Baldwin 1991) (The Kentucky Living Will and Health Care Directive Acts “shall not impair or supersede any common law or statutory right that an adult has to effect the withholding or withdrawing medical care”); 1993 Md. Laws 372 (common-law rights not superseded by statute); Thomas W. Mayo, Constitutionalizing the “Right to Die”, 49 MD. L. REV. 103, 136-37 (1990) ("Natural Death Acts and 'living will' statutes generally are regarded as having added rights to those that existed at common law, not being in derogation of those pre-existing rights."); see also Jordan, supra note 16, at 1152 ("The right to die was independently developed by the common law courts, and the statutes generally contain a disclaimer that they are not intended to impair or supersede any previously existing rights.").

58. See, e.g., Counselman v. Hitchcock, 142 U.S. 547, 570 (1892) (“It is, of course, competent for the legislature to change any doctrine of the common law”); United States v. Thomas, 82 U.S. (15 Wall.) 337, 344 (1872) (“But the legislature can undoubtedly, at its pleasure, change the common-law.”).

59. This Comment recognizes that several state appellate courts have found a state-based constitutional right to forego medical treatment. See supra note 12 and accompanying text. However, this Comment looks to federal constitutional law to defend the right to forego medical treatment, recognizing that states are free to find greater rights than exist under the federal Constitution, but that the federal Constitution protects the minimum of rights that all Americans will be entitled to exercise, regardless of what their particular state constitution protects.

60. See, e.g., supra notes 12-13, 53, 57; infra notes 81, 97, 127.

61. 381 U.S. 479 (1965).

62. 381 U.S. at 484.

63. Id. at 486.

64. The Fourteenth Amendment states in relevant part that: “nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any
Court held that the Connecticut law at issue deprived married persons of the liberty protected by their fundamental right to be married and to make decisions about whether or not to use birth control.\(^{65}\)

Thus, the court will protect certain fundamental rights despite the lack of specific language in the Constitution or Bill of Rights that defines those rights.\(^{66}\) States cannot infringe upon these fundamental rights that are protected by the penumbras of the Bill of Rights\(^{67}\) without a compelling reason to do so.\(^{68}\) Though there is no explicit basis in the Constitution for the decision in *Griswold*, the opinion of the Court was correct "in finding that the values of privacy, including freedom from government intrusion with private thoughts, association, and liberty, had long been a part of American legal philosophy."\(^{69}\)

The genesis of the right to privacy in American jurisprudence began with an article written by Louis Brandeis and Samuel Warren in 1890.\(^{70}\) In that article, Brandeis and Warren posited that a general right existed to be free from the intrusions of society in private affairs, and, in particular, to be free from the intrusion of newspapers into the life of the individual.\(^{71}\) From that article, the right to privacy has developed along four main branches of constitutional analysis. These four branches are: (1) the common law tort freedom from intrusion by others into the personal property of an individual and from disclosures of information about the individual's private affairs;\(^{72}\) (2) Fourth Amendment privacy that protects the individual from unreasonable governmental searches and seizures;\(^{73}\) (3) First Amendment privacy in speech and association;\(^{74}\) and (4) privacy under the Due Process and Equal Protection Clauses of the Fourteenth Amendment, which allows the individual to engage in certain highly personal activi-


\(^{66}\) *Griswold*, 381 U.S. at 486 (Goldberg, J., concurring).

\(^{67}\) 381 U.S. at 484; *see also* Poe v. Ullman, 367 U.S. 497 (1961) (Harlan, J., dissenting).

\(^{68}\) 381 U.S. at 497 (Goldberg, J., concurring).


\(^{70}\) Samuel Warren & Louis Brandeis, *The Right to Privacy*, 4 Harv. L. Rev. 193 (1890); *see also* Ken Gormley, *One-Hundred Years of Privacy*, 1992 Wis. L. Rev. 1335.

\(^{71}\) Gormley, *supra* note 70, at 1348-51.

\(^{72}\) Warren & Brandeis, *supra* note 70; Gormley, *supra* note 70, at 1345 ("The 'right to be let alone,' which Warren and Brandeis went on to introduce to American jurisprudence, was a basic tort notion.").


ties without undue governmental intrusion, i.e. fundamental decision-making privacy.\textsuperscript{75}

The right of an incompetent pregnant woman to have her prior directive effectuated is based on the fundamental decision-making right to privacy found in the Constitution. This privacy right is controversial, however, because it has no explicit basis in the Constitution.\textsuperscript{76} Griswold was the first case to recognize a fundamental decision-making privacy right.\textsuperscript{77} The privacy right enunciated in Griswold was soon after reaffirmed in Eisenstadt v. Baird.\textsuperscript{78} In Eisenstadt, the Court held that unmarried couples, just as married couples, could not be barred from the use of contraceptives because to do so violated the equal protection clause of the Fourteenth Amendment.\textsuperscript{79}

A year later, "[i]n the single most noteworthy and (simultaneously) notorious decision of the twentieth century, the Court extended its privacy logic in . . . Roe v. Wade\textsuperscript{80} and created a species of privacy unattached to specific guarantees of the Bill of Rights, now burrowed in the single word 'liberty' appearing in the Fourteenth Amendment."\textsuperscript{81} Roe held that a state could not completely forbid a woman from choosing to obtain an abortion because such state action violated the due process clause of the Fourteenth Amendment as well as the right to privacy.\textsuperscript{82} As stated by Justice Blackmun, author of the majority opinion, the right to privacy is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."\textsuperscript{83}

\textsuperscript{75} Griswold v. Connecticut, 381 U.S. 479 (1965); see also Roe v. Wade, 410 U.S. 113 (1973); Gormley, supra note 70, at 1406 ("Certainly, Griswold, Roe and subsequent cases involving fundamental decision making privacy do share a common theme relating to a repulsion from governmental intrusion. That is, privacy protects the individual from an ever 'normalizing' state . . . by preventing the government from imposing certain fundamental decisions upon the individual.").

\textsuperscript{76} Gormley, supra note 70, at 1391-92. Although a majority of the justices in Griswold agreed that there is a fundamental right of privacy under the Constitution, the Court was divided on the specific source. Id.

\textsuperscript{77} See supra note 65 and accompanying text.

\textsuperscript{78} 405 U.S. 438, 455 (1972).

\textsuperscript{79} Id. at 446-55.

\textsuperscript{80} 410 U.S. 113 (1973).

\textsuperscript{81} Gormley, supra note 70, at 1392; see also Roe, 410 U.S. at 153 (The right to privacy is "founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action."); Anita L. Allen, Feminist Moral, Social, and Legal Theory: Taking Liberties: Privacy, Private Choice, and Social Contract Theory, 56 U. Cin. L. Rev. 461, 465 (1987) ("[P]rivacy refers to an aspect of liberty. It refers to freedom from governmental or other outside interference with decisionmaking and conduct, especially respecting appropriate private affairs.").

\textsuperscript{82} 410 U.S. at 164.

\textsuperscript{83} Id. at 153.
The Roe Court recognized that there was no explicit basis in the Constitution for the right of fundamental decision-making privacy, but the Court reiterated that it has consistently recognized a right of personal privacy and that personal rights that can be seen as 'fundamental' or 'implicit in the concept of ordered liberty' are included within the zone of privacy protected by the Constitution. The Court stated, however, that these fundamental privacy rights are not absolute. They will be balanced against relevant state interests which can override the individual interest if the state's interests are compelling and the statute in question is narrowly drawn to express the legitimate state interests. Roe has led to a long line of cases that have further refined the parameters of the right of privacy and bodily integrity while looking at the issue of abortion rights. These cases include Planned Parenthood v. Danforth, Carey v. Population Services International, Akron v. Akron Center for Reproductive Health, Inc., Thornburgh v. American College of Obstetricians & Gynecologists, Webster v. Reproductive Health Services, and Planned Parenthood v. Casey.

Although these cases dealt mainly with abortion rights, the principle that the right to privacy includes a right to bodily autonomy and integrity was well established. As stated by the plurality in Casey I, "Roe . . . may be seen not only as an exemplar of Griswold liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection." While it has been argued that the right to autonomy and privacy does

85. Roe, 410 U.S. at 152.
86. Id. at 154; see also Maher v. Roe, 432 U.S. 464, 473 (1977) ("Roe did not declare an unqualified 'constitutional right to an abortion.'").
87. Roe, 410 U.S. at 154.
88. Id. at 155.
89. 428 U.S. 52 (1976).
95. See Doe v. Bolton, 410 U.S. 179, 213 (1973) (Douglas, J., concurring) (A fundamental aspect of privacy is the "freedom to care for one's health and person, [free] from bodily restraint or compulsion"); see also Allen, supra note 81, at 474 ("Post-Roe cases have illuminated the Court's understanding that the right of privacy is really an aspect of constitutionally protected liberty.").
96. 112 S. Ct. at 2810.
not sustain the right to forego medical treatment, this view is in error. "It is settled now, as it was when the Court heard arguments in Roe v. Wade, that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood . . . as well as bodily integrity."98

Thus, the basic principles that can be gleaned from the Court's decisions in this area are that certain realms of personal decision-making fall under a right of privacy and bodily integrity which restricts the state from infringing upon those decisions unless there is a compelling state interest to do so and the statute is narrowly drawn to effectuate those compelling state interests.99 These protected areas include decisions regarding contraception,100 marriage,101 procreation,102 child rearing and education,103 family relationships,104 and bodily integrity.105

Under the Griswold-Roe line of cases, an incompetent pregnant woman's decision to forego life sustaining treatment may also be protected by the right of privacy and liberty.106 A woman's decision to execute a prior directive, and to have it effectuated, implicates her fundamental right to make decisions regarding procreation, family relationships, and bodily integrity. Because these matters involve "the most intimate and personal choices a person may make in a lifetime,

98. Casey I, 112 S. Ct. at 2806.
99. See supra note 68 and accompanying text.
105. See, e.g., Casey I, 112 S. Ct. 2791; Cruzan, 497 U.S. 261. In Cruzan, the Court did not address whether a person could refuse medical treatment based on a right to privacy because the Court assumed that the Constitution included a "liberty" interest sufficient to do so. Id. at 278-79 n.7. Further, "the concept of privacy embodies the moral fact that a person belongs to himself and not others nor society as a whole." Thornburgh, 476 U.S. at 777-78 (Stevens, J., concurring).
106. See generally Janice MacAvoy-Snitzer, Pregnancy Clauses in Living Will Statutes, 87 Colum. L. Rev. 1280, 1287 (1987) ("Although Roe and its progeny have examined the right of privacy in terminating pregnancy in the context of anti-abortion legislation, it does not follow that Roe protects a woman's right of privacy only when she seeks to have an abortion. Roe addressed a broad right of privacy.").
choices central to personal dignity and autonomy," they are central to the "liberty" interest protected by the Fourteenth Amendment.

Further, an incompetent pregnant woman has the "right to define [her] own concept of existence, of meaning, of the universe, and of the mystery of human life," and those concepts should not be "formed under compulsion of the State." As this right extends to competent individuals, so it must extend to incompetent individuals in order to maintain and respect their constitutional rights.

Although the interests of an incompetent pregnant woman are not absolute and must be balanced against the interests of the state, those state interests do not become compelling until the fetus is viable. Therefore, pregnancy clauses in statutes that do not allow the prior directive of an incompetent pregnant woman to be effectuated even before viability must be struck down as an unconstitutional violation of the right to privacy and bodily integrity, which is "broad enough to encompass a patient's decision to decline medical treatment," and which is an "ultimate exercise" of that constitutional right.

a. Pregnancy Clauses Before Fetal Viability.—Before the point of fetal viability, the state's interest in the fetal life or the health of the fetus

107. Casey I, 112 S. Ct. at 2807.
108. Id. at 2807. The reasoning of Casey I has most recently been relied upon to support the right of a mentally competent, terminally ill patient to commit physician-assisted suicide. Compassion In Dying v. Washington, 850 F. Supp. 1454, 5831 (W.D. Wa. 1994). In that case, the district court judge concluded "that the suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental interference, than that of a pregnant woman." Id. at 1460. It is a short logical step to conclude that an incompetent pregnant woman should have the right to have her prior directive, which was created when she was competent, carried out. As the court went on to note, "[t]he liberty interest protected by the Fourteenth Amendment is the freedom to make choices according to one's individual conscience about those matters which are essential to personal autonomy and basic human dignity." Id. at 1459.
109. See Saikewicz, 370 N.E.2d at 428 ("To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford that person the same panoply of rights and choices it recognizes in competent persons."); see also In re Eichner, 426 N.Y.S.2d 517, 542-43 (N.Y. App. Div. 1980), modified, In re Storar, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981).
110. See supra notes 7, 86-88 and accompanying text.
111. "Viability means that the fetus's condition is such that it can survive after birth with help from neonatal intensive care resources." Mary Mahowald, Beyond Abortion: Refusal of Cesarean Section, 3 Bioethics 106, 110 (1989). The point of fetal viability is generally thought to be 28 weeks of gestation. Roe, 410 U.S. at 160. While it is recognized that viability may occur as early as 24 weeks of gestation, id. at 160 n.60, it is assumed for argument that 28 weeks is the point of viability.
incompetent pregnant woman can never be compelling enough to override her privacy and bodily integrity interests.\textsuperscript{114} Although the \textit{Casey I} plurality has rejected the trimester framework established in \textit{Roe}, the basic holding of \textit{Roe} still stands.\textsuperscript{115} As stated by the plurality in \textit{Casey I}, "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability."\textsuperscript{116} By analogy, a state may not stop an incompetent pregnant woman from rejecting life-sustaining procedures before her fetus is viable.

There can be no doubt that, just as a prior directive statute with a pregnancy clause denying enforcement of a directive in the case of an incompetent woman with a pre-viable fetus is an "undue burden"\textsuperscript{117} on her right to abortion, it is an "undue burden" on her right to forego medical treatment.\textsuperscript{118}

\textbf{b. Pregnancy Clauses After Fetal Viability.}—Although a state cannot interfere with an incompetent pregnant woman's decision to forego life-sustaining treatment before her fetus is viable, the state's interest in fetal life does become compelling at the point of fetal viability.\textsuperscript{119} At that point, the state may forbid an abortion from occurring\textsuperscript{120} unless the health of the mother is in danger.\textsuperscript{121} However, in

\begin{itemize}
\item \textsuperscript{114} See \textit{Roe}, 410 U.S. at 162-64.
\item \textsuperscript{115} 112 S. Ct. at 2818, 2821.
\item \textsuperscript{116} Id. at 2821.
\item \textsuperscript{117} See \textit{id.} at 2820 ("A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a womanseeking an abortion of a nonviable fetus. A statute with this purpose is invalid . . . . [A]n undue burden is an unconstitutional burden."). For the developing interpretation of what an 'undue burden' encompasses, see, e.g., Planned Parenthood v. Casey, 114 S. Ct. 909, 910-11 (1994) (\textit{Casey II} (Souter, J.) (noting that the Third Circuit's construction of the Supreme Court's decision in \textit{Casey I}, 112 S. Ct. 2791 (1992), as only requiring a plaintiff to show that an abortion regulation would be an 'undue burden' "in a large fraction of the cases" as correct); Fargo Women's Health Org. v. Schafer, 113 S. Ct. 1668, 1669 (1993) (O'Connor, J.) (noting that laws restricting abortion are an 'undue burden' if, "in a large fraction of the cases in which [the law] is relevant, [they] will operate as a substantial obstacle to a woman's choice to undergo an abortion.").
\item \textsuperscript{119} \textit{Roe}, 410 U.S. at 163. \textit{See also \textit{Casey I}, 112 S. Ct. at 2821.
\item \textsuperscript{120} \textit{Roe}, 410 U.S. at 163-64; \textit{see also \textit{Colautti v. Franklin}, 439 U.S. 379, 386 (1979).
\item \textsuperscript{121} \textit{Casey I}, 112 S. Ct. at 2821; \textit{Roe}, 410 U.S. at 164-65.
\end{itemize}
the case of an incompetent pregnant woman whose prior directive is at issue, this last point is moot because there is no health of the mother to protect. Thus, at the point of fetal viability, just as a state could forbid an abortion from occurring, it seems likely that a state would be allowed to forbid a prior directive from being carried out that would end the incompetent pregnant woman's life, and thus the life of the fetus.

The argument can be made that the potential fetal life should not be allowed to override the interests of the mother in bodily integrity and personal autonomy, and such an argument apparently has support in the language of certain state court appellate decisions. Specifically, the New Jersey Supreme Court stated in In re Quinlan that "the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."123

There is little doubt that keeping an incompetent woman alive against her will is an invasive procedure when her prognosis is dim. In such a case, it is likely that a court would uphold her right to forego medical treatment. Where a viable fetal life is involved, however, the individual rights of the mother will likely be seen as not overcoming the state interest in the fetal life. Quinlan did not address a situation in which an incompetent woman was pregnant, so it is unlikely that the case could be used to significantly bolster an argument that fetal rights should not be able to overcome the right of the mother to have her prior directive effectuated in light of Casey I and its predecessors.126

In re A.C., however, did address a situation in which the incompetent woman was pregnant. The court stated that

in virtually all cases the decision of the patient, albeit discerned through the mechanism of substituted judgment, will control. We do not quite foreclose the possibility that a conflicting state interest may be so compelling that the patient's wishes must yield, but we anticipate that such cases will be extremely rare and truly exceptional.128

123. Id. at 663 (emphasis in original).
124. See Casey I, 112 S. Ct. at 2821; Roe, 410 U.S. at 163.
126. See, e.g., supra notes 80, 89-93.
128. Id. at 1252 (citations omitted).
The court held that the ordering of a cesarean section against the wishes of the mother was improper, even though such a procedure seemed necessary to save the life of the fetus.\(^{129}\) The court failed to explain "in what circumstances . . . the state's interests can ever prevail over the interests of a pregnant patient."\(^{130}\) This is a strong statement in support of the woman's interest in protecting her right to bodily integrity either directly or through the doctrine of substituted judgment.\(^{131}\) However, as pointed out by the partially dissenting opinion, the statements of the majority are dictum and seem to go further than what is seen under present federal case law.\(^{132}\) "The state's interest in preserving human life and the viable unborn child's interest in survival are entitled, I think, to more weight than I find them assigned by the majority when it states that 'in virtually all cases the decision of the patient . . . will control.'\(^{133}\) Federal case law has made it clear that "the state's interest in potential human life becomes compelling at the point of viability"\(^{134}\) and that even before viability there is "an important and legitimate state interest in protecting the potentiality of human life."\(^{135}\)

Some courts have recognized that a viable fetus born live may have a cause of action for prenatal injury.\(^{136}\) From this principle, many state courts have applied a balancing test in cases of "maternal-fetal conflict"\(^{137}\) involving a viable fetus. This test weighs the interests of the fetus and the state against the mother's interest in bodily integrity and autonomy.\(^{138}\) In such circumstances, though rare, most courts have found that the state's interest in protecting the unborn

\(^{129}\) Id.

\(^{130}\) Id.

\(^{131}\) See infra note 217 and accompanying text.

\(^{132}\) In re A.C., 573 A.2d at 1254 (Belson, J., concurring in part and dissenting in part).

\(^{133}\) Id.

\(^{134}\) Id.; see also supra notes 119-121 and accompanying text.

\(^{135}\) Roe, 410 U.S. at 162. See also Casey I, 112 S. Ct. at 2849 ("[A]s the fetus evolves into its postnatal form, and as it loses its dependence on the uterine environment, the State's interest in the fetus' potential human life, and in fostering a regard for human life in general, becomes compelling.") (Blackmun, J., concurring in part and dissenting in part).

\(^{136}\) See, e.g., Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946) (holding that a viable fetus, later born, may have a cause of action for injuries sustained while in the womb); see also Patricia King, The Juridical Status of the Fetus: A Proposal for Legal Protection of the Unborn, 77 Mich. L. Rev. 1647, 1657-59 (1979) ("[T]he live birth criterion [is] important not as a sign of physical separation, which could occur at any time during the gestational period, but as verification of a capacity for continued life.").

\(^{137}\) This term is not altogether accurate, as often the conflict is between the wishes of the woman and the wishes of the health care provider and/or state as to what course of medical treatment should be followed.

\(^{138}\) See, e.g., Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981). In Jefferson, the court weighed the interest of the mother in protecting her individ-
child is compelling and should prevail over the interests of the mother.\textsuperscript{139}

Thus, while the argument exists that the fetal (and state) interest in life should not override the maternal interest in individual liberty and bodily integrity, it appears that after viability the state's interest in the fetal life will generally be seen as compelling and that the state interest will be recognized by most federal and state courts and enforced over the wishes of the mother in protecting her individual rights.\textsuperscript{140} This legal principle does not mean, however, that the right

\textsuperscript{139} See Dawn E. Johnsen, \textit{Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty}, 43 HASTINGS L.J. 569, 571 (1992) ("[C]ourts in eleven states have ordered pregnant women to submit to cesarean sections against their will. In at least one such case, the compelled surgery required physically tying the woman to the operating table.") (citations omitted); William J. Curren, \textit{Court-Ordered Cesarean Sections Receive Judicial Defeat}, 323 NEW ENG. J. MED. 489 (1990) ("In a quiet, often unnoticed, but consistent manner, a number of trial-court judges in at least 11 states across the country have ordered that a pregnant woman must submit to a cesarean section to deliver a viable fetus against the known and clearly expressed will of the woman."); Veronica E.B. Kolder et al., \textit{Court-Ordered Obstetrical Interventions}, 316 NEW ENG. J. MED. 1192, 1193 (1987) (Judges granted petitions to order cesarean sections in 13 out of 15 cases).

\textsuperscript{140} See, e.g., \textit{In re} Jamaica Hosp., 491 N.Y.S.2d 898 (N.Y. Sup. Ct. 1985) (ordering a blood transfusion over the religious objections of the mother to protect the life of a mid-term fetus); Crouse Irving Mem. Hosp. v. Paddock, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985); Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457 (Ga. 1981) (court-ordered cesarean section over wishes of mother); \textit{In re} Yetter, 62 Pa. D. & C.2d 619, 623 (1973) ("right of privacy includes a right to die with which the State should not interfere where there are no minor or unborn children."). Nevertheless, it must be noted that \textit{In re} A.C., supra notes 127-135 and accompanying text, and the recent case of \textit{Mother Doe}, supra, may signal a new trend by the courts to recognize and uphold the rights of the individual pregnant woman to personal autonomy and bodily integrity over the interest of the State in potential fetal life.

Mother Doe, later identified as Tabita Bricci, a 22-year-old Chicago woman, was 37 weeks pregnant and suffered from a medical condition in which the placenta was "not delivering sufficient oxygen to the viable unborn fetus." Emergency Petition for a Writ of Certiorari to the Appellate Court of Illinois, First District, \textit{Baby Boy Doe v. Mother Doe} (No. A-502) (hereinafter "Emergency Petition"), at 3-4, \textit{cert. denied}, 114 S. Ct. 652 (1993). On December 9, 1993, the State filed a Petition for Adjudication of Wardship in the Cook County Juvenile Court, alleging that the unborn fetus was neglected because Ms. Bricci refused to submit to a cesarean section. \textit{Id}. The juvenile court declined to rule, holding that it lacked jurisdiction under the Illinois Juvenile Court Act. \textit{Id}.

On December 10, 1993, an emergency hearing was held before the Illinois Appellate Court, Third Division. \textit{Id} at 5. The court ruled that the juvenile court lacked jurisdiction to rule on the original Petition, but that the case could go forward in the circuit court under its equity powers. \textit{Id}. On that same date, the State filed a new petition in the circuit court requesting that "the court . . . approve a temporary custodian solely to consent to the performance of a cesarean section." \textit{Id}. At the hearing before the circuit court, a doctor "testified that if a cesarean section [was] not performed, the unborn fetus [had] a close to zero percent chance of surviving the natural birth process through the vaginal canal." \textit{Id}. The doctor testified that he believed that brain damage had already occurred. \textit{Id} at 6.
to privacy of the individual and her right to bodily integrity may be trampled in order to serve the state's interest. Simply allowing the state at the point of fetal viability to dictate what shall be done with an incompetent pregnant woman's body is violative of basic societal, moral, and philosophical beliefs and would equate an incompetent pregnant woman with an incubator or reproductive vessel.\(^\text{141}\)

Judge Brownfield, in his ruling on December 11, 1993, found that Ms. Bricci refused to submit to a cesarean section based on her religious beliefs and that failure to have the cesarean section posed serious risks to the unborn child. \textit{Id.} at 6. Nevertheless, he refused to grant the State's request for a temporary custodian to consent to the cesarian section. \textit{Id.} On December 14, 1993, the Illinois Appellate Court, Second Division, unanimously affirmed the lower court ruling without written opinion. \textit{Id.} On December 16, 1993, the Illinois Supreme Court denied the Public Guardian's Emergency Petition for Leave to Appeal. \textit{Id.} at 7. On December 18, 1993, the United States Supreme Court denied the Public Guardian's Emergency Petition for a Writ of Certiorari. Baby Boy Doe v. Mother Doe, 114 S. Ct. 652 (1993).

The Public Guardian argued in its Emergency Petition to the Supreme Court that the State had a compelling interest in protecting the life of a viable unborn fetus and that the case should be remanded back to the lower courts to weigh that State interest against the interest of the mother to practice her religion freely and to make decisions concerning her medical care. Emergency Petition at 13. As already stated, the Court declined to hear the case.

However, on April 5, 1994, the Illinois Appellate Court issued a written opinion in this case "[c]ognizant of the seriousness of the question presented, and believing that the [ ] courts of Illinois require some guidance in this area . . . ." Baby Boy Doe v. Mother Doe, 632 N.E.2d 326 (Ill. App. Ct. 1994). The court held that "a woman's competent choice in refusing a medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus." \textit{Id.} at 330.

Relying on federal and state court precedent, the court found that the right of a competent pregnant woman to forego such medical treatment arose from "her rights to privacy, bodily integrity, and religious liberty . . . ." \textit{Id.} at 332. The court went on to state that "[t]he potential impact upon the fetus is not legally relevant; to the contrary, [the Illinois Supreme Court] explicitly rejected the view that the woman's rights can be subordinated to fetal rights." \textit{Id.} (citing 531 N.E.2d at 355). Thus, when such an invasive procedure as a cesarean section is at issue, the state cannot trump the rights of the pregnant woman and cannot compel her "to do or not do anything merely for the benefit of the unborn child." \textit{Id.}

Baby Boy Doe was delivered by a successful natural birth in December 1993. Tracy Shryer, Woman at Center of Dispute Gives Birth, L.A. TIMES, Dec. 31, 1993, at A24. Physicians said it would be six months before they would be able to determine if he suffered any brain damage while in utero. \textit{Id.}

\(^{141}\) See Dawn E. Johnsen, \textit{The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection}, 95 YALE L.J. 599, 613 (1986) ("By substituting its judgment for that of the woman, the state deprives women of their right to control their lives during pregnancy—a right to liberty and privacy protected by the Constitution. Furthermore, by regulating women as if their lives were defined solely by their reproductive capacity, the state perpetuates a system of sex discrimination that is based on the biological difference between the sexes, thus depriving women of their constitutional right to equal protection of the laws.").
2. Equal Protection Analysis.—Under the equal protection clause of the Fourteenth Amendment, similarly situated people must be treated similarly and any sex-based classification "must serve important governmental objectives and be substantially related to those objectives to pass scrutiny by constitutional measures."142 Pregnancy clauses in prior directive statutes do not meet this standard before the incompetent woman's fetus is viable. Before viability—before the state’s interest in fetal life becomes compelling143—pregnancy clauses create classifications which on their face are not necessary to the achievement of an important state interest144 and they do not treat similarly situated people similarly.145

Pregnancy clauses in prior directive statutes violate the equal protection clause because they classify women on the basis of whether they are pregnant and competent, or incompetent. Conversely, they classify women based upon whether they are incompetent and pregnant, or not pregnant. If a woman is competent and pregnant, she may choose to have life support withdrawn or to have an abortion with little restriction on her rights, as set forth by the Court in its abortion rights cases.146 However, if the woman is incompetent and pregnant, her rights are stripped away by pregnancy clauses because they do not allow her to end her life-sustaining treatment. The Equal Protection Clause is violated because there is no legitimate state interest in denying an incompetent pregnant woman the same rights that it allows competent pregnant women to exercise, i.e., the right to natural death. When a prior directive document is executed, the woman is competent; thus, competent women are also treated differently based upon whether they are pregnant. Such "outright refusal to administer the right of natural death to a pregnant woman because she is incompetent amounts to impounding her body and using it as an incubator."147

A variation of the first classification arises from pregnancy clauses in prior directive statutes that distinguish between whether an incompetent woman is pregnant or not. If a woman is not pregnant and incompetent, her prior directive will be effectuated in most states; but, once it is determined that an incompetent woman is pregnant, her

143. See supra notes 116, 119 and accompanying text.
145. Sharrin, supra note 142.
146. See supra notes 80, 89-94.
right to have a prior directive effectuated disappears in most states.\textsuperscript{148} Again, there is no compelling state reason for such a statutory provision before the point of fetal viability. While the Supreme Court has held that a state may classify on the basis of whether or not an individual is pregnant, a state may not do so unless the classification is rationally related to a legitimate state interest.\textsuperscript{149} Such is not the case here because before fetal viability the state can have neither a legitimate nor a compelling interest in fetal life that overrides the individual’s right to bodily integrity.\textsuperscript{150} Before the point of fetal viability occurs, pregnancy clauses in prior directive statutes violate the Equal Protection Clause of the Fourteenth Amendment because they “den[y] women the equal right of choice to act as equal participants in all of life’s activities,”\textsuperscript{151} either between men and women or among women themselves.

\textbf{B. Ninth Amendment Analysis}

The Ninth Amendment\textsuperscript{152} was largely ignored by the Court in its protection of individual rights for the first two-hundred years of its existence.\textsuperscript{153} This changed, however, with the concurring opinion of Justice Goldberg in \textit{Griswold v. Connecticut}.\textsuperscript{154} In his concurrence, Justice Goldberg argued that the right to privacy in marriage was a fundamental right protected from state infringement under the Ninth Amendment.\textsuperscript{155} Without a compelling state interest as well as a nar-

\textsuperscript{148}. See \textit{supra} notes 26-28, 30-31, 33-35, 37, 39, 41, 46-47 and accompanying text.
\textsuperscript{149}. Geduldig v. Aiello, 417 U.S. 484 (1974). \textit{Geduldig} involved a California statute that did not pay benefits to women for normal pregnancy-related conditions as a disability covered by the statute, although it did cover certain male-specific conditions such as prostatectomies, circumcision, hemophilia and gout. \textit{Id.} at 501 (Brennan, J., dissenting). In \textit{Geduldig}, the Court stated “that pregnancy-related restrictions are not first-order sex-based equal protection problems because they are based on a real physical difference between men and women.” Ruth Colker, \textit{An Equal Protection Analysis of United States Reproductive Health Policy: Gender, Race, Age, and Class}, 1991 DUKE L.J. 324, 358. Such pregnancy clauses, however, do more than discriminate upon a sex-based, real physical difference; they also discriminate between women based upon whether or not they are competent.
\textsuperscript{150}. See \textit{supra} notes 114-116 and accompanying text.
\textsuperscript{151}. Sharrin, \textit{supra} note 142, at 1402.
\textsuperscript{152}. The Ninth Amendment states: “The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.” U.S. CONST. amend. IX.
\textsuperscript{154}. 381 U.S. 479 (1965).
\textsuperscript{155}. \textit{Id.} at 496.
rowly drawn statute to effectuate that interest, such fundamental rights may not be infringed.  

A Ninth Amendment analysis of pregnancy clauses in prior directive statutes would conclude that they violate an incompetent pregnant woman's right to forego medical treatment because they forbid her from exercising a liberty that is "so rooted in the traditions and conscience of our people as to be ranked as fundamental." Before 1950, people generally died in the home and the state played little, if any, role in decisions to forego medical treatment. Thus, the tradition of our nation is that people died at home where they made their own decisions whether to undergo medical treatment. With the recent advent of medical technology and the ubiquitous rise of hospitals the focus of decision-making has changed. There is, however, no reason to ignore the individual's traditional right to decide whether to forego medical treatment.

Although the right to forego medical treatment is not explicitly stated in the Constitution, "[t]he language and history of the Ninth Amendment reveal that the framers of the Constitution believed that there are additional fundamental rights, protected from governmental infringement, which exist alongside those fundamental rights specifically mentioned in the first eight constitutional amendments." The founding fathers believed that fundamental rights that exist outside those specifically mentioned in the Bill of Rights should not be deemed unprotected simply because they are not enumerated.

Just as marriage is a fundamental right protected by the Ninth Amendment, so too is the fundamental right to privacy and bodily integrity and the right to forego medical treatment. These rights

156. Id. at 497.
157. Id. at 487 (citing Snyder v. Massachusetts, 291 U.S. 97, 105 (1925)).
159. Id.
160. PRESIDENT'S COMMISSION, supra note 8, at 17-18; see also Linda C. Fentiman, Privacy & Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent, Incurably Ill Adult, 57 GEO. WASH. L. REV. 801, 802-04 (1989) (noting that more than 80% of Americans over the age of 65 die in an institutional setting).
161. Griswold, 381 U.S. at 488 (Goldberg, J., concurring).
162. Wachtler, supra note 153, at 599 ("[T]he founders believed that the people were the source of all legitimate political authority and possessed fundamental personal liberties that had their origin in the laws of nature."); see also Gormley, supra note 70, at 1411 (entering into the social contract did not "obliterate the liberty and personal autonomy of the individual").
163. Griswold, 381 U.S. at 485.
164. See supra notes 12-14 and accompanying text.
cannot be infringed upon without a compelling state interest to do so.165

Dying at home without interference from the state is 'deeply rooted' in our society.166 Our founding fathers “recognized the significance of man’s spiritual nature, of his feelings and of his intellect,” and protected individuals by enacting the Ninth Amendment, which confers upon them, “as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.”167

As marital relations fall within the “private realm of family life,”168 so does the personal decision to forego medical treatment. As this right is fundamental, as it is protected by the Ninth Amendment,169 it cannot be abridged except for a compelling state interest, which cannot arise before the point of fetal viability.170

C. Thirteenth Amendment Analysis

Pregnancy clauses in prior directive statutes are also unconstitutional under the Thirteenth Amendment171 because they reduce an incompetent pregnant woman to a state of slavery and involuntary servitude. An incompetent pregnant woman who is kept alive without her consent by attachment to life-support systems becomes nothing more than a machine—an incubator or reproductive vessel for the potential life that she is carrying—in order to serve the state.

It is clear, however, that the Thirteenth Amendment is an “absolute declaration that slavery or involuntary servitude shall not exist” in the United States.172 By turning an incompetent pregnant woman

165. Griswold, 381 U.S. at 491 (Goldberg, J., concurring).
166. Snyder, 291 U.S. at 105.
167. Griswold, 381 U.S. at 494 (Goldberg, J., concurring); see also Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (arguing that every unjustified intrusion upon the privacy of an individual by the government violates the Constitution).
168. Griswold, 381 U.S. at 495 (Goldberg, J., concurring).
169. Although it is recognized that there is much debate over the Ninth Amendment and the scope of its power and usage by the judiciary, it cannot be ignored or considered surplusage to the Constitution. Marbury v. Madison, 5 U.S. (1 Cranch) 137, 174 (1803). “To treat the Ninth Amendment as an historical anomaly that adds nothing to serious constitutional jurisprudence . . . not only violates the mandate that unenumerated rights be neither denied nor disparaged, but also ignores the framer’s intent that the Constitution be read broadly to protect fundamental rights.” Wachtler, supra note 153, at 609.
170. See supra notes 114-116, 150 and accompanying text.
171. The Thirteenth Amendment states: “Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.” U.S. Const. amend. XIII, § 1.
into an unwilling incubator or reproductive vessel, she is reduced to slavery in order to serve the state. Her body is completely controlled by the state and she is not allowed to carry out her individual choice as to what should be done with, or to, her body. This recalls aspects of slavery as they existed when the Thirteenth Amendment was enacted. Just as the African American woman's body was controlled by her master in all respects including reproduction, so is the body of an incompetent pregnant woman controlled by its new master—the state. This nation's "leading Thirteenth Amendment cases" make it clear "that no person may be compelled to serve another."

Such reproductive slavery is especially offensive in light of the Supreme Court's consistent holding that under the Thirteenth Amendment states and individuals cannot require another individual to labor for them in order to discharge their debts. If peonage is considered a form of involuntary servitude prohibited by the Thirteenth Amendment, then a state order to remain attached to medical machines and produce a child must also be considered a form of involuntary servitude prohibited by the Thirteenth Amendment.

"[T]he phrase 'involuntary servitude' was intended to extend to cover those forms of compulsory labor akin to African slavery which in practical operation would tend to produce like undesirable results." And while it is easier to understand the "general spirit" of the phrase involuntary servitude than to exactly define the phrase, it is clear that impounding the body of an incompetent pregnant woman would fit within the prohibitions of the Thirteenth Amendment. Forced la-


174. See, e.g., Toibb v. Radloff, 501 U.S. 157, 166 (1991) (expressing concern over the possibility that a bankruptcy debtor would be forced to work for creditors in violation of the Thirteenth Amendment); Pollock v. Williams, 322 U.S. 4 (1944) (stating that the Thirteenth Amendment's purpose was not only to end slavery, but to ensure a system of free and voluntary labor); Taylor v. Georgia, 315 U.S. 25, 29 (1942) (noting that coerced labor is a form of involuntary servitude within the meaning of the Thirteenth Amendment); United States v. Reynolds, 235 U.S. 133, 146 (1914) ("compulsion of such service by constant fear of imprisonment under the criminal laws" violates the Thirteenth Amendment); Bailey v. Alabama, 219 U.S. 219 (1911); Clyatt v. United States, 197 U.S. 207, 215 (1905) (holding that peonage, coercing the victim by threat of legal sanction to work off debt to a master, is involuntary servitude).


bored through physical or legal coercion has always been barred by the Thirteenth Amendment. That prohibition has been reenforced by recent courts' examination and condemnation of forced labor camps and forced confinement. "[T]he critical factor in every case finding involuntary servitude is that the victim's only choice is between performing the labor on the one hand and physical and/or legal sanctions on the other." 179

The logic of these cases extends to the situation where an incompetent pregnant woman is being forced to 'labor' for the state against her will. She has no choice because the state has pre-ordained that choice for her through legal sanctions and the physical appropriation of her body. Although the government "may require individuals to perform certain well-established 'civic duties,' such as military service and jury duty,"181 such is not the case here. It can hardly be argued that procreating for the state is a well established civic duty in light of Roe and its progeny. Further, "the nation does not seem to be in danger of becoming depopulated unless women are compelled to bear children."182

Treatment of an incompetent pregnant woman so that she becomes nothing more than an incubator or reproductive vessel is antithetical to our Constitution,183 "akin to African slavery,"184 and cannot

177. Id. at 943; see also supra note 174 and accompanying text.
178. See, e.g., United States v. Kozminski, 487 U.S. 931, 939-53 (1988) (holding that involuntary servitude exists when victim is forced to work under threat of physical restraint or physical injury or by use of legal threats); United States v. King, 840 F.2d 1280-82 (6th Cir.), cert. denied, 488 U.S. 894 (1988) (holding that defendant's repeated use of threats to use physical force to make victims perform labor constitutes involuntary servitude and violates the Thirteenth Amendment); United States v. Booker, 655 F.2d 562, 564 (4th Cir. 1981) (concluding that the Thirteenth Amendment was intended to end not only formal slavery as it had existed in the South prior to the Civil War, but all types of involuntary servitude); Jobson v. Henne, 355 F.2d 129, 131 (2d Cir. 1966) (noting the purpose of the Thirteenth Amendment was to proscribe conditions of enforced compulsory service of one to another).
179. Steirer, 987 F.2d at 999; see also Kozminski, 487 U.S. at 943 (finding involuntary servitude existed because victim had no choice but to work or face legal sanction).
180. "The pun on the word 'labor' should not distract attention from the fact that when a woman is forced against her will to carry a child to term, control over her body and its (re)productive capacities is seized from her and directed to a purpose not her own." Koppelman, supra note 173, at 489.
181. Steirer, 987 F.2d at 999; see also Selective Draft Cases, 245 U.S. 366, 368-73 (1918) (holding that a military draft does not violate the Thirteenth Amendment).
182. Koppelman, supra note 173, at 519.
183. Marcus Brown Bldg. Co. v. Feldman, 256 U.S. 170, 199 (1921) ("[T]he traditions of our law are opposed to compelling a man to perform strictly personal services against his will.").
be sanctioned by society. The legislative proposal below precludes such an undesirable result.

III. POLICY DEFICIENCIES OF PREGNANCY CLAUSES IN PRIOR DIRECTIVE STATUTES AND A LEGISLATIVE PROPOSAL

As discussed in Parts I and II above, pregnancy clauses in prior directive statutes violate both common law and constitutional rights of an incompetent pregnant woman, especially before the fetus is viable. Even after fetal viability, however, there are some serious questions as to whether it is wise to allow the state to command what will be done with an incompetent pregnant woman's body. Arguments about individual autonomy or state interests are not enough in this situation, and in fact serve an injustice to those involved. This Comment will propose a more humane approach to this problem after first addressing the policy deficiencies of pregnancy clauses in prior directive statutes as they are currently written.

A. Policy Deficiencies of Pregnancy Clauses in Prior Directive Statutes

The first major policy deficiency of pregnancy clauses in prior directive statutes is that they ignore the circumstances or wishes of the incompetent pregnant woman. As stated in Part I, one goal of legislatures in enacting prior directive statutes was to allow individuals to be able to exercise their right to forego medical treatment and to avoid being indefinitely hooked up to a machine against their will. This concern evaporates, however, if the patient is incompetent and pregnant under most statutes as written because wishes and desires expressed in a prior directive will be ignored.

The second policy deficiency of pregnancy clauses in prior directive statutes is that they undermine the goals of the Patient Self-Determination Act (hereinafter PSDA). The PSDA was signed into law approximately five months after the Supreme Court issued its decision in *Cruzan* and "reflected an effort to ensure that the new constitutionally protected right to 'self-determination in health care decisions' be given force by ensuring that individuals were given an opportunity to indicate their wishes with clear and convincing evidence."
In effect, the PSDA requires hospitals that receive Medicare or Medicaid funding to maintain written policies and procedures which guarantee that every adult receiving care will be given written information concerning patient involvement in treatment decision-making. Hospitals must inform patients about the prior directive laws of the state as well as the institution's policies respecting such documents.¹⁹¹

While the PSDA's intention to educate society and to foster communication between physician and patient is laudable, its effectiveness for the pregnant woman entering a maternity ward is questionable. Essentially, a pregnant woman will be informed that she has the right to create a prior directive, even though at least thirty-five jurisdictions prohibit physicians from following this directive.¹⁹² The medical literature itself makes it clear, moreover, that a prior directive executed by the pregnant woman would likely be ignored by her health care providers.¹⁹³ Because of state law or health care provider reluctance to abide by an executed prior directive,¹⁹⁴ pregnancy clauses undermine the PSDA's public policy goals of fostering the communication between patient and physician that allows the patient to control what occurs to her body.¹⁹⁵

A third deficiency with pregnancy clauses in prior directive statutes concerns conflicting requirements in the statutes¹⁹⁶ that make it unclear exactly what rights an incompetent pregnant woman retains. In states with integrated statutes, or a single statute, it is clear that a pregnancy clause would control if there was a prior directive.¹⁹⁷ In states with separate statutes, however, the conflicting provisions lead to unclear law. A woman may be better off not having a prior directive at all in order to rely more effectively on her common-law and


¹⁹². See supra notes 26-28, 30-31, 33-35, 37, 39, 41, 46, 47 and accompanying text.


¹⁹⁴. See supra note 192.

¹⁹⁵. See Cate, supra note 190, at 13 (noting the PSDA's focus on "opening discourse" about a patient's right to choose medical treatment).

¹⁹⁶. See supra notes 21-50 and accompanying text.

¹⁹⁷. See supra notes 26-36 and accompanying text.
constitutional rights. Again, such an outcome contradicts the stated legislative policy goals for enacting such statutes.

A fourth policy deficiency exists in prior directive statutes with pregnancy clauses because they completely ignore the "detriment that the state would impose upon the pregnant woman" and her family "by denying this choice altogether." Just as a woman may face many hardships if denied the option to obtain an abortion and forced to undergo an unwanted pregnancy, so too might she suffer if denied the right to forego medical treatment. The incompetent pregnant woman may not wish to leave behind a motherless child, nor make her family suffer the hardship of witnessing her helpless incubation of the fetus and of facing the child who will always remind them that the mother was kept alive against her, and perhaps the family's, wishes.

The incompetent pregnant woman may also not want the family to bear the financial and emotional burden of raising the child without her participation. "There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it."

These likely concerns of the incompetent pregnant woman are totally ignored by the blind application of pregnancy clauses in prior directive statutes. Again, these concerns have been ignored by the legislatures, though their stated goal is to protect individual rights and

198. See supra notes 37-49 and accompanying text. The question also arises whether prior directive statutes limit the rights of those without prior directives. See, e.g., Cruzan, 760 S.W.2d at 420 (declining to rule on the question of whether the common law right to refuse medical treatment was broader than the rights given under the Missouri Living Will Act). This question, though relevant, exceeds the scope of this Comment.

199. Even in states without pregnancy clauses, prior directive statutes generally provide no guidance to health care providers or individuals as to what should occur if the patient is pregnant and incompetent. It is unclear whether the health care provider should follow the patient's prior directive, the provider's own moral belief, or the request of the patient's family. The incompetent pregnant woman's directive may be ignored because of the provider's fear of civil or criminal liability. The proposal below avoids ambiguity and gives guidance to health care providers, individuals, and practitioners of law as to what should occur in the situation where there is an incompetent pregnant woman both with, and without, a prior directive.


201. See Elizabeth Benton, The Constitutionality of Pregnancy Clauses in Living Will Statutes, 43 Vand. L. Rev. 1821, 1826 (1990) (noting that the "risk of psychological harm to the woman's partner and family must be considered when a pregnant woman's body is maintained against her express wishes").

202. See generally Benton, supra note 201, at 1826-27 (discussing the financial burdens imposed on the woman's family when the state forces the birth of a child).

to promote individual and family decisionmaking. Pregnancy clauses as presently written expressly thwart these goals.

As a society we must recognize and work to change laws that indiscriminately deny half our population individual rights long protected by common-law and the Constitution. This Comment proposes a remedy to end such discrimination by incorporating the idea of the feminist ethic of care with the legally recognized doctrine of substituted judgment to create a pregnancy clause that recognizes and addresses the interests of those parties responsible for an incompetent pregnant woman with a prior directive.204

B. Feminist Ethic of Care

The struggle between the right of patient autonomy and bodily integrity and the physician’s (or the State’s) paternal duty to help the patient achieve the best outcome is well documented in bioethics literature.205 This simple dichotomy, however, is inadequate to analyze the real life circumstances and concerns of most individuals in our society. Rarely does one make a decision without considering its effect upon family and friends. Seeing events as polar opposites, viewing the world in dichotomies, sets up a false dualism that lead us, as a society, “to an either/or, self/other analysis instead of a plural, multiple, variant, and contextualized analysis.”206

Feminist ethics207 looks beyond this narrow framework, and false dualism, to consider how autonomy arises and flourishes in a larger social context. An ethic of caring enhances autonomy.208 The law must recognize that life decisions are made within a broad personal context and that we cannot truly understand an individual’s choices

204. As stated earlier, supra note 51, this proposal will also help protect the interests of an incompetent pregnant woman who has not executed a prior directive, because it will clarify the roles of the patient, health care provider, and surrogate decision-maker.

205. SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS & HEALTH CARE 137 (1992) (describing the struggle “as a clash between the basic moral principles of autonomy and beneficence”).

206. Bender, supra note 5, at 530.

207. Feminist ethics and feminism are “varied and multiple.” Bender, supra note 5, at 519. This Comment recognizes that feminism is a label which encompasses more than a “political struggle for woman’s rights.” Id. The Comment examines feminist theories which emphasize “the need to value and focus on care, compassion, responsiveness, responsibility, conversation, and communication, as well as learning to listen closely to others and to pay attention to others’ needs, regardless of their differences from our own.” Id. See also NEL NODDINGS, CARING: A FEMININE APPROACH TO ETHICS AND MORAL EDUCATION 24 (1984) (“Caring involves stepping out of one’s own personal frame of reference into the other’s. When we care, we consider the other’s point of view.”).

208. See infra notes 214-215 and accompanying text.
without understanding the larger circumstances of a person's life.\textsuperscript{209} The argument of individual autonomy or compelling state interest is the argument of a general rule applied to a particular situation—an ethic of justice—that often fails to look at the situation in context and proceed to an equitable resolution within an ethic of care.\textsuperscript{210} An ethic of justice looks either to what the state must win in the situation or what the individual must win and ignores not only the family, but more importantly, the individual.

By not acknowledging or adopting an ethic of care, we not only ignore the autonomy of the individual, but also the context of the individual's life. “A care-based ethic arises out of perceptions of human beings as relational, interdependent, and supportive as opposed to our current rights-based ethic in which people are separate, autonomous, and equally empowered actors.”\textsuperscript{211} An ethic of care recognizes that emotions and familial interaction play a large role in our everyday life and in our decision-making.\textsuperscript{212} The ethic of care questions, at the time of death, the attempt to separate individuals from those who have been part of their lives and who have been a part of their decision-making throughout life. Just as a model of friendship and amicalism should be supported and fostered between patient and physician, so too should it be promoted between patient and the state. “Under amicalism, the intention would be to enlist friends and family, who both understand and care personally and specifically for a patient, in the task of medical decision-making, rather than treating medical choice as a contest between [an] isolated patient and [the] physician”\textsuperscript{213} or state.

In the situation of an incompetent pregnant woman, it is not simply enough to advocate strict autonomy or compelling state interest,

\textsuperscript{209} Feminist ethics generally “reject[ ] the notion of an ethics founded on general principles in favour of a context specific analysis.” Helen B. Holmes & Laura M. Purdy, Feminist Perspectives in Medical Ethics 24 (1992).

\textsuperscript{210} Holmes & Purdy, supra note 209, at 18; see also Leslie Bender, Teaching Feminist Perspectives on Health Care Ethics and Law: A Review Essay, 61 U. Cin. L. Rev. 1251, 1259 (1993) (noting that an ethic of justice is generally seen as a rights-based model “in which problems are analyzed using abstract principles organized in hierarchies by autonomous decisionmakers,” while an ethic of care, by comparison, is seen as “being more particularized, contextual, relational, and interdependent, and rooted in values of caring and responsibility”).

\textsuperscript{211} Bender, supra note 5, at 535.

\textsuperscript{212} See generally An Ethic of Care: Feminist & Interdisciplinary Perspectives 71 (Mary Jeanne Larrabee ed., 1993) (“[T]he justice orientation organizes moral perception by highlighting issues of fairness, right, and obligation. . . . The care orientation meanwhile focuses on other saliencies: on the interconnections among the parties involved, on their particular personalities, and on their weal and woe.”).

\textsuperscript{213} Sherwin, supra note 205, at 157.
there is another interest at stake: that of family and friends in protecting the rights of an individual from being trampled by the state. The interest of family and friends should be recognized and considered before making the decision to attach or remove life-sustaining treatment from an incompetent pregnant woman.

By adopting an ethic of care, we do not delegitimize or ignore the autonomy and bodily integrity of the incompetent pregnant woman, but rather strengthen it and give it added meaning. As Professor Bender explains:

Autonomy, the power of an individual to control her own life and death, is as much a cornerstone of a care-based ethic as it is of modern medical ethics and legal practice. The differences are in the sources or meanings of autonomy. In a care-based ethic, individual autonomy is a process nurtured in webs of relationships and responsibilities instead of a static condition pre-existing them. Whereas the ideological basis of a rights-based ethic rests on an assumption of equally empowered, independent people, an ethic of care recognizes that many relationships contain dependencies between differently empowered people. . . . The autonomy of an ethic of care can be melded with the autonomy concerns in a rights-based medical ethic, if it is understood to mean self-governing moral agency, rather than independent or self-contained decisionmaking. Self-governing in an ethic of care does not mean governing alone by abstract reasoning and distant observations, but means choosing options with respect to responsibilities, relationships, conversations, and dialogues with others. 214

By recognizing an ethic of care in decision-making, we further illuminate the right of autonomy and recognize that the context of the situation is important to any decision. An ethic of care further effectuates the autonomy and dignity of the individual, 215 in this case the incompetent pregnant woman. This ethic is easily adapted to the legal system and dovetails nicely with the doctrine of substituted judgment which allows family and friends to take part in the decision about whether medical treatment should be withheld or withdrawn from an incompetent pregnant woman. 216

214. Bender, supra note 5, at 536-37.
215. Id. at 539.
216. See Fentiman, supra note 160, at 805 ("[S]ubstitute decision-making for an incompetent adult should seek to respect and promote that individual's right to autonomy and privacy, both by seeking to effectuate his medical treatment choice, to the extent that it can be determined once he is no longer competent, and by providing a sphere for private
C. Substituted Judgment

The substituted judgment doctrine arose under the common law to provide a means by which the courts could deal with the incompetent individual without a prior directive. As explained by the New Jersey Supreme Court:

[under the substituted judgment doctrine, where an incompetent's wishes are not clearly expressed, a surrogate decisionmaker considers the patient's personal value system for guidance. The surrogate considers the patient's prior statements about and reactions to medical issues, and all facets of the patient's personality that the surrogate is familiar with—with, of course, particular reference to his or her relevant philosophical, theological, and ethical values—in order to extrapolate what course of medical treatment the patient would choose.]

Although this Comment is particularly concerned with the situation in which a prior directive exists, it is evident that a prior directive could be discounted when a fetus is involved because the interests of the state, the family, and friends are implicated. The choices expressed in a prior directive are obviously precedent, and it is difficult to decisionmaking by that individual, his family, and his physician, into which the state cannot intrude.”) (emphasis added).

217. In re Jobes, 529 A.2d 434, 444 (N.J. 1987); see also Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977). The doctrine of substituted judgment evolved from English estate law which called upon the court to 'don the mental cap' of the person who was incompetent to look after an estate. See Ex Parte Whitbread in re Hinde, a Lunatic, 35 Eng. Rep. 878 (1816).

218. The argument can be made that if a prior directive exists and the fetus is not viable, the directive should be effectuated under all circumstances. While this may be an attractive argument initially in protecting the individual interest, reality counsels otherwise. It is naive to think that a health care provider will effectuate a prior directive if an incompetent woman is pregnant without discussing such action with the woman's family and friends. The proposal below recognizes and attempts to address this reality.

219. One can argue that because the incompetent pregnant woman can not make a contemporaneous choice whether or not to remain on life-sustaining treatment until the fetus's birth, her precedent wishes, as evidenced by a prior directive, should not be followed. This is especially true if the prior directive is unclear and does not address the situation where a woman is incompetent and pregnant. The argument suggests that an unclear prior directive could violate the present wishes of an incompetent pregnant woman. The morally correct action in this situation is to look to family and close friends to make such a decision. See, e.g., Sanford H. Kadish, Letting Patients Die: Legal & Moral Reflections, 80 CALIF. L. REV. 857, 888 (1992) (arguing that “an advance choice has force, but not the conclusive moral force of a contemporary choice”).

It must be understood that upon completion of a prior directive, no one can reasonably contemplate all the possible situations in which it might be effectuated. Legislatures generally do not expect such a level of specificity when a prior directive is executed because the purpose of having such statutes would be undermined. Again, however, the
know whether the incompetent pregnant woman foresaw the event occurring.

In such a situation it should be evident that a court or health care provider may be reluctant to carry out a prior directive under the belief that the incompetent pregnant woman's wishes are truly not known in this situation. Moreover, "[m]any physicians are refusing to discontinue life-sustaining medical treatment without judicial authorization, due either to their own sense of professional ethics or to the fear of civil or criminal liability."220 Under an ethic of care, family and friends should decide the course of action in this difficult situation rather than let the state step in and dictate what should occur. "Almost invariably the patient's family has an intimate understanding of the patient's medical attitudes and general world view and therefore is in the best position to know the motives and considerations that would control the patient's medical decisions."221 While there is always the possibility that a woman may be left without either a family or partner, this is an unlikely prospect. If it occurs, then close friends should be given the same role that a family member or partner would carry out in this situation.222 As stated by the New Jersey Supreme Court, "our common human experience teaches us that family members and close friends care most and best for a patient. They offer love and support and concern, and have the best interest of the patient at heart. The importance of the family in medical treatment decisions is axiomatic."223 Further, it is family and friends that treat a "patient as a person, rather than a symbol of a cause."224

By combining the feminist ethic of care with the legally recognized doctrine of substituted judgment (a 'caring substituted judgment' approach), a better solution emerges to deal with the incompetent pregnant woman who has executed a prior directive. While a simple or decisive answer is difficult to achieve, the following proposal, which incorporates a caring substituted-judgment approach,

situation where a woman is incompetent and pregnant is unusual because the fetus must be considered. In order to insure that her wishes are respected, a woman would have to specify in her prior directive what actions should take place if she is pregnant and incompetent. The proposal addresses this concern.

220. Fentiman, supra note 160, at 807.
221. In re Jobes, 529 A.2d at 445.
222. There is no legitimate reason to cut off the individual from friends and family when the individual is most in need of their assistance. Excluding family and friends from medical decision-making should be the rare exception, not the rule. See In re Jobes, 529 A.2d at 445 (noting that "family members are best qualified to make substitute judgments for incompetent patients").
should enable society to deal more humanely, compassionately, and openly with the wishes of a dying incompetent pregnant woman.

D. Legislative Proposal

This Comment proposes that prior directive statutes be re-written so that they take into account not only the common-law and constitutional rights of the individual woman, but also the rights of family and friends. Consideration of these rights will provide clearer guidance as to what should occur if there is an incompetent pregnant woman with (or without) a prior directive.

Pregnancy clauses in prior directive statutes must first address the situation where the fetus is not yet viable. In that situation, the wishes of the pregnant woman, as set forth in her prior directive, must be effectuated if they are clearly stated. Until the point of viability, there is simply no state interest that can overcome the interest of the incompetent pregnant woman to exercise her common-law and constitutional rights to privacy and bodily integrity. In order to determine what the wishes of the woman are, statutes should require that women clearly state in their prior directive what is to occur if they become incompetent while they are pregnant. If the woman does so, then her wishes must be effectuated before the fetus is viable. If she does not make her wishes clearly known, then the decision whether to withdraw or withhold life-sustaining treatment from an incompetent pregnant woman should go to family and friends, instead of to the health care provider or the state.

Once fetal viability occurs, a look at strict individual autonomy versus state interest reveals that most courts will likely rule that a state has a compelling interest in fetal life and could prohibit life-sustaining procedures from being withheld or withdrawn. The state should not, however, be allowed to mandate the outcome of this decision because the state will usually not suffer the consequences of its act. Family and friends of the incompetent pregnant woman will suffer the consequences and should be allowed to make the decision as to what

225. See supra notes 114-116 and accompanying text.

226. Several states' prior directive forms contain pregnancy clauses. Such forms require that women initial them, cross them out, or specify what should be done if incompetent and pregnant. See, e.g., Md. Code Ann., Health-Gen. § 5-603 (1994) ("If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows . . . ").

227. See supra notes 119-121 and accompanying text.
should occur. Where there is no family, then close friends of the individual should be consulted.\textsuperscript{228}

This proposal would be similar to the Maryland Health Care Decisions Act of 1993.\textsuperscript{229} Like the Maryland Act, it would designate surrogate decision-makers for an individual if they have not executed a prior directive.\textsuperscript{230} All prior directive statutes should contain a section worded substantially as follows:

\textit{Effect Of Directive During Pregnancy}

(A) Before the fetus of an incompetent pregnant woman is viable,\textsuperscript{231} as defined in the definitional section of this Act, a directive executed in accordance with this Act shall be given effect if the woman has clearly stated her intent as to what should be done in the event that she is pregnant at the time of her incompetency\textsuperscript{232} and the fetus is not yet viable.

(1) If the woman has failed to indicate her intent as to what should be done in the event that her fetus is not viable and she is incompetent, then the mechanism set out in subsection (B) shall be followed.\textsuperscript{233}

\textsuperscript{228} This legislative proposal contains a priority system, which would ensure that even if there are no family members available, or if the woman has not designated a surrogate decision-maker, close friends would be consulted.


\textsuperscript{230} Id. § 5-605.

\textsuperscript{231} As discussed earlier, viability is generally thought to occur at 28 weeks of gestation, though it can occur as early as 23 or 24 weeks. Supra note 111. In this instance, the statute should adopt bright-lines in order to be effective and give guidance to health care providers. In recognition of the fact that a legislature may not want to adopt such a bright-line rule, the statute may allow the attending physicians to determine the point of viability. This, too, could prove problematic. Concerns over possible liability on their part may cause a health care provider to delay making a determination of viability long enough to ensure fetal viability. In order to ensure uniformity in the Act's operation, it would be more prudent for the legislature to establish 28 weeks as the point of viability.

\textsuperscript{232} Incompetency should be defined by the Act as it is presently done in prior directive statutes, as discussed supra note 8.

\textsuperscript{233} This subsection recognizes that when a woman executes her prior directive she may not be able to decide what she would like done in a situation where she is incompetent and pregnant. It also recognizes that a woman may want her family to make this decision. In addition, it is noted that health care providers are unlikely to follow an ambiguous prior directive, particularly if the patient is incompetent and pregnant.

The argument could be made that this subsection incorrectly presumes that no choice is made when a woman chooses not to say anything in her prior directive. In other words, by not saying anything in the prior directive, the woman perhaps has made a choice that her directive is not to be affected by the pregnancy and that it should be carried out. In this situation where a woman is incompetent and pregnant, the better course is to require her to make an explicit statement as to what she wants to occur. If a woman truly wants her wishes to be effectuated, she needs to clearly state what they are. This requirement is minimal in light of the fact that the alternative is that the state will make the decision for her.
(B) Once the fetus of an incompetent pregnant woman is viable, as defined in the definitional section of this Act, the health care providers should turn to the husband or partner, family or close friends of the incompetent pregnant woman, in order of priority established in subsection (C), to determine whether or not life-sustaining procedures should be maintained or withheld or withdrawn. The decision of the surrogate shall be given effect unless there is a conflict as discussed in subsection (D).

(C) The following priority for surrogate decision-making is established:

1. Guardian, if one has been appointed;
2. Surrogate or Proxy;\textsuperscript{234}
3. The patient's husband or partner;\textsuperscript{235}
4. An adult child of the patient;
5. A parent of the patient;
6. An adult brother or sister of the patient;
7. A friend or relative of the patient who is competent and presents an affidavit stating that the person is a relative or close friend of the patient and that they are familiar with the patient's activities, health, and personal beliefs.

(D) If persons with equal decision-making priority under subsection (C) of this section disagree as to what should be decided as to life-sustaining procedures for the incompetent pregnant woman, the case shall be referred to the institution's patient care advisory committee.\textsuperscript{236}

(E) Standards for Surrogate Decision-makers are as follows:

1. Any person authorized to make health care decisions for an incompetent pregnant woman under this section

\textsuperscript{234} In most circumstances, it is likely that a family member would be named by the individual as their guardian, or a surrogate or proxy. This, however, is not always the case. Generally, the individual has the right, in a prior directive, to name a guardian, or a surrogate or proxy. If an individual is named, that person is given priority in this subsection. However, if there is only a living will, a surrogate will not have been named. This hierarchy would make it possible that family members or friends, instead of the state, would be the individuals who would make the decision as to what should occur.

\textsuperscript{235} Use of the term partner recognizes that an incompetent pregnant woman may not be married, or that she may be involved in a same-sex relationship.

shall base those decisions on the wishes of the woman, recognizing that any prior directive executed by her shall be given great weight in the ultimate determination whether to withhold or withdraw life-sustaining treatment.\footnote{237. The existence of a prior directive is "persuasive evidence of [the] incompetent [pregnant woman's] intention and it should be given great weight by the person or persons who substitute their judgment on [her] behalf." John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984).}

(2) In determining the wishes of the incompetent pregnant woman, a surrogate shall also consider her:

(a) current diagnosis and prognosis without the treatment at issue, i.e. what effects will such treatment have on the incompetent pregnant woman as well as the effects of such treatment on the fetus;\footnote{238. This subsection recognizes that many types of life-sustaining treatment may be harmful to fetal development and allows the surrogate to consider this in their decision-making. See, e.g., T.W. Sadler, Langman's Medical Embryology 113-15 (5th ed. 1985) (examining the harmful effect of chemical agents and pharmaceutical drugs on the fetus).}

(b) expressed preferences regarding the provision, withholding, or withdrawal of specific treatment at issue or of similar treatments;

(c) relevant religious and moral beliefs and personal values;

(d) behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally;

(e) reactions to the provision, withholding, or withdrawal of a similar treatment for another individual; and,

(f) expressed concerns about the effect on the family or intimate friends of the incompetent pregnant woman if a treatment were provided, withheld, or withdrawn.

A policy such as that set out above will best effectuate all the interests involved in what is, admittedly, a difficult situation. Before fetal viability, the interests of the individual woman are paramount unless she has failed to clearly state in a prior directive what should occur if she becomes incompetent. After fetal viability, the state is still not allowed to interfere in the decision as to what should occur. Nor may the state ordain what should occur. The interests of the state are assuaged by the fact that there can be no doubt that family and friends are also interested in the fetal life as well as in the life and wishes of the incompetent pregnant woman.

The obvious criticisms of this proposal may center around the viability distinction in this context and how a woman's prior directive may be brought into question if she has clearly stated her wishes. In
an ideal world such distinctions would never have to be made and whatever the woman desired as expressed in her prior directive would govern in all circumstances. Such an ideal world does not exist, however, and it must be recognized that the state can, and will, likely step in when the fetus of a woman is viable, if not before that point. This is clearly seen in the abortion rights cases and the forced cesarean section cases. States have consistently intervened in the situation where a woman is pregnant and she has attempted to exercise her rights in contradiction to what her health care providers or the state believe to be in the best interest of the unborn fetus. This proposal recognizes that fact and attempts to cope with this reality.

The distinction between pre and post viability is recognized and incorporated into this proposal because the United States Supreme Court has made this distinction a part of the law of abortion. The Court would likely look to this law if it were to recognize the right to forego medical treatment as a constitutionally protected privacy right and apply it to the situation where a woman is pregnant and incompetent. It is important to note that this proposal does not call into question the wishes of an incompetent woman as expressed in her prior directive. The proposal recognizes these wishes and requires that family or friends take those wishes into account when making their decision as to what should be done. In light of current federal and state law, the wishes of a woman that are clearly expressed in a prior directive, whether the fetus is pre or post viable, are far more likely to be carried out by family or friends than by a health care provider or the state acting alone. This is especially true if the fetus is viable. By recognizing this fact and by dealing with it directly, the first step is taken toward moving the law to a better place.

By allowing family and friends to make the decision of whether to forego life-sustaining treatment where a woman is incompetent and pregnant with a viable fetus (or before viability, if her choice is not clearly enunciated in her prior directive), we arrive at a method that can best fit everyone's needs. Family and friends have the best interests of the woman, the fetus (and, consequently, the interest of the state) in mind and know best the beliefs and desires of the woman at the moment of incompetency. Throughout our lives we rely on family and friends to protect our autonomy, to do what is best for us, and to help us arrive at our decisions. This fact of life should not change at

239. See supra notes 80, 89-94.
240. See supra notes 127, 138-140.
241. See supra note 119.
242. See supra note 237 and accompanying text.
the end of life when we are most in need of the ones that have supported us throughout life.

By adopting a caring, substituted judgment standard, which is a "shared decision-making process:"

individual participants are able to view each other not as adversaries, but as partners in reaching the resolution of a difficult problem. Then, after a decision is made, there is not enmity, but connection. This paves the way for future relations of mutual respect, rather than malpractice litigation, or rifts within the family. Accordingly, just as is the case with alternative dispute resolution, the process of conversation, of structuring a decisionmaking model on the basis of human connection rather than on a hierarchy of rights and rules, enhances both the quality of the decision made and the participants' acceptance of it.243

Such is the import of this proposal. It may not be perfect, but it is workable, clear, and best addresses the various competing interests in such a manner that the state will not dictate its decisions to the individuals involved.

CONCLUSION

It is clear that pregnancy clauses in prior directive statutes must be changed. As currently written, they violate common-law and constitutional rights of women, as well as leave the state of the law unclear and ambiguous. This is especially true before the fetus reaches viability.

Once the fetus is viable, however, the state's interest becomes compelling. That should not, however, override the autonomy of the incompetent pregnant woman as expressed and exercised through her family and friends in consideration of her prior directive and by their personal knowledge of the woman. Through a "caring substituted judgement" model, we can best effectuate the interests of all in an admittedly difficult circumstance.

TIMOTHY J. BURCH