

Notes

DECISIONS IN THE DARK: WHY “PREGNANCY EXCLUSION” STATUTES ARE UNCONSTITUTIONAL AND UNETHICAL

Shea Flanagan

ABSTRACT—Advance health care directives are tools that allow people to state their health care treatment wishes or designate a health care proxy in anticipation of being unable to make those decisions in the future, including preferences to remove life-sustaining medical treatment. However, thirty-six states currently have “pregnancy exclusion” laws that require physicians to void the advance directives of pregnant women receiving life-sustaining treatment. This Note assesses the constitutionality and ethics of state pregnancy exclusion statutes by employing a new five-category typology of current pregnancy exclusion laws. This Note argues that all categories of these statutes violate an individual’s constitutional rights to terminate a pregnancy and to refuse lifesaving medical treatment, and also contends that pregnancy exclusion laws as they currently exist violate basic bioethical principles by restricting the autonomy of patients. To conclude, this Note provides a potential reform to pregnancy exclusion laws that passes constitutional muster and meets today’s ethical standards.

AUTHOR—J.D. Candidate, Northwestern Pritzker School of Law, 2020; B.A., University of Connecticut, 2017. I would like to thank Professor Candice Player for her advising of this Note. I would also like to thank the entire *Northwestern University Law Review* team, especially Abigail Bachrach, Alex Becker, Joe Blass, Andrew Borrasso, Rebekah Kim, Annie Prossnitz, Kristen Stoicescu, and Nora Snyder, for their thoughtful and thorough edits.

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INTRODUCTION

In 2013, a Texas woman named Marlise Muñoz suffered a sudden blood clot in her lungs and was rushed to the hospital from her home.¹ Marlise was fourteen weeks pregnant at the time and was later determined to be brain-dead.² Her family instructed the hospital to remove her from life support since she had previously expressed that she did not want to be kept on life support under any circumstances.³ However, because the hospital discovered the pregnancy, it refused to comply and continued to keep Marlise’s body connected to life support machines.⁴ The physicians decided to override Marlise’s instructions and continue treating her, despite the fact that the fetus was not yet viable and would likely have been born with birth defects if

¹ Manny Fernandez & Erik Eckholm, *Pregnant, and Forced to Stay on Life Support*, N.Y. TIMES (Jan. 7, 2014), <https://www.nytimes.com/2014/01/08/us/pregnant-and-forced-to-stay-on-life-support.html> [<https://perma.cc/3YM9-JJJ7>]; Wade Goodwyn, *The Strange Case of Marlise Munoz and John Peter Smith Hospital*, NPR (Jan. 28, 2014, 5:44 PM), <https://www.npr.org/sections/health-shots/2014/01/28/267759687/the-strange-case-of-marlise-munoz-and-john-peter-smith-hospital> [<https://perma.cc/PU2H-9LHC>].

² Goodwyn, *supra* note 1.

³ *Id.*

⁴ Fernandez & Eckholm, *supra* note 1.

brought to term.⁵ Marlise’s body remained on life support for two months until a court ordered the hospital to respect her wishes.⁶

In justifying its decision, the hospital cited a Texas state statute that voids the advance health care directives of pregnant patients and directs physicians to maintain life-sustaining measures until the fetus is brought to term,⁷ even if a woman has clearly communicated that she does not wish to be placed on life support upon entering a persistent vegetative state.⁸ Advance health care directives are legal instruments by which a competent person either instructs physicians to withhold medical treatment in certain conditions where the person will be unable to make medical decisions (i.e., a living will) or designates a health care agent to make health care decisions for her if she becomes unable to do so (i.e., a durable power of attorney for health care).⁹ Although Marlise did not have advance directives, the Texas “pregnancy exclusion” law allowed the physicians to lawfully ignore the instructions of Marlise’s husband acting as her health care agent.¹⁰ A state trial judge ultimately ruled that the hospital had to remove Marlise from life support because she was brain-dead—which is a legal form of death under Texas law¹¹—and thus the life support treatment was not a “[l]ife-[s]ustaining [m]easure.”¹² However, the judge made no determination about

⁵ *Id.*; Manny Fernandez, *Judge Orders Hospital to Remove Pregnant Woman from Life Support*, N.Y. TIMES (Jan. 24, 2014) [hereinafter Fernandez, *Judge Orders*], <https://www.nytimes.com/2014/01/25/us/judge-orders-hospital-to-remove-life-support-from-pregnant-woman.html> [<https://perma.cc/U75F-HMRX>] (“Lawyers for Ms. Muñoz’s husband, Erick Muñoz, said they were provided with medical records that showed the fetus was ‘distinctly abnormal’ and suffered from hydrocephalus—an accumulation of fluid in the cavities of the brain—as well as a possible heart problem.”).

⁶ *Id.*; Judgment, *Muñoz v. John Peter Smith Hospital*, No. 096-270080-14, 9th Jud. District Tex. (Jan. 24, 2014), http://thaddeuspope.com/images/MUNOZ_202053415-Judges-Order-on-Munoz-Matter.pdf [<https://perma.cc/6B3Y-LDAP>].

⁷ See Fernandez & Eckholm, *supra* note 1; 2 TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 2019) (“A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient.”).

⁸ See 2 TEX. HEALTH & SAFETY CODE ANN. § 166.033 (West 2019). The arguments in this Note would apply equally to any pregnant person, regardless of gender identity. See Saru M. Matambanadzo, *Reconstructing Pregnancy*, 69 SMU L. REV. 187, 197 n.56 (2016) (discussing pregnant men). However, this Note will continue to refer to pregnant women because it is still overwhelmingly women who are pregnant and because discussions and laws concerning reproductive rights have long assumed that only women can become pregnant. See *id.* at 195–98.

⁹ *Advance Directives: Definitions*, PATIENTS RTS. COUNCIL (2013), <http://www.patientsrights.council.org/site/advance-directives-definitions/> [<https://perma.cc/SUL4-FMB8>].

¹⁰ See Susan Donaldson James, *Husband Wants Pregnant Wife off Life Support*, ABC NEWS (Dec. 23, 2013, 12:00 AM), <https://abcnews.go.com/Health/husband-pregnant-wife-off-life-support/story?id=21291086> [<https://perma.cc/QHZ5-JGTU>].

¹¹ 8 TEX. HEALTH & SAFETY CODE § 671.001(b) (West 2019).

¹² Judgment, *supra* note 6.

whether this Texas law was constitutional as applied to pregnant patients in a persistent vegetative state who have previously communicated their end-of-life wishes to remove life support in this condition.¹³

This story sparked national conversation about the constitutional and bioethical issues underlying state pregnancy exclusion laws that void the advance health care directives of pregnant women being sustained through life-support technology.¹⁴ In addition to Texas, thirty-five other states have similar statutes that either prohibit or greatly restrict physicians from honoring a pregnant patient's advance health care directives to refuse life-sustaining treatment.¹⁵ The ethical issues these laws pose are made even more complex today, given advances in new technology that can ventilate and sustain the bodily functions of patients in a persistent vegetative state for extended periods of time.¹⁶ Technology and advanced mechanical

¹³ See *id.*; Fernandez, *Judge Orders*, *supra* note 5. A persistent vegetative state occurs when the patient is only being kept alive by medical intervention due to a state of complete unresponsiveness for more than a month to psychological and physical stimuli, with no sign of higher brain function. See Joseph J. Fins, *Brain Injury: Neuroscience and Neuroethics*, HASTINGS CTR., <https://thehastingscenter.org/briefingbook/the-vegetative-and-minimally-conscious-states/> [<https://perma.cc/87C2-ANHN>]. In most cases, people in a persistent vegetative state do not recover; however, in rare cases people may slowly improve over a period of months to years. Kenneth Maiese, *Vegetative State*, MERCK MANUAL: CONSUMER VERSION, <https://www.merckmanuals.com/home/brain,-spinal-cord,-and-nerve-disorders/coma-and-impaired-consciousness/vegetative-state> [<https://perma.cc/4DZK-4VUH>].

¹⁴ See, e.g., Goodwyn, *supra* note 1; Malcolm Parker, *Brain Death, Pregnancy and Ethics: The Case of Marlise Munoz*, CONVERSATION (Jan. 20, 2014, 10:31 PM), <https://theconversation.com/brain-death-pregnancy-and-ethics-the-case-of-marlise-munoz-22076> [<https://perma.cc/6QJT-KRQH>]; Katherine Taylor & Lynn Paltrow, *Marlise Munoz Case Shines Light on Dehumanizing 'Pregnancy Exclusion' Laws*, REWIRE.NEWS (Jan. 9, 2014, 2:35 PM), <https://rewire.news/article/2014/01/09/marlise-munoz-case-shines-light-on-dehumanizing> [<https://perma.cc/GF2F-497S>].

¹⁵ See *infra* note 56. Many litigants have attempted to challenge state pregnancy exclusion laws as unconstitutional in state courts, but these attempts have been largely unsuccessful due to issues with injury and standing—the women whose rights are injured as a result of these laws are unable to bring a challenge in their incapacitated state. Cf. *DiNino v. State ex rel. Gorton*, 684 P.2d 1297, 1300–01 (Wash. 1984) (declining to find Washington's pregnancy exclusion law unconstitutional and holding patient's action largely unsuccessful because she was neither pregnant nor terminally ill). *But see* *Univ. Health Servs. Inc. v. Piazzi*, No. CV86-RCCV-464 (Ga. Super. Ct. Aug. 4, 1986) (upholding Georgia's pregnancy exclusion law by relying on public policy and clarifying that a woman's right to abort a nonviable fetus is based on the right to privacy which is extinguished upon brain death). In May 2018, four plaintiffs filed a lawsuit in federal court in Idaho challenging the state's pregnancy exclusion law, bringing the underlying constitutional and bioethical issues back into the spotlight. See *Complaint, Almerico v. Idaho*, No. 1:18-cv-00239-EJL (D. Idaho May 31, 2018), http://docs.legalvoice.org/Almerico_v_Idaho_Complaint.pdf [<https://perma.cc/CDW2-SEDQ>]. The district court dismissed the plaintiffs' facial constitutional challenge to Idaho's pregnancy exclusion law on March 28, 2019, but with leave to amend to assert an as-applied challenge. See *Memorandum Decision and Order, Almerico v. Idaho*, No. 1:18-cv-00239-BLW (D. Idaho Mar. 28, 2019), <https://cases.justia.com/federal/district-courts/idaho/iddce/1:2018cv00239/41475/33/0.pdf> [<https://perma.cc/98P4-J4ME>].

¹⁶ See Majid Esmailzadeh et al., *One Life Ends, Another Begins: Management of a Brain-Dead Pregnant Mother—A Systemic Review*, 8 BMC MED. 74, 79–80 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3002294/pdf/1741-7015-8-74.pdf> [<https://perma.cc/3YTV-7PGX>] (explaining

ventilators now allow for gestation in a woman's body, even if a woman is brain-dead.¹⁷ According to a 2010 study, there are only thirty reported cases where such posthumous gestation has occurred using life-support technology thus far, with twelve viable fetuses successfully brought to term and only one of those fetuses experiencing deformities at birth.¹⁸ Since this 2010 study, there have only been a few additional cases in the international media where pregnant women who are either brain-dead or in a persistent vegetative state have successfully brought a fetus to term using advanced neonatal technology.¹⁹

Despite the arguable success of such technology, there is a clear tension between state pregnancy exclusion laws and bioethical principles that suggest physicians should respect advance health care directives, or at least allow health care agents or family members to make final decisions based on their understanding of the patient's values.²⁰ For instance, the Committee on Ethics of the American College of Obstetricians and Gynecologists has stated that “[p]hysicians are encouraged to support a pregnant woman's autonomy and decisions whenever legally possible,” and “[t]he health care facility should not attempt to contravene her wishes and values, whether she voices them or they are relayed by a surrogate decision maker.”²¹ When a physician ignores the advance directives of a pregnant patient, not only does such a decision prevent a woman from dying a natural death, but the forced application of technology to sustain the fetus could also cause the woman's body to subsequently deteriorate—adding additional anguish to surviving family and friends.²² Pregnancy exclusion laws would thus likely force

potential technological ways to sustain fetal life in pregnant women who are brain-dead, including mechanical respiratory ventilation, cardiovascular support and monitoring, endocrine support, thermoregulation, warming blankets, and nutritional support).

¹⁷ *Id.* at 74.

¹⁸ *Id.* at 75–76, 79.

¹⁹ See, e.g., *Czech Doctors Deliver Baby Girl 117 Days After Mother's Brain-Death*, REUTERS (Sept. 2, 2019, 9:22 AM), <https://www.reuters.com/article/us-czech-birth/czech-doctors-deliver-baby-girl-117-days-after-mothers-brain-death-idUSKCN1VN1HQ> [<https://perma.cc/QL92-2SFG>]; *Portugal Baby Born to Woman Brain Dead for Three Months*, BBC NEWS (Mar. 29, 2019), <https://www.bbc.com/news/world-europe-47741343> [<https://perma.cc/LB8K-KR94>]; see also Amelia McDonnell-Parry, *Woman in 14-Year Coma Gives Birth in Arizona*, ROLLING STONE (Jan. 23, 2019, 4:54 PM), <https://www.rollingstone.com/culture/culture-news/coma-birth-woman-arizona-hacienda-healthcare-776902> [<https://perma.cc/6CDC-CWV9>].

²⁰ See *infra* Part III.

²¹ COMM. ON ETHICS, AM. C. OF OBSTETRICIANS & GYNECOLOGISTS, COMM. OP. NO. 617, END-OF-LIFE DECISION-MAKING (2015), <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/End-of-Life-Decision-Making> [<https://perma.cc/6QAM-57A3>] (committee opinion reaffirmed in 2018).

²² The case of Marlise Muñoz is representative of the connection between diminished brain function and subsequent bodily deterioration. Marlise's husband, Erick, argued that “sustaining her body artificially amounted to ‘the cruel and obscene mutilation of a deceased body,’” and in an affidavit to the

physicians to sustain a pregnant woman in a persistent vegetative state on life-support technology until “she dies, the fetus dies, or she gives birth.”²³ While such cases of physicians keeping a pregnant woman on life support in contravention of her advance health care directives are rare,²⁴ those cases that have occurred nevertheless raise serious concerns about whether pregnancy exclusion statutes violate these women’s constitutional rights to refuse lifesaving care and to terminate a nonviable pregnancy.

This Note proceeds as follows: Part I provides general background on advance health care directives and pregnancy exclusion laws, followed by a survey of current state pregnancy exclusion statutes that categorizes the laws into five different types based on restrictiveness. Building on existing scholarship, this Note employs a new five-category typology to account for important variations in statutory language and analyzes the constitutional impact of pregnancy exclusion laws as they apply to all advance directives—both living wills and the use of health care proxies. Part II then argues that all existing pregnancy exclusion laws are unconstitutional because laws that force physicians to void a pregnant patient’s advance directives violate a woman’s right to terminate a pregnancy under the *Planned Parenthood v. Casey* “undue burden” standard.²⁵ Part II further argues that all state pregnancy exclusion laws also violate an individual’s right to refuse lifesaving medical treatment under *Cruzan v. Director, Missouri Department*

court he “said little to him was recognizable about his wife. Her bones crack when her stiff limbs move. Her usual scent has been replaced by the ‘smell of death.’ And her once lively eyes have become ‘soulless.’” Caleb Hellerman et al., *Brain-Dead Texas Woman Taken Off Ventilator*, CNN (Jan. 27, 2014, 7:26 AM), <https://www.cnn.com/2014/01/26/health/texas-pregnant-brain-dead-woman> [<https://perma.cc/P6LL-692Q>]. Similar deterioration, such as wasting muscles, skin breakdown, and the formation of ulcers can occur in pregnant women in a persistent vegetative state due to the continuation of life-support technology. See Cheryl Arenella, *Coma and Persistent Vegetative State: An Exploration of Terms*, AM. HOSPICE FOUND., <https://americanhospice.org/caregiving/coma-and-persistent-vegetative-state-an-exploration-of-terms> [<https://perma.cc/G8BY-M6DT>].

²³ Elizabeth Villarreal, *Pregnancy and Living Wills: A Behavioral Economic Analysis*, 128 YALE L.J. F. 1052 (Apr. 8, 2019).

²⁴ A medical case study reports that a MEDLINE search of the terms “pregnancy” and “persistent vegetative state” showed only twenty cases of pregnant patients in a persistent vegetative state from December 1977 through January 2016. Matthew P. Romagano et al., *Treatment of a Pregnant Patient in a Persistent Vegetative State*, 129 OBSTETRICS & GYNECOLOGY 107, 108 (2017). It is unclear how many of those cases involved physicians voiding the advance directives of pregnant patients in a persistent vegetative state.

²⁵ See 505 U.S. 833, 877–79 (1992) (holding the state’s interest in protecting the potential life of a fetus does not override the right of a woman to have an abortion until after viability, and before viability the state may only regulate that right to the extent the regulation does not pose an “undue burden” to exercising it).

of Health,²⁶ especially in cases where a woman has clearly communicated her end-of-life wishes in the case of pregnancy. Part III argues that pregnancy exclusion laws as they currently exist are further objectionable because they violate basic bioethical principles by restricting the autonomy of competent individuals to make informed decisions relating to their end-of-life care. This argument is novel and will be critical if pregnancy exclusion statutes are narrowly upheld as constitutional in the future, and it also informs appropriate reforms to the existing laws. To conclude, Part IV proposes reforms to state pregnancy exclusion statutes that would bring them into compliance with both the Constitution and today's bioethical principles.

I. ADVANCE DIRECTIVES AND PREGNANCY EXCLUSION STATUTES

Advance health care directives allow people to state their health care treatment wishes in anticipation of being unable to make those decisions, including their preferences to refuse or end life-sustaining medical treatment.²⁷ Advance health care directives can be instructional, such as a living will that specifies treatment preferences in certain scenarios, or can designate a health care agent to make those decisions for the patient.²⁸ To create a living will, a competent person signs a witnessed directive instructing a “physician to withhold or withdraw medical interventions” under certain future conditions if the person is unable to make medical decisions.²⁹ A living will could include instructions on “life support or breathing machines, the denial of tube feeding, and whether or not the individual would like her organs and tissues donated.”³⁰ To create a durable health care power of attorney, a competent person signs a witnessed document designating a proxy “to make health care decisions” for the person if she becomes “unable to make such decisions” in the future.³¹ A person may choose to execute both a living will expressing her end-of-life wishes in specific situations, as well as a health care power of attorney to designate a decision-making proxy for potential situations not covered in a living will.³²

²⁶ 497 U.S. 261, 284–87 (1990) (recognizing a patient's right to remove life support if there is “clear and convincing evidence” of a patient's wishes). This case prompted the creation of advance directives. See UNIF. HEALTH-CARE DECISIONS ACT prefatory note at 1 (UNIF. LAW COMM'N 1994).

²⁷ See UNIF. HEALTH-CARE DECISIONS ACT §§ 2(a)–(b) (UNIF. LAW COMM'N 1994).

²⁸ See *id.* Advance directives can also take the form of a hybrid approach, where the patient gives instructions for certain situations, and designates a proxy for other situations. See *id.* § 2(e).

²⁹ PATIENTS RTS. COUNCIL, *supra* note 9.

³⁰ Hannah Schwager, Note, *The Implications of Exclusion: How Pregnancy Exclusions Deny Women Constitutional Rights*, 13 CARDOZO PUB. L. POL'Y & ETHICS J. 595, 597 (2015).

³¹ PATIENTS RTS. COUNCIL, *supra* note 9.

³² Villarreal, *supra* note 23.

When a health care proxy makes decisions on behalf of an incompetent patient, the agent engages in substitute decision-making by speaking for the patient—ultimately becoming the “voice of the principal.”³³ This means that when a health care agent conveys that the wishes of a patient are to remove lifesaving medical treatment, it is legally the patient exercising her constitutional right.³⁴ Accordingly, an action that conflicts with or ignores a proxy’s directives on behalf of a patient implicates the patient’s rights, rather than the proxy’s secondary exercise of that right.³⁵ Though dependent largely on state law,³⁶ a proxy is generally bound to make good-faith decisions on behalf of the patient, and such decisions can be challenged by individuals with standing who believe a decision is made in bad faith or is contrary to the patient’s wishes.³⁷ There are a number of people who may serve as a health care agent depending on the patient’s preferences; however, the patient’s attending physician may not be appointed as a health care agent.³⁸

In the absence of advance directives, responsibility for an incompetent patient’s health care decisions usually falls to the patient’s spouse or next of kin.³⁹ When health care agents are responsible for making end-of-life health care decisions for an incompetent patient, state law holds them to a “substituted judgment” standard, based on what they believe the patient would have chosen in that situation, or a “best interests” standard, which gives the agent more discretion to make decisions based on what they believe is best for the patient.⁴⁰ Most courts use a “substituted judgment” standard

³³ Wendy H. Sheinberg, *In Matters of Life and Death: Do Our Clients Truly Give Informed Consent?*, 71 N.Y. ST. B.J. 36, 39 (1999).

³⁴ See Sally J.T. Necheles, *Individual Right to Refuse Treatment Despite Failure to Take Advantage of Statutory Mechanisms*, 77 C.J.S. *Right to Die* § 9 (2019) (explaining that a health care proxy is not the only way for an individual to exercise his or her constitutional right to refuse life-sustaining treatment, as the court may appoint a conservator in some scenarios).

³⁵ Catherine J. Jones, *Decisionmaking at the End of Life*, 63 AM. JUR. *Trials* 1 §§ 32–34 (2019); see Sheinberg, *supra* note 33, at 39–40.

³⁶ All fifty states and the District of Columbia have statutes providing for a durable power of attorney. See Claire C. Obade, *Patient Care Decision-Making: A Legal Guide for Providers* § 11.2 (2018).

³⁷ See, e.g., Sheinberg, *supra* note 33, at 40.

³⁸ Jones, *supra* note 35, § 34.

³⁹ Unif. Health-Care Decisions Act § 5(b) (providing that in the absence of an advance directive, decisions are to be made by surrogates in the following order: spouse, unless legally separated; adult child; parent; or adult sibling).

⁴⁰ See, e.g., Lawrence A. Frolik & Linda S. Whitton, *The UPC Substituted Judgment/Best Interest Standard for Guardian Decisions: A Proposal for Reform*, 45 U. MICH. J.L. REFORM 739, 739–40, 742–43 (2012) (comparing the UPC’s old best interests standard which “instructs guardians to ‘consider the expressed desires and personal values of the ward’ when making decisions and to ‘at all times . . . act in the ward’s best interest,’” with the UPC’s new substituted judgment standard, which requires “guardians to consider what the incapacitated person would want”).

that evaluates whether the incompetent patient would have refused lifesaving medical treatment under the circumstances.⁴¹ The most important consideration is the patient's expressed wishes before becoming incompetent, such as any recent statements to family or friends about not wanting "to be a vegetable" or wanting to be sustained by life support.⁴²

State legislatures began developing pregnancy exclusion statutes around the 1980s in an effort to gain widespread "support for advance directives laws."⁴³ Coming on the heels of an intense abortion debate surrounding *Roe v. Wade*,⁴⁴ exceptions to advance directives laws that would protect fetuses helped make these laws more palatable to those who would otherwise be concerned about them.⁴⁵ California was one of the first states to pass advance directives legislation in 1976 by legalizing patients' directives to physicians to withhold or withdraw medical treatment.⁴⁶ The ethical debate on the California Natural Death Act mainly focused on clarifying that the right to die a natural death did not facilitate patient suicide, allowing the potential consequences of the pregnancy exclusion to be largely overlooked.⁴⁷ For instance, in explaining the features of the recently passed California Natural Death Act at a medical staff conference, the author of the legislation briefly explained that "[t]he clause that the directive could not be effectuated if the signator were pregnant was one of the collateral ethical issues we simply did not want to get involved in. It would have brought the whole question of abortion into the legislative dialogue."⁴⁸

⁴¹ Karl A. Menninger, *Proof of Basis for Refusal or Discontinuance of Life-Sustaining Treatment on Behalf of Incapacitated Person*, 40 AM. JUR. 3D *Proof of Facts* 287 § 13 & n.21 (2019) (providing examples of courts applying the substituted judgment standard).

⁴² *Id.* § 13. Courts also have evaluated other factors to infer what an incompetent patient would have decided, such as "[t]he patient's age[,] [t]he probable side effects of treatment[,] [t]he likelihood that the treatment will cause suffering[,] [t]he patient's reaction to medical treatment of others[,] [t]he patient's religious beliefs[, and] [t]he patient's prognosis with and without the treatment." *Id.*

⁴³ See Villarreal, *supra* note 23, at 1054 (explaining that state legislatures added pregnancy exclusions to advance directives laws to "sidestep the abortion debate").

⁴⁴ 410 U.S. 113 (1973); see Villarreal, *supra* note 23, at 1054 (explaining that "limitations on advance directives for pregnant women have been part of the contentious fight around the ethics of abortion").

⁴⁵ Fernandez & Eckholm, *supra* note 1.

⁴⁶ CAL. ANN. HEALTH & SAFETY CODE §§ 7185–7195 (1976) (repealed 2000); Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211, 213 (2010).

⁴⁷ In the late 1970s, many doctors were "taught to regard death as an enemy and to do all they can to defeat it . . . [and] [m]any regard 'pulling the plug' as an act akin to euthanasia, which is forbidden by both law and the medical code." *A Life in the Balance*, TIME, Nov. 3, 1975; see, e.g., California's Natural Death Act—Medical Staff Conference, Univ. of Cal., San Francisco, 128 W.J. MED. 318, 326 (1978) ("It has never been labeled suicide for a patient to refuse treatment and such a decision has been invariably respected by physicians and by the law.").

⁴⁸ *Id.* at 322.

After the passage of advance directives legislation in California, forty-one states followed suit and adopted similar advance directives legislation by 1986.⁴⁹ In 1990, the Supreme Court addressed whether a person has a constitutional right to refuse lifesaving medical treatment in *Cruzan v. Director, Missouri Department of Health*.⁵⁰ The controversy focused on whether the parents of Nancy Cruzan, a patient in a persistent vegetative state caused by a car accident, could direct physicians to remove life-sustaining treatment because Nancy would have wanted that decision.⁵¹ The Court assumed that a competent patient has “a constitutionally protected right to refuse lifesaving hydration and nutrition,” and held that an incompetent patient’s surrogates may communicate the patient’s wishes to remove lifesaving medical treatment if they meet a high burden of proof.⁵² Shortly after *Cruzan*, Congress passed the Patient Self-Determination Act of 1991, which operates as an information mandate by requiring that medical facilities receiving Medicare or Medicaid funds inform patients of their right to establish advance directives and comply with applicable state law governing advance directives.⁵³ However, the Act does not explicitly require medical facilities to inform pregnant patients that their advance directives may be voided according to applicable state law.⁵⁴

Currently, only fourteen states do not have a law restricting a physician from honoring a pregnant woman’s advance health care directives.⁵⁵ The

⁴⁹ See Sabatino, *supra* note 46, at 214.

⁵⁰ *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 269 (1990).

⁵¹ *Id.* at 266–68.

⁵² *Id.* at 279–80. The Court noted that the majority of states would require a high burden of proof to show that “the patient would have indeed wanted to end the life-sustaining treatment.” Schwager, *supra* note 30, at 600. In this case, Missouri’s burden of proof was a “clear and convincing evidence” requirement, and the existence of advance directives would be sufficient to meet this requirement. *Cruzan*, 497 U.S. at 280; Schwager, *supra* note 30, at 600.

⁵³ 42 U.S.C. § 1395cc(f) (2012).

⁵⁴ *Id.*; MEGAN GREENE & LESLIE R. WOLFE, CTR. FOR WOMEN POLICY STUDIES, PREGNANCY EXCLUSIONS IN STATE LIVING WILL AND MEDICAL PROXY STATUTES 6 (2012), http://www.centerwomenpolicy.org/programs/health/statepolicy/documents/REPRO_PregnancyExclusionsinStateLivingWillandMedicalProxyStatutesMeganGreeneandLeslieR.Wolfe.pdf [<https://perma.cc/384Q-74K3>] (arguing that “[o]ne of the biggest problems with pregnancy exclusions is that there is virtually no public awareness that they even exist, in part because there is no uniformity in the way in which pregnancy exclusion clauses are written into state statutes and they often appear under ambiguous or unrelated titles”); see also Letter from Katherine S. Kohari, MD, Asst. Professor & Associate Medical Dir., Yale School of Med. (Mar. 2, 2018) (writing in support of H.B. 5148).

⁵⁵ As of December 2019, fourteen states do not have a “pregnancy exclusion” law: California, Hawaii, Louisiana, Maine, Massachusetts, Mississippi, New Mexico, New York, North Carolina, Oregon, Tennessee, Virginia, West Virginia, and Wyoming. See *infra* app. However, states that do not have pregnancy exclusion laws may have “conscience clauses” in their respective advance directives legislation, which permit physicians to opt out of withholding life-sustaining treatment. See, e.g., HAW.

remaining thirty-six states have varying types of pregnancy exclusion laws that share one commonality in their statutes' language: they restrict physicians from removing life-sustaining treatment from a patient.⁵⁶ Assuming other state courts would interpret this language as the Texas state court did in 2014, the life-sustaining treatment requirement would not require physicians to prolong the use of artificial medical treatment to those who are deemed brain-dead; it would, however, require a physician to prolong treatment to patients in a persistent vegetative state, minimally conscious state,⁵⁷ or other types of severe brain disabilities short of brain death where removing life support is contemplated.⁵⁸ This Note focuses on women in a persistent vegetative state.

REV. STAT. § 327E-7(e) (1999) (“A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience.”).

⁵⁶ See ARIZ. REV. STAT. ANN. § 36-3262 (2018); CONN. GEN. STAT. ANN. § 19a-575a (2018); COLO. REV. STAT. ANN. § 15-18-104(2) (2018); NEV. REV. STAT. ANN. § 449A.451 (2018); S.C. CODE ANN. § 62-5-507 (2018); N.H. REV. STAT. ANN. § 137-J:10 (2018); IDAHO CODE ANN. § 39-4510 (2019); VT. STAT. ANN. tit. 18, § 9702 (2018); UTAH CODE ANN. § 75-2a-123 (2018); GA. CODE ANN. § 31-32-9 (2018); 755 ILL. COMP. STAT. ANN. 35/3(c) (2018); MD. CODE ANN. HEALTH-GEN. § 5-603 (2018); WIS. STAT. § 154.03 (2018); OKLA. STAT. tit. 63, § 3101.8(c) (2018); 20 PA. STAT. AND CONS. STAT. ANN. § 5429 (2018); N.D. CENT. CODE ANN. § 23-06.5-09(5) (2017); ALASKA STAT. ANN. § 13.52.055(c) (2018); MICH. COMP. LAWS § 700.5512 (2018); ARK. CODE ANN. § 20-17-206(c) (2018); MONT. CODE ANN. § 50-9-202(3) (2019); ALA. CODE § 22-8A-4(e) (2018); TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 2019); DEL. CODE ANN. tit. 16, § 2503(j) (2018); KY. REV. STAT. ANN. § 311.629 (2018); KAN. STAT. ANN. § 65-28, 103 (2016); IND. CODE § 16-36-4-8(d) (West 2017); FLA. STAT. ANN. § 765.113 (2019); NEB. REV. STAT. ANN. § 20-408 (2018); N.J. STAT. ANN. § 26:2H-56 (2018); 23 R.I. GEN. LAWS ANN. § 23-4.11-6(c) (2018); WASH. REV. CODE ANN. § 70.122.030 (2019); MINN. STAT. ANN. § 145B.13(3) (2019); OHIO REV. CODE ANN. § 2133.06 (2018); S.D. CODIFIED LAWS § 34-12D-10 (2018); IOWA CODE ANN. § 144A.6 (2018); MO. ANN. STAT. § 459.025 (2018).

⁵⁷ See Fins, *supra* note 13 (“Unlike the vegetative state, [the minimally conscious state (MCS)] is a state of consciousness. MCS patients demonstrate unequivocal, but fluctuating, evidence of awareness of self and the environment. They may say words or phrases and gesture. They also may show evidence of memory, attention, and intention. . . . The prognosis can be fixed or open-ended, with rare occurrences of dramatic recoveries of emergence from MCS years and decades after injury.”).

⁵⁸ See Judgment, *supra* note 6. While other states may not share the same interpretation of “life-sustaining treatment,” a medical ethicist who helped write the Texas law at issue in the Muñoz case stated that the Texas court interpreted the statute correctly because the statute “applies only if the woman is alive.” Melissa Repko, *Fort Worth Hospital Withdraws Life Support for Pregnant, Brain-Dead Woman*, DALL. MORNING NEWS (Jan. 26, 2014, 11:37 PM), <https://www.dallasnews.com/news/2014/01/27/fort-worth-hospital-withdraws-life-support-for-pregnant-brain-dead-woman> [https://perma.cc/3MRD-8DGC]. However, a Georgia superior court has held that a brain-dead pregnant woman could not be removed from life support despite her husband’s wishes, reasoning that “the privacy rights of the mother are not a factor in this case because the mother is dead” *Univ. Health Servs. Inc. v. Piazzi*, No. CV86-RCCV-464, at *416–17 (Ga. Super. Ct. Aug. 4, 1986), http://www.thaddeuspope.com/images/Univrsity_Health_v_Piazzi_Ga_Sup_1986_.pdf [https://perma.cc/4MVZ-AGY2].

Though the constitutionality of pregnancy exclusion laws has not yet been settled in U.S. courts,⁵⁹ it has been questioned in recent years.⁶⁰ For example, Hannah Schwager analyzed the constitutionality of pregnancy exclusion statutes by employing the Center for Women Policy Studies' (CWPS) 2012 study. The study categorized state pregnancy exclusion laws into five groups based on restrictiveness: (1) the most restrictive states, (2) the *Uniform Rights of the Terminally Ill Act* (URTIA) states that restrict based on "probable development" of a fetus to live birth, (3) the viability standard states, (4) the silent states, and (5) the states that explicitly explain that a woman can specify in her advance directives her desires in the case of pregnancy.⁶¹ Schwager focused her analysis only on CWPS's most restrictive categories, arguing that states that void the advance directives of all pregnant patients, no matter the circumstances, violate the constitutional rights to terminate a nonviable pregnancy and to refuse lifesaving medical treatment.⁶² In her analysis, Schwager also only discussed cases where a pregnant woman's end-of-life wishes have been executed in living wills, leaving a scholarly gap in how to apply these constitutional principles to situations where a health care agent expresses a pregnant patient's end-of-life wishes in the absence of specific advance directives.⁶³ Nikolas Youngsmith, another student author who, like Schwager, focused his analysis on the strictest form,⁶⁴ has argued that using the abortion framework to analyze pregnancy exclusion statutes is misguided, and that pregnancy exclusion statutes should be analyzed as an unconstitutional infringement on the right to bodily autonomy.⁶⁵ Finally, Elizabeth Villarreal recently applied a behavioral economic analysis to pregnancy exclusion laws to argue that advance directives law can be drafted to "more accurately capture women's

⁵⁹ See *supra* note 15.

⁶⁰ See, e.g., Wendy Adele Humphrey, "But I'm Brain-Dead and Pregnant": *Advance Directive Pregnancy Exclusions and End-of-Life Wishes*, 21 WM. & MARY J. WOMEN & L. 669 (2015) (arguing pregnancy exclusion laws implicate the rights to terminate a pregnancy and to refuse medical treatment); Schwager, *supra* note 30, at 607–23 (arguing pregnancy exclusion laws implicate the right to privacy, right to bodily integrity, gender discrimination, and potentially the Establishment Clause); Nikolas Youngsmith, Note, *The Muddled Milieu of Pregnancy Exceptions and Abortion Restrictions*, 49 COLUM. HUM. RTS. L. REV. 415 (2018) (arguing that pregnancy exclusion laws implicate the right to refuse lifesaving medical treatment, and that this framework is more appropriate to challenge pregnancy exclusion laws than the right to terminate a pregnancy); Villarreal, *supra* note 23 (arguing pregnancy exclusion laws appear to violate the constitutional rights to terminate a pregnancy and refuse unwanted medical treatment).

⁶¹ Schwager, *supra* note 30, at 601–07; see GREENE & WOLFE, *supra* note 54, at 3.

⁶² See Schwager, *supra* note 30, at 607, 614–20.

⁶³ *Id.* at 597, 599.

⁶⁴ Youngsmith, *supra* note 60, at 426.

⁶⁵ *Id.* at 418–21, 434.

preferences and, in the process, provide women with greater individual autonomy.”⁶⁶

Building on this scholarship, this Note employs a new five-category typology to analyze the constitutional impact of pregnancy exclusion laws as they apply to all advance directives—both living wills and the use of health care proxies. It is necessary to create a new five-category typology in light of the complexity and variation of modern pregnancy exclusion laws, and because some future court may determine, contra this Note’s conclusions, that some categories of these laws are constitutional while others are not.

Conducting an updated fifty-state survey, this Note categorizes current pregnancy exclusion laws into five general types based on restrictiveness. These categories reflect whether, when a pregnant patient is on life support, the laws treat her advance directives as (1) Void Per Se; (2) Void if the Fetus Can Develop to Birth at Some Level of Certainty; (3) Void Unless an Ethical Condition Is Met; or (4) Void Unless the Woman Specifically States “In the Case of Pregnancy”; the fifth category is for laws that (5) Honor Directives if Pregnant, Unless the Fetus Is Viable. In contrast, the CWPS study cited by Schwager grouped many states into a category called “the URTIA states,” and the URTIA provides that “a pregnant woman be given life-sustaining treatment if she is pregnant and if it is ‘probable’ that the fetus will develop to the point of ‘live birth.’”⁶⁷ But this single categorization ignores important variations of the levels of certainty required by states in what this Note calls “Category Two” restrictions, which include not only “probable development” to live birth, but also “possible” development, or the absence of “reasonable medical certainty that a fetus could not be brought to term.”⁶⁸ These additional two levels of certainty are much broader than the URTIA’s term “probable,” and lead to important analytical outcomes when evaluating the constitutional effect of this language.⁶⁹ The CWPS study also includes states such as New Hampshire, North Dakota, Pennsylvania, and South Dakota in “the URTIA states,” even though these states make certain exceptions based on physical harm to the woman or “severe pain which cannot be alleviated by medication.”⁷⁰ These states warrant their own category because they attempt to balance the rights of the woman and fetus in a way that is constitutionally problematic.⁷¹ This Part proceeds to explain

⁶⁶ Villarreal, *supra* note 23, at 1052.

⁶⁷ GREENE & WOLFE, *supra* note 54, at 3–4.

⁶⁸ *See infra* Section I.B.

⁶⁹ *See infra* Section II.A.2.

⁷⁰ GREENE & WOLFE, *supra* note 54, at 4.

⁷¹ *See infra* Section I.C.

each of this Note's five categories of pregnancy exclusion laws in further detail.

A. Category One: Void Per Se

As of December 2019, there are ten states that void a pregnant woman's advance health care directives "per se" in all circumstances, no matter how far along the fetus is, whether it would cause the woman pain or harm, or whether the fetus could be brought to term without complications or deformities.⁷² This category constitutes the most restrictive and constitutionally suspect type of pregnancy exclusion law out of all five categories. Category One laws prohibit a physician from removing life support from a pregnant woman despite a clear statement in her advance directives that that is what she wants—even if that woman directed that her end-of-life preferences would not change in the case of pregnancy.⁷³

B. Category Two: Void if the Fetus Can Develop to Birth at Some Level of Certainty

Eleven states void a pregnant woman's advance health care directives based on three different levels of knowledge the physician has about whether the fetus can potentially develop to live birth: (1) "probable," (2) "possible," or (3) unless there is "reasonable medical certainty" that the fetus cannot be

⁷² Those states are Alabama, Idaho, Indiana, Kansas, Michigan, Missouri, South Carolina, Texas, Utah, and Wisconsin. ALA. CODE § 22-8A-4(e) (2018) ("The advance directive for health care of a declarant who is known by the attending physician to be pregnant shall have no effect during the course of the declarant's pregnancy."); IDAHO CODE ANN. § 39-4510 (2018) ("If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy."); IND. CODE § 16-36-4-8(d) (West 2017) ("The living will declaration of a person diagnosed as pregnant by the attending physician has no effect during the person's pregnancy."); KAN. STAT. ANN. § 65-28, 103 (2016) ("The declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient's pregnancy."); MICH. COMP. LAWS. § 700.5512(1) (2018) ("A patient advocate cannot make a medical treatment decision . . . to withhold or withdraw treatment from a pregnant patient that would result in the pregnant patient's death."); MO. ANN. STAT. § 459.025 (2018) ("The declaration to withdraw or withhold treatment by a patient diagnosed as pregnant by the attending physician shall have no effect during the course of the declarant's pregnancy."); S.C. CODE ANN. § 62-5-507 (2018) ("If a principal has been diagnosed as pregnant, life-sustaining procedures may not be withheld or withdrawn pursuant to the health care power of attorney during the course of the principal's pregnancy."); TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 2019) ("A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient."); UTAH CODE ANN. § 75-2a-123(1) (2018) ("A health care directive that provides for the withholding or withdrawal of life sustaining procedures has no force during the course of a declarant's pregnancy."); WIS. STAT. § 154.03(2) (2018) ("If you know that the patient is pregnant, this document [DECLARATION TO PHYSICIANS] has no effect during her pregnancy.").

⁷³ See Villarreal, *supra* note 23, at 1059 (explaining that laws that "automatically invalidate a woman's living will . . . are indifferent to whether the living will was created prior to or during a pregnancy, or whether the will specifically contemplates the possibility that the writer may become pregnant").

born.⁷⁴ Six states void a pregnant woman's advance directives if a physician determines it is "probable" the fetus can develop to live birth or viability,⁷⁵ while four do so if a physician determines it is "possible."⁷⁶ Ohio voids a pregnant woman's advance directives unless there is a "reasonable degree of medical certainty . . . that the fetus would not be born alive."⁷⁷ Under any of these state laws, if a physician finds that the required level of certainty of a

⁷⁴ Those states are Alaska, Arkansas, Delaware, Illinois, Iowa, Minnesota, Montana, Nebraska, Nevada, Ohio, and Rhode Island. Of these three sub-categories, "probable" is the least restrictive and "reasonable medical certainty" is the most restrictive.

⁷⁵ Importantly, Alaska and Delaware's pregnancy exclusion statutes contain the permissive language "may not be given effect," instead of the more standard mandatory language of "cannot," "shall not," and "shall be given no force" contained in the pregnancy exclusion statutes of Montana, Nebraska, Nevada, and Rhode Island. It is ambiguous whether the apparently permissive language would be interpreted as to allow hospitals to void a pregnant woman's advance directives, rather than require hospitals to void them, as in the states with mandatory language. Compare ALASKA STAT. ANN. § 13.52.055(b) (2018) ("[A]n advance health care directive by a patient or a decision by the person then authorized to make health care decisions for a patient may not be given effect if[:] (1) the patient is a woman who is pregnant and lacks capacity . . . [and] it is probable that the fetus could develop to the point of live birth if the life-sustaining procedures were provided."), and DEL. CODE ANN. tit. 16, § 2503(j) (2018) ("A life-sustaining procedure may not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of a life-sustaining procedure."), with MONT. CODE ANN. § 50-9-202(3) (2019) ("Life-sustaining treatment cannot be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician . . . to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment."), NEB. REV. STAT. ANN. § 20-408(3) (2018) ("Life-sustaining treatment shall not be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment."), NEV. REV. STAT. ANN. § 449A.451 (2018) ("Life-sustaining treatment must not be withheld or withdrawn pursuant to a declaration from a qualified patient known to the attending physician . . . to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment."), and 23 R.I. GEN. LAWS ANN. § 23-4.11-6(c) (2018) ("The declaration of a qualified patient known to the attending physician to be pregnant shall be given no force or effect as long as it is probable that the fetus could develop to the point of live birth with continued application of life sustaining procedures.").

⁷⁶ ARK. CODE ANN. § 20-17-206(c) (2018) ("The declaration of a qualified patient known to the attending physician to be pregnant 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."); 755 ILL. COMP. STAT. ANN. 35/3(c) (2018) ("The declaration of a qualified patient diagnosed as pregnant by the attending physician shall be given no force and effect as long as in the opinion of the attending physician it is possible that the fetus could develop to the point of live birth with the continued application of death delaying procedures."); IOWA CODE ANN. § 144A.6 (2018) ("The declaration of a qualified patient known to the attending physician to be pregnant shall not be in effect as long as the fetus could develop to the point of live birth with continued application of life-sustaining procedures."); MINN. STAT. ANN. § 145B.13(3) (2019) ("[T]he 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.").

⁷⁷ OHIO REV. CODE ANN. § 2133.06 (2018) ("Life-sustaining treatment shall not be withheld or withdrawn from a declarant . . . if the declarant is pregnant . . . unless the declarant's attending physician and one other physician . . . determine, to a reasonable degree of medical certainty . . . that the fetus would not be born alive.").

live birth or viability is met, then the physician is required to void the woman's advance health care directives (or, in the cases of Alaska and Delaware, they are at least enabled to)—even if the woman clearly stated that her end-of-life preferences would not change in the case of pregnancy.⁷⁸

C. Category Three: Void Unless an Ethical Condition Is Met

Five states currently void a pregnant woman's advance directives based on the existence of at least one condition that takes into account potential health consequences to the pregnant woman or the chance the fetus could develop to term. Kentucky voids a pregnant woman's advance directives unless treatment (1) will not permit live birth, (2) "will be physically harmful to the woman," or (3) will "prolong severe pain which cannot be alleviated by medication."⁷⁹ Similarly, New Hampshire, North Dakota, and South Dakota void a pregnant woman's advance directives unless (1) the fetus will not develop to live birth, (2) treatment will be "physically harmful" or "unreasonably painful" to the woman, or (3) treatment will "prolong severe pain that cannot be alleviated by medication."⁸⁰ Lastly, Pennsylvania's

⁷⁸ See GREENE & WOLFE, *supra* note 54, at 4 (explaining that the URTIA originally included the phrase "unless the declaration otherwise provides," but this phrase was ultimately removed from its final form—ensuring that advance directives would still be voided "regardless of the woman's expressed desires to the contrary").

⁷⁹ KY. REV. STAT. ANN. § 311.629(4) (2018) ("Notwithstanding the execution of an advance directive, life sustaining treatment and artificially-provided nutrition and hydration shall be provided to a pregnant woman unless, to a reasonable degree of medical certainty, as certified on the woman's medical chart by the attending physician and one (1) other physician who has examined the woman, the procedures will not maintain the woman in a way to permit the continuing development and live birth of the unborn child, will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication.").

⁸⁰ N.H. REV. STAT. ANN. § 137-J:10 (2018) ("Nothing in this chapter shall be construed to condone, authorize, or approve: (a) The consent to withhold or withdraw life-sustaining treatment from a pregnant principal, unless, to a reasonable degree of medical certainty, . . . such treatment or procedures will not maintain the principal in such a way as to permit the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication."); N.D. CENT. CODE ANN. § 23-06.5-09(5) (2017) ("Notwithstanding a contrary direction contained in a health care directive executed under this chapter, health care must be provided to a pregnant principal unless, to a reasonable degree of medical certainty . . . such health care will not maintain the principal in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful or unreasonably painful to the principal or will prolong severe pain that cannot be alleviated by medication."); S.D. CODIFIED LAWS § 34-12D-10 (2018) ("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.").

statute is similar to these with an additional requirement honoring a woman's advance directive if it is probable the fetus cannot be brought to a live birth.⁸¹

Based on the language used in the state statute variations, physicians hold great power over whether they will choose to honor or void a pregnant woman's advance directives due to the medical determinations required to apply the statute, and must only take the above considerations into account. This is because “[n]o doctor, judge or legislative body can possibly determine with any certainty when a fetus has reached a point in development at which it will ‘probably’ reach live birth.”⁸²

Furthermore, anecdotal evidence suggests that physicians experience confusion on exactly what the law requires when treating pregnant patients in a persistent vegetative state. For example, there has been at least one case where Pennsylvania physicians rejected a family's requests to remove lifesaving treatment from a pregnant patient in a persistent vegetative state.⁸³ The physicians there cited the Pennsylvania law to justify continued treatment, though they disagreed about the right thing to do.⁸⁴ The physicians acknowledged the great weight of the decision they were forced to make under the law, and reported that there were “strongly held differences of opinion among the caregivers”—some feeling “uncomfortable with the decision to maintain [the] patient on artificial nutrition and a ventilator” and some feeling “her family's initial request to withdraw life support should have been honored.”⁸⁵

D. Category Four: Void Unless the Woman Specifically States “In the Case of Pregnancy”

Nine states provide a clear option for a woman to state in advance health care directives what her wish would be in the case of pregnancy.⁸⁶ These

⁸¹ 20 PA. STAT. AND CONS. STAT. ANN. § 5429(a)(2018) (“Notwithstanding the existence of a living will, a health care decision by a health care representative or health care agent or any other direction to the contrary, life-sustaining treatment, nutrition and hydration shall be provided to a pregnant woman who is incompetent and has an end-stage medical condition or who is permanently unconscious 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) will cause pain to the pregnant woman that cannot be alleviated by medication.”).

⁸² GREENE & WOLFE, *supra* note 54, at 6.

⁸³ See Romagano et al., *supra* note 24, at 107, 110.

⁸⁴ See *id.*; 20 PA. STAT. AND CONS. STAT. ANN. § 5429.

⁸⁵ Romagano et al., *supra* note 24, at 110.

⁸⁶ Those states are Arizona, Florida, Oklahoma, Connecticut, Georgia, Maryland, New Jersey, Vermont, and Washington. FLA. STAT. ANN. § 765.113 (2019); ARIZ. REV. STAT. ANN. § 36-3262 (2018) (“Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live

types of laws may still void a pregnant woman's advance health care directives that direct a physician to remove life-sustaining treatment if there is no specification in her advance directives about how those preferences would change in the case of pregnancy.⁸⁷ Furthermore, in the absence of advance directives, these types of laws may also prohibit a physician from honoring the decision of a pregnant woman's health care agent to remove life support, even if the fetus is not viable.⁸⁸

E. Category Five: Honor if Pregnant, Unless the Fetus Is Viable

Colorado is the only state with a pregnancy exclusion statute that honors a pregnant woman's advance health care directives to remove life-sustaining treatment before viability, even if the woman does not state specifically if her preferences would change in the case of pregnancy.⁸⁹ Under Colorado's statute, a physician must honor a woman's advance directives to remove life-sustaining treatment if the fetus is not yet viable and must void a woman's advance directives if the fetus is viable.⁹⁰ This law also allows physicians to honor the decisions of a health care agent in the absence of advance directives as long as this decision is made prior to fetal viability.⁹¹ Furthermore, this law should not allow physicians to honor a health care agent's request to maintain life support of a pregnant woman pre-viability if the woman had advance directives directing removal of life support.⁹² This could potentially place physicians in an uncomfortable position if there is

birth with the continued application of life-sustaining treatment.”); OKLA. STAT. tit. 63, § 3101.8(c) (2018) (“[T]he pregnant patient shall be provided with life-sustaining treatment and artificially administered hydration and nutrition, unless the patient has specifically authorized, in her own words, that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.”); CONN. GEN. STAT. ANN. § 19a-575a (2018); GA. CODE ANN. § 31-32-9 (2018); MD. CODE ANN. HEALTH-GEN. § 5-603 (2018); N.J. STAT. ANN. § 26:2H-56 (2018); VT. STAT. ANN. tit. 18, § 9702 (2018); WASH. REV. CODE ANN. § 70.122.030 (2019).

⁸⁷ See statutes cited *supra* note 86. Arizona does not automatically void a pregnant woman's advance health care directive if there is no specification about how her preferences would change in the case of pregnancy, but rather may void a directive if it is “possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.” ARIZ. REV. STAT. ANN. § 36-3262 (2018).

⁸⁸ See, e.g., FLA. STAT. ANN. § 765.113 (“Unless the principal expressly delegates such authority to the surrogate in writing, or a surrogate or proxy has sought and received court approval . . . a surrogate or proxy may not provide consent for . . . [w]ithholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability . . .”).

⁸⁹ COLO. REV. STAT. ANN. § 15-18-104(2) (2018) (“In the case of a declaration of a qualified patient known to the attending physician to be pregnant, a medical evaluation shall be made as to whether the fetus is viable. If the fetus is viable, the declaration shall be given no force or effect until the patient is no longer pregnant.”).

⁹⁰ *Id.*

⁹¹ See *id.* §§ 15-18-104(1)–(2).

⁹² See *id.*

compelling evidence that the woman would have changed her mind and wanted to sustain the fetus to birth.⁹³

II. UNCONSTITUTIONALITY OF STATE PREGNANCY EXCLUSION STATUTES

The five categories of state pregnancy exclusion laws described above raise substantial concerns when analyzed in light of a woman’s constitutional right to decide not to continue a pregnancy and to refuse lifesaving medical treatment.⁹⁴ This Part argues that all categories of pregnancy exclusion laws that void a woman’s advance directives or her health care agent’s directives to remove life support before fetal viability are unconstitutional under the *Planned Parenthood v. Casey* “undue burden” framework.⁹⁵ Furthermore, such statutes violate the constitutional right to refuse unwanted lifesaving medical treatment under *Cruzan v. Director, Missouri Department of Health*.⁹⁶ Part II provides an overview of the constitutional rights articulated in *Casey* and *Cruzan*, and applies those frameworks to all five categories of pregnancy exclusion statutes.

A. Right to Terminate a Pregnancy

First, it is appropriate to analyze pregnancy exclusion statutes under an abortion restriction framework because pregnancy exclusion laws are “driven by a desire on the part of state governments to ensure, to the extent legally possible, that pregnant women carry their fetuses to term.”⁹⁷ Similarly, pregnancy exclusion statutes show a preference for bringing the fetus to term over the right of the pregnant woman to refuse unwanted medical treatment, suggesting the laws are guided by the same motivation to

⁹³ However, an argument could be made that the advance directive is maximally reflective of her wishes. See *infra* notes 195–205 and accompanying text.

⁹⁴ See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990).

⁹⁵ *Casey*, 505 U.S. at 878.

⁹⁶ *Cruzan*, 497 U.S. at 286–87. State constitutions may be even more protective of these rights than the U.S. Constitution because many states explicitly protect a “privacy” right, unlike the U.S. Constitution, in which the right to privacy is not an explicit right but is derived from a substantive due process theory. See *Casey*, 505 U.S. at 846–47; *infra* note 111; *Privacy Protections in State Constitutions*, NAT’L CONF. OF STATE LEGISLATURES (Nov. 7, 2018), <http://www.ncsl.org/research/telecommunications-and-information-technology/privacy-protections-in-state-constitutions.aspx> [<https://perma.cc/2YG7-G7JL>] (“Constitutions in 11 states—Alaska, Arizona, California, Florida, Hawaii, Illinois, Louisiana, Montana, New Hampshire, South Carolina and Washington—have explicit provisions relating to a right to privacy.”). However, this analysis is outside the scope of this Note.

⁹⁷ Youngsmith, *supra* note 60, at 419; Schwager, *supra* note 30, at 614 (arguing pregnancy exclusion statutes “violate the female patient’s right to abortion, especially those statutes which automatically invalidate a woman’s advance directive upon a pregnancy diagnosis”).

protect the “potentiality of life.”⁹⁸ Because most pregnancy exclusion laws void the advance directives of all pregnant women, even if they stated their wishes would not change in the case of pregnancy, it is evident that “accurately capturing a woman’s preferences cannot be legislators’ only concern.”⁹⁹

However, one can question whether the abortion restriction framework appropriately applies to pregnancy exclusion statutes because there are some fundamental differences between abortion restriction laws and pregnancy exclusion laws. For instance, Youngsmith argues that analyzing pregnancy exclusion statutes as a violation of the right to terminate a nonviable pregnancy is misguided because “those who would seek to have a pregnant woman’s advance directive enforced are not seeking an abortion of the fetus, but rather seeking the proper administration of that woman’s choice of her own end-of-life care.”¹⁰⁰ One important distinction between pregnancy exclusion statutes and abortion restrictions is that “abortion restrictions stop women from getting the health care that they want or need; [but] pregnancy exceptions forcibly subject women to health care that they neither require nor desire.”¹⁰¹ The enforcement of advance directives functionally ends a pregnancy as a byproduct of dying a natural death; however, a woman is not so much deciding that she affirmatively wants to abort the fetus as she is deciding she does not want to artificially have her body be kept alive for use as an incubator.¹⁰² These types of scenarios were undoubtedly not contemplated when *Roe* and *Casey* were decided, and this Note does not argue that pregnant women in persistent vegetative states are fundamentally the same as pregnant women who want to seek abortions.¹⁰³

Nonetheless, pregnancy exclusion statutes should still be analyzed under *Casey*, along with *Cruzan*, because the Court instructed that laws aimed at protecting the future life of a fetus must be balanced against the

⁹⁸ See *Roe v. Wade*, 410 U.S. 113, 162 (1973).

⁹⁹ Villarreal, *supra* note 23, at 1054.

¹⁰⁰ Youngsmith, *supra* note 60, at 418.

¹⁰¹ *Id.* at 419, 439 (arguing pregnancy exclusion statutes “reach beyond abortion regulations, legally forcing women to essentially act as hosts, supporting a fetus which would not survive without modern medicine”).

¹⁰² *Id.*

¹⁰³ *Id.* Youngsmith also notes that the abortion restriction framework actually “provides for significant limitations on the autonomy rights of pregnant women” compared to the right to refuse lifesaving medical treatment because “[i]f [only] the rules of the abortion cases apply to advance directives, then incompetent pregnant women face a built-in—and misapplied—set of rights restrictions, carved out over time by *Roe*, *Casey*, and other cases.” *Id.* at 448. For this reason, the arguments advanced in Section II.B of this Note regarding the right to refuse lifesaving medical treatment are less controversial than the arguments regarding the right to terminate a nonviable pregnancy, and thus may be more useful to any constitutional challenge of pregnancy exclusion laws.

burden placed on the mother.¹⁰⁴ This overarching principle of the right to bodily autonomy does not limit itself to abortion specifically, but applies to broader scenarios allowing pregnant women to make their own decisions. Thus, *Casey* stands for the principle that a state cannot interfere with a pregnant woman's pregnancy-terminating health care decisions pre-viability in the interest of protecting the fetus, and this rule applies to pregnancy exclusion laws where the termination of pregnancy is a byproduct of the health care decision to die a natural death.¹⁰⁵

Additionally, it is appropriate to analyze pregnancy exclusion statutes as abortion restrictions because, like abortion restrictions, pregnancy exclusion laws seek to ensure that as many fetuses as possible are brought to term.¹⁰⁶ Pregnancy exclusion statutes place a higher value on the fetus coming to term than the right of the pregnant woman to make autonomous decisions, suggesting the laws are guided by the motivation to protect the "potentiality of life."¹⁰⁷ Because most pregnancy exclusion laws void the advance directives of all pregnant women, even if they stated their wishes would not change in the case of pregnancy, it is evident that "accurately capturing a woman's preferences cannot be legislators' only concern."¹⁰⁸ In this sense, pregnancy exclusion laws "represent an unprecedented and extraordinary step beyond abortion restrictions" because unlike abortion restrictions, which prohibit action a pregnant woman wants to take, pregnancy exclusions "mandate action that a pregnant woman must take despite her clearly indicated intentions."¹⁰⁹

The right to an abortion is grounded in the U.S. Constitution's Due Process Clauses, in both the Fifth and Fourteenth Amendments, which state

¹⁰⁴ Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 874–79 (1992).

¹⁰⁵ *Id.* at 846. *But see* David McQuoid-Mason, *Does Withdrawing Treatment from a Pregnant Persistent Vegetative State Patient Resulting in Her Death Constitute a Termination of Pregnancy?*, 8 S. AFR. J. BIOETHICS & L. 8, 9 (2015) (explaining that withdrawing life support from a pregnant patient in a persistent vegetative state is not classified as a termination of pregnancy because it is "merely the natural consequence of a pregnant PVS mother dying").

¹⁰⁶ Schwager, *supra* note 30, at 614 (noting that opponents of pregnancy exclusion statutes argue that they "violate the female patient's right to abortion [before the fetus is viable], especially those statutes which automatically invalidate a woman's advance directive upon a pregnancy diagnosis"); Youngsmith, *supra* note 60, at 419 (admitting that a "common thread . . . weaves through pregnancy exceptions and state limits on abortion: both seek to inhibit the medical decisions of pregnant women in an effort to protect fetal life"); Anna North & Catherine Kim, *The "Heartbeat" Bills that Could Ban Almost All Abortions, Explained*, VOX (June 28, 2019, 9:50 AM), <https://www.vox.com/policy-and-politics/2019/4/19/18412384/abortion-heartbeat-bill-georgia-louisiana-ohio-2019> [<https://perma.cc/AK32-4A7L>] (explaining that the justification for state heartbeat bills, which ban abortions as early as six weeks after conception, is to "save lives").

¹⁰⁷ *Roe v. Wade*, 410 U.S. 113, 162 (1973).

¹⁰⁸ Villarreal, *supra* note 23, at 1054.

¹⁰⁹ Youngsmith, *supra* note 60, at 433–34.

that no person shall be deprived of “life, liberty, or property, without due process of law.”¹¹⁰ Modern jurisprudence concludes that the concept of liberty in the Due Process Clause guarantees protection of certain fundamental rights.¹¹¹ The Supreme Court first held that a right to privacy in reproductive decision-making is one such due process right fundamental to one’s personal liberty when it decided *Griswold v. Connecticut* in 1965.¹¹² In 1973, the Supreme Court extended this right in *Roe v. Wade* when it held that the right to privacy encompasses a woman’s decision to terminate a pregnancy and determined that the state’s interest in preserving fetal life only reaches its “compelling” point at fetal viability.¹¹³ In reaching its decision, the Supreme Court was guided by a set of concerns raised by situations in which a woman did not have the choice to have an abortion, such as forcing a woman to take care of an additional life and potential psychological harm.¹¹⁴ The Court in *Roe v. Wade* set up a trimester framework giving women an absolute right to terminate a pregnancy during the first trimester, with the option for states to impose more stringent restrictions in the last two trimesters when their interests in maternal health and potential fetal life are more compelling.¹¹⁵

¹¹⁰ U.S. CONST. amend. V, XIV; see *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833,846–47 (1992).

¹¹¹ See, e.g., *Casey*, 505 U.S. at 846–49. The fundamental rights derived from the concept of liberty in the Due Process Clause are considered “substantive due process” rights, and there exists controversy around their legitimacy. See, e.g., Christopher R. Green, *Twelve Problems with Substantive Due Process*, 16 GEO. J.L. & PUB. POL’Y 397 (2018) (criticizing the substantive due process doctrine); Timothy Sandefur, *In Defense of Substantive Due Process, or the Promise of Lawful Rule*, 35 HARV. J.L. & PUB. POL’Y 283, 284 (2012) (“Perhaps no doctrine in constitutional law has produced so much calumny as the theory commonly known as substantive due process.”).

¹¹² 381 U.S. 479, 485–86 (1965) (holding that the fundamental right to privacy encompasses the right of married couples to use contraceptives).

¹¹³ 410 U.S. 113, 153, 163 (1973).

¹¹⁴ *Id.* at 153 (“The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent.”).

¹¹⁵ *Id.* at 163–65. According to the trimester framework outlined in *Roe*, a woman’s right to terminate a pregnancy is unregulated in the first trimester. *Id.* at 163. During the second trimester, “a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.” *Id.* The Court provided certain examples of what would constitute permissible state regulation in the second trimester, such as “the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.” *Id.* During the third trimester, a woman’s right to terminate a pregnancy may be legally denied by a state because the state’s interest in protecting fetal life becomes compelling after viability “except when it is necessary to preserve the life or health of the mother.” *Id.* at 163–64.

In 1992, in *Planned Parenthood v. Casey*, the Supreme Court reaffirmed the central holding of *Roe v. Wade* regarding the existence of a fundamental right to terminate a pregnancy, but the plurality reframed that right as the right to terminate a pregnancy without an “undue burden” from the state.¹¹⁶ Furthermore, the Court in *Casey* changed the trimester framework to the current “fetal viability” framework in determining when the state’s interest in the potential life of a fetus could become compelling enough to justify restrictions that override a woman’s right to terminate her pregnancy.¹¹⁷ By enacting this change, the Court allowed states to impose more restrictions on a woman’s right to terminate a pregnancy before viability than was previously permissible under the trimester framework, as long as those restrictions did not operate as undue burdens.¹¹⁸ The undue burden test from *Casey* states that regulations that have the purpose or effect of presenting a substantial obstacle to a woman who seeks an abortion *before* viability impose an undue burden on that right, and are therefore invalid.¹¹⁹ Even though fetal viability serves as a crucial line in defining a woman’s right to an abortion without an undue burden, it is also important to note that the Supreme Court emphasized in *Casey* that a state’s compelling interest in potential fetal life after viability can still be overcome if the mother’s life would be threatened by continuing the pregnancy.¹²⁰

In 2016, in *Whole Woman’s Health v. Hellerstedt*, the Supreme Court clarified how lower courts should apply the undue burden test by explaining that the “rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.”¹²¹ Following this decision, courts have applied the undue

¹¹⁶ 505 U.S. at 879–901 (plurality opinion) (holding that Pennsylvania’s Abortion Control Act’s provisions requiring informed consent, a 24-hour waiting period, and parental consent were not an undue burden).

¹¹⁷ *Id.* at 860 (“[V]iability marks the earliest point at which the State’s interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions.”). According to the “fetal viability” framework, if a fetus is not yet viable (“the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb”), a woman has the right to terminate the pregnancy without an undue burden by the state. *Id.* at 870. An undue burden exists “if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.” *Id.* at 878. If a fetus is determined to be viable, a woman may be legally denied an abortion because the state’s interest in protecting fetal life becomes compelling enough to outweigh the woman’s right to terminate the pregnancy, except when the abortion is necessary to preserve the life or health of the mother. *Id.* at 860, 879.

¹¹⁸ *Id.* at 877.

¹¹⁹ *Id.* (“[A] statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.”).

¹²⁰ *Casey*, 505 U.S. at 879.

¹²¹ 136 S. Ct. 2292, 2309 (2016).

burden test by weighing the benefits of restrictions against the burden on a woman's right to terminate her pregnancy.¹²² As a result, scholars have noted that it has become easy for state abortion restrictions to survive the undue burden test.¹²³ Although pregnancy exclusion laws are not about abortion specifically, the principles of undue burdens and fetal viability are thus applicable to evaluating pregnancy exclusion laws under *Casey*'s abortion restriction framework, which is what this Section proceeds to do.¹²⁴

I. Category One: Void Per Se

Based on *Casey*'s framework, it follows that Category One state pregnancy exclusion laws, which never honor a woman's advance health care directives, even when she clearly communicates her wishes to refuse treatment in the case of pregnancy (and, by implication, end the pregnancy), are unconstitutional in cases where the fetus is not viable.¹²⁵ Under the undue burden test, Category One laws that automatically void the advance directives of pregnant patients constitute undue burdens by restricting "a woman from exercising her right to abortion whether the fetus is developed

¹²² See, e.g., *Whole Woman's Health v. Paxton*, 280 F. Supp. 3d 938, 947–53 (W.D. Tex. 2017) (analyzing the constitutionality of restrictions that imposed penalties on physicians who performed a standard procedure for a second-trimester abortion, by weighing the benefits of the restrictions with the burdens).

¹²³ See, e.g., Linda J. Wharton et al., *Preserving the Core of Roe: Reflections on Planned Parenthood v. Casey*, 18 YALE J.L. & FEMINISM 317, 385 (2006) (explaining multiple ways courts have manipulated the undue burden standard to "substantially undermine *Roe*'s core protections"); see also Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When "Protecting Health" Obstructs Choice*, 125 YALE L.J. 1428, 1476, 1478 (2016) (explaining that "judgments about which burdens are undue will vary across contexts" and can depend "on the manner in which the state is vindicating its interest in regulating abortion"); Chelsea M. Donaldson, Note, *Constitutional Law/Reproductive Justice—Breaking the Trap: How Whole Woman's Health Protects Abortion Access, and the Substantive Due Process Clause's Rebuke of Anti-Abortion Regulations*, 40 W. NEW ENG. L. REV. 257, 282 (2018) (arguing that the "cloudiness surrounding the 'undue burden' standard has led to many clashes of thought within the court system, allowing for legislatures to make the argument that any state interest (ranging from protecting women's health to the potentiality of life) is justifiable against the undue burden it places upon a woman's right to seek and obtain an abortion").

¹²⁴ See *supra* Section II.A.

¹²⁵ Category One states include Alabama, Idaho, Indiana, Kansas, Michigan, Missouri, South Carolina, Texas, Utah, and Wisconsin. ALA. CODE § 22-8A-4(e) (2018); IDAHO CODE ANN. § 39-4510 (2019); IND. CODE § 16-36-4-8(d) (West 2017); KAN. STAT. ANN. § 65-28, 103(a) (2016); MICH. COMP. LAWS § 700.5512(1) (2018); MO. ANN. STAT. § 459.025 (2018); S.C. CODE ANN. § 62-5-507 (2018); TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 2019); UTAH CODE ANN. § 75-2a-123 (2018); WIS. STAT. § 154.03 (2018); see Schwager, *supra* note 30, at 615 (arguing that automatic statutes voiding the advance directives of pregnant patients is inconsistent with *Casey*); Villarreal, *supra* note 23 (arguing that the most restrictive state statutes appear to be unconstitutional because they represent an undue burden of a woman's right to terminate a pregnancy); Humphrey, *supra* note 60, at 692 (arguing that "pregnancy exclusions that automatically invalidate a woman's advance directive impose a substantial obstacle in the path of a woman seeking to terminate her pregnancy when the fetus is non-viable, and thus likely violate the 'undue burden' test set forth in *Casey*"); see also Youngsmith, *supra* note 60, at 442 (arguing that states with "the most severe pregnancy exceptions" conflict with the right to bodily autonomy).

to 22 weeks or simply two days.”¹²⁶ Under the undue burden standard, if a woman has advance health care directives clearly communicating that she wants to be removed from life-sustaining treatment even if she is pregnant, then in the event of incapacitation the woman’s physicians should honor her request to suspend life support, provided the fetus is not yet viable. Because the statutory language does not allow a physician to suspend life support for a pregnant woman under any circumstances, this functionally prevents the woman from terminating her pregnancy before fetal viability, despite a manifestation of intent to do so. Thus, Category One laws present a substantial obstacle to exercising the constitutional rights enshrined in *Roe* and *Casey*.

Even where a woman’s advance directives instruct a physician to remove life support but do not clarify whether she would want to remove life support in the case of pregnancy, Category One laws are still unconstitutional under *Casey* because these laws do not respect a woman’s competent decision to terminate a pregnancy before viability, under the assumption that every woman would change her mind despite what health care directives say. These laws also unconstitutionally restrict the decisions of health care agents acting on behalf of the incapacitated woman, as in the Marlise Muñoz case, where the physicians refused the husband’s request to take his wife off life support.¹²⁷ Health care agents have the power to engage in substitute decision-making on behalf of an incapacitated person, meaning that when a health care agent conveys that a pregnant patient would want to remove life support to die a natural death, the agent operates as the patient legally exercising her constitutional right.¹²⁸

Accordingly, restricting the right of health care agents to terminate the principal’s pregnancy before viability operates as an undue burden on the woman’s right to terminate a pregnancy by placing the decision in the hands of an attending physician instead—an actor who is notably prohibited by law to act as a health care agent for their own patient.¹²⁹ Thus, these laws not only prevent competent pregnant women from exercising their right to pre-viability abortion by voicing their decisions in advance, but also prevent incompetent women from exercising their right by voicing their decisions through health care agents.¹³⁰ These laws therefore operate as undue burdens by providing no option at all to exercise the right to a pre-viability abortion,

¹²⁶ GREENE & WOLFE, *supra* note 54, at 5.

¹²⁷ See *supra* notes 1–12 and accompanying text.

¹²⁸ See *supra* notes 33–35 and accompanying text.

¹²⁹ Jones, *supra* note 35, at § 34.

¹³⁰ GREENE & WOLFE, *supra* note 54, at 5.

though two alternative ways can certainly exist through the use of a living will or a health care proxy.¹³¹

2. *Category Two: Void if the Fetus Can Develop to Birth at Some Level of Certainty*

Category Two state pregnancy exclusion laws, which require physicians to void a pregnant woman's advance directives based on a physician's determination of whether it is "possible" or "probable" that the fetus could be brought to live birth or viability, as well as Ohio's law requiring a "reasonable degree of medical certainty" that a fetus could *not* be born alive, also constitute undue burdens on a woman's right to terminate her pregnancy.¹³² All of these standards are difficult for physicians to apply due to vagueness and because it is "difficult to determine if a pregnancy will develop to a live birth since these cases are rare and the prognosis of many of these fetuses is poor or unknown."¹³³ Despite advances in medical technology with the ability to sustain a fetus to term,¹³⁴ the treatment of pregnant women in a persistent vegetative state for this particular purpose is not standardized and there is no guidance as to how a physician would interpret these terms.¹³⁵

The language of whether it is "possible" that the fetus could be brought to live birth is similarly broad enough to be met in all cases of pregnancy

¹³¹ *See id.*

¹³² Category Two states include Alaska, Arkansas, Delaware, Illinois, Iowa, Minnesota, Montana, Nebraska, Nevada, Ohio, and Rhode Island. ALASKA STAT. ANN. § 13.52.055(b) (2018); ARK. CODE ANN. § 20-17-206(c) (2018); DEL. CODE ANN. tit. 16, § 2503(j) (2018); 755 ILL. COMP. STAT. ANN. 35/3(c) (2018); IOWA CODE ANN. § 144A.6 (2018); MINN. STAT. ANN. § 145B.13(3) (2019); MONT. CODE ANN. § 50-9-202(3) (2019); NEB. REV. STAT. ANN. § 20-408 (2018); NEV. REV. STAT. ANN. § 449A.451 (2018); OHIO REV. CODE ANN. § 2133.06 (2018); 23 R.I. GEN. LAWS ANN. § 23-4.11-6(c) (2018); *see* Schwager, *supra* note 30, at 616 (arguing that terms like "probable" are too vague and subjective, and thus likely present an undue burden to the right to terminate a pregnancy); Villarreal, *supra* note 23, at 1067 (arguing that states who "force women to accept unwanted medical care if it is 'possible' or 'probable' the fetus will develop to have a 'live birth' may also be violating the Constitution" because the standards are too all-encompassing); Humphrey, *supra* note 60, at 692 (arguing that pregnancy exclusion statutes with the terms "probable" and "live birth" are phrased too broadly and constitute an undue burden on the right to terminate a pregnancy); GREENE & WOLFE, *supra* note 54, at 6 (arguing the term "probable live birth" is too vague and all-encompassing that it "creates the same problem that arises with statutes that invalidate advance directives for pregnant patients altogether").

¹³³ Villarreal, *supra* note 23, at 1060.

¹³⁴ Esmailzadeh et al., *supra* note 16, at 79–80.

¹³⁵ Romagano et al., *supra* note 24, at 107; *cf.* *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (defining medical judgment broadly by stating it "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.").

with today's advanced medical technology.¹³⁶ "Possible" is defined by *Merriam-Webster* as "being within the limits of ability, capacity, or realization," "being something that may or may not occur," or "being something that may or may not be true or actual."¹³⁷ Under this broad definition of "possible," considering the advanced medical technology that can sustain a fetus in an incapacitated body for the entire term of pregnancy,¹³⁸ it will almost always be "possible" with today's technology that a fetus could be brought to term.¹³⁹ Thus, the four state statutes¹⁴⁰ that void a woman's advance directives if it is "possible" that the fetus could be born alive pose undue burdens under *Casey* by presenting a substantial obstacle to exercising the right to terminate a pregnancy before viability.

Similarly, the statutes that require a physician to void a pregnant woman's advance health directives if it is "probable" that a fetus could be brought to live birth are also so all-encompassing that they would require voiding a pregnant woman's advance directives in most pregnancy circumstances.¹⁴¹ "Probable" implies a greater than fifty-percent chance, and is defined by *Merriam-Webster* as "supported by evidence strong enough to establish presumption but not proof," "establishing a probability," or "likely to be or become true or real."¹⁴² These broad and obscure definitions of "probable" do not give meaningful guidance to physicians on how to make a determination of whether it is probable a fetus could develop to term. Further, while "probable" is a more demanding standard in this context than "possible," the existence of modern prenatal technology that can sustain a fetus in an incapacitated body seem to make it "probable" the fetus could

¹³⁶ The term "possible" is even less restrictive than the term "probable," so it creates the same problem of vagueness and overly broad application.

¹³⁷ *Possible*, MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/possible> [<https://perma.cc/W88L-TZRH>].

¹³⁸ Romagano et al., *supra* note 24, at 107–08.

¹³⁹ *Cf.* GREENE & WOLFE, *supra* note 54, at 6.

¹⁴⁰ These states include Arkansas, Illinois, Iowa, and Minnesota. ARK. CODE ANN. § 20-17-206(c) (2018); 755 ILL. COMP. STAT. ANN. 35/3(c) (2018); IOWA CODE ANN. § 144A.6 (2018); MINN. STAT. ANN. § 145B.13(3) (2019).

¹⁴¹ These states include Alaska, Delaware, Montana, Nebraska, Nevada, and Rhode Island. ALASKA STAT. ANN. § 13.52.055(b) (2018); DEL. CODE ANN. tit. 16, § 2503(j) (2018); MONT. CODE ANN. § 50-9-202(3) (2017); NEB. REV. STAT. ANN. § 20-408(3) (2018); NEV. REV. STAT. ANN. § 449A.451 (2018); 23 R.I. GEN. LAWS ANN. § 23-4.11-6(c) (2018). For discussion regarding these statutes' breadth, see GREENE & WOLFE, *supra* note 54, at 6 ("The term[] 'probable live birth' is extremely vague and can be easily be stretched to encompass any stage of pregnancy. A fetus will 'probably' develop to live birth from any point in development as long as the woman carrying it continues to receive life-prolonging treatment, barring severe complications.").

¹⁴² *Probable*, MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/probable> [<https://perma.cc/XN8M-RGLY>].

develop to live birth in nearly all cases¹⁴³—even if that results in harm to the woman or deformities to the fetus, because these statutes do not appear to consider what condition the fetus is born in, as long as it is technically alive. Thus, statutes that void a woman’s advance directives if it is “probable” that the fetus could be born alive also operate as undue burdens under *Casey* by presenting a substantial obstacle to exercising the right to terminate a pregnancy before viability.

Finally, Ohio’s pregnancy exclusion law, which voids a pregnant woman’s advance directives unless there is a “reasonable degree of medical certainty”¹⁴⁴ that the fetus *would not* be born alive, is even more restrictive than the previous two levels of certainty, given advances in prenatal care.¹⁴⁵ Only in exceptional cases would a physician be able to determine it is “reasonably certain” that the fetus *would not* develop to live birth with the assistance of today’s advanced medical technology, given that the statute does not consider whether the fetus is born with deformities or complications.¹⁴⁶ Ohio’s law thus seems to function in practice as a Category One law, rendering advance directives void per se. Overall, these broad statutes impose significant restrictions that qualify as undue burdens on a woman’s ability to terminate her pregnancy before viability, and they should be considered unconstitutional under *Casey*. Thus, Category Two state pregnancy exclusion laws are also unconstitutional.

3. *Category Three: Void Unless an Ethical Condition Is Met*

Category Three state pregnancy exclusion laws attempt to balance the rights of the woman and fetus in a way that is nonetheless still constitutionally problematic under *Casey*.¹⁴⁷ Generally, these laws provide that physicians must void the advance directives of pregnant women unless sustaining treatment “will not maintain the woman in a way to permit the continuing development and live birth” of the fetus, will be “physically harmful to the woman,” or will “prolong severe pain which cannot be

¹⁴³ Esmailzadeh et al., *supra* note 16, at 75, 80 (explaining potential technological needs to sustain fetal life in women who are brain-dead or in a persistent vegetative state, including mechanical respiratory ventilation, cardiovascular support and monitoring, endocrine support, thermoregulation, warming blankets, and nutritional support).

¹⁴⁴ OHIO REV. CODE ANN. § 2133.06 (2018).

¹⁴⁵ *See, e.g.*, Romagano et al., *supra* note 24 (describing extensive medical interventions to protect a fetus developing in its brain-dead mother). It is important to note that advanced technologies are not yet at the point of erasing the concept of “viability.” *See id.*

¹⁴⁶ *Id.* (explaining the ventilator and nutritional technological support that can sustain a fetus to live birth after the mother experiences clinical brain-death).

¹⁴⁷ These states include Kentucky, New Hampshire, North Dakota, Pennsylvania, and South Dakota. KY. REV. STAT. ANN. § 311.629 (2018); N.H. REV. STAT. ANN. § 137-J:10 (2018); N.D. CENT. CODE ANN. § 23-06.5-09(5) (2017); 20 PA. STAT. AND CONS. STAT. ANN. § 5429(a) (2018); S.D. CODIFIED LAWS § 34-12D-10 (2018).

alleviated by medication.”¹⁴⁸ These types of laws appear to provide physicians with more flexibility to take into account the dignitary rights of an incapacitated pregnant woman by considering physical harm and severe pain,¹⁴⁹ though “if a pregnant woman is ‘unable to communicate verbally or nonverbally,’ whether or not severe pain has been ‘alleviated by medication’ is a matter of sheer speculation by the physician.”¹⁵⁰ However, these laws operate as undue burdens because they completely ignore the concept of *present* fetal viability, as *Casey* demands.¹⁵¹ Instead, these laws focus on *future* fetal viability by voiding advance directives even if the fetus is not viable at that moment, unless the fetus is likely not to survive. Thus, based on the face of the statutory language, even if such laws appear to balance the dignitary interests of the pregnant woman with the interests of the state, they

¹⁴⁸ See KY. REV. STAT. ANN. § 311.629 (2018) (“Notwithstanding the execution of an advance directive, life sustaining treatment and artificially-provided nutrition and hydration shall be provided to a pregnant woman unless, to a reasonable degree of medical certainty . . . the procedures will not maintain the woman in a way to permit the continuing development and live birth of the unborn child, will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication.”); N.H. REV. STAT. ANN. § 137-J:10 (2018) (“Nothing in this chapter shall be construed to condone, authorize, or approve: (a) The consent to withhold or withdraw life-sustaining treatment from a pregnant principal, unless, to a reasonable degree of medical certainty . . . such treatment or procedures will not maintain the principal in such a way as to permit the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication.”); N.D. CENT. CODE ANN. § 23-06.5-09(5) (2017) (“Notwithstanding a contrary direction contained in a health care directive executed under this chapter, health care must be provided to a pregnant principal unless, to a reasonable degree of medical certainty . . . such health care will not maintain the principal in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful or unreasonably painful to the principal or will prolong severe pain that cannot be alleviated by medication.”); 20 PA. STAT. AND CONS. STAT. § 5429 (2018) (“Notwithstanding the existence of a living will, a health care decision by a health care representative or health care agent or any other direction to the contrary, life-sustaining treatment, nutrition and hydration shall be provided to a pregnant woman who is incompetent and has an end-stage medical condition or who is permanently unconscious 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) will cause pain to the pregnant woman that cannot be alleviated by medication.”); S.D. CODIFIED LAWS § 34-12D-10 (2018) (“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.”).

¹⁴⁹ See Schwager, *supra* note 30, at 603 (noting these types of laws “provide for more leeway” for physicians). Note that Schwager’s framework categorizes pregnancy exclusion laws differently and calls these laws “Category Two,” while the framework in this Note puts them in Category Three. *Id.*

¹⁵⁰ Hope E. Matchan & Kathryn E. Sheffield, *Adding Constitutional Deprivation to Untimely Death: South Dakota’s Living Will Pregnancy Provision*, 37 S.D. L. REV. 388, 389 (1992) (citation omitted).

¹⁵¹ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 860 (1992) (“[V]iability marks the earliest point at which the State’s interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions.”).

could also justify voiding the advance directives of an incapacitated woman who is only one week pregnant and therefore fail under *Casey*.

4. *Category Four: Void Unless the Woman Specifically States “In the Case of Pregnancy”*

Category Four state pregnancy exclusion laws—which void a woman’s advance directives if she does not specifically state her wishes “in the case of pregnancy”—allow physicians to honor a pregnant woman’s advance directives to remove life support if these specify that her wishes would be the same in the case of pregnancy.¹⁵² However, these laws are still unconstitutional because they prohibit physicians from honoring the decision of health care agents to terminate a woman’s pregnancy before fetal viability in cases where a woman did not clearly communicate what her decision would be in the case of pregnancy. As mentioned above,¹⁵³ health care agents have the power to exercise substituted decision-making on behalf of an incapacitated person, meaning that a proxy’s decision to remove life support for a pregnant patient operates as the patient legally exercising her constitutional right.¹⁵⁴ This right is respected in the abortion context when a health care proxy communicates that an incompetent person would have wanted to terminate a pregnancy legally,¹⁵⁵ and accordingly should be respected in this context where a health care agent instructs a physician to remove life support, where ending a pregnancy is merely the byproduct of a medical decision. Restricting the right of health care agents to suspend life support of a pregnant person before fetal viability, functionally terminating the pregnancy, is an undue burden on the woman’s right to terminate a pregnancy.

5. *Category Five: Honor if Pregnant, Unless the Fetus Is Viable*

Finally, Colorado’s Category Five pregnancy exclusion law, which honors a woman’s advance directives before viability even if she does not specify her preferences in the case of pregnancy, is unconstitutional because it fails to include an exception after viability to save the life or health of the

¹⁵² These states include Florida, Arizona, Oklahoma, Connecticut, Georgia, Maryland, New Jersey, Vermont, and Washington. FLA. STAT. ANN. § 765.113 (2019); ARIZ. REV. STAT. ANN. § 36-3262 (2018); OKLA. STAT. tit. 63, § 3101.8(c) (2018); CONN. GEN. STAT. ANN. § 19a-575a (2018); GA. CODE ANN. § 31-32-9 (2018); MD. CODE ANN. HEALTH-GEN. § 5-603 (2018); N.J. STAT. ANN. § 26:2H-56 (2018); VT. STAT. ANN. tit. 18, § 9702 (2018); WASH. REV. CODE ANN. § 70.122.030 (2019).

¹⁵³ See *supra* notes 33–35 and accompanying text.

¹⁵⁴ See Necheles, *supra* note 34, § 9.

¹⁵⁵ See Hilary Mabel et al., *Decision-Making for an Incapacitated Pregnant Patient*, 47 HASTINGS CTR. REP. 12, 12–15 (2017) (describing a case that came before a clinical ethics team where an incompetent pregnant patient’s mother was deemed her health care surrogate, and instructed physicians to terminate her daughter’s eighteen-week pregnancy based on her daughter’s previous abortions and the health risks of the pregnancy).

mother. At first glance, Colorado's Category Five law may appear to pass constitutional muster under *Casey* because it requires physicians to honor a pregnant woman's advance directives to remove life support so long as the fetus is not viable, and thus arguably respects the right to terminate a pregnancy before fetal viability without undue burden from the state.¹⁵⁶ This law also allows physicians to honor the decisions of a health care agent to suspend life support in the absence of advance directives so long as this decision is made prior to viability.¹⁵⁷

However, Colorado's Category Five pregnancy exclusion law is still unconstitutional because the law directs physicians to void the advance directives of pregnant patients after viability, and yet fails to include an exception after viability to save the life or health of the mother, which *Casey* demands.¹⁵⁸ It is unclear whether a "life or health" exception post-viability would apply in this context, given that an incapacitated pregnant patient would be kept alive to sustain a fetus; thus, this theory hinges on whether a woman's health would suffer severe harm if the pregnancy were sustained.

Furthermore, as described in Part III, this law is ethically problematic because it risks restricting the autonomy of individuals to make informed decisions about their end-of-life care through a health care agent when there is overwhelming evidence that a woman would not have intended to suspend life support in the event of a nonviable pregnancy.¹⁵⁹ That is, from the face of the law's language, it appears a doctor could *not* honor a health care agent's request to *maintain* life support of a pregnant woman if the advance directive ordered removal but did not address the issue of pregnancy, which could potentially place physicians in an uncomfortable position when there is compelling evidence that the woman would have changed her mind.¹⁶⁰

¹⁵⁶ COLO. REV. STAT. § 15-18-104(2) (2018) ("In the case of a declaration of a qualified patient known to the attending physician to be pregnant, a medical evaluation shall be made as to whether the fetus is viable. If the fetus is viable, the declaration shall be given no force or effect until the patient is no longer pregnant.").

¹⁵⁷ *See id.* §§ 15-18-104(1)-(2), (7)-(8).

¹⁵⁸ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992) (explaining that a woman may be legally denied an abortion after viability because the state's interest in protecting fetal life becomes compelling enough to outweigh the woman's right to terminate the pregnancy, except when the abortion is necessary to preserve "the life or health of the mother").

¹⁵⁹ *See infra* Part III.

¹⁶⁰ COLO. REV. STAT. ANN. § 15-18-104(2) (2018) ("In the case of a declaration of a qualified patient known to the attending physician to be pregnant, a medical evaluation shall be made as to whether the fetus is viable. If the fetus is viable, the declaration shall be given no force or effect until the patient is no longer pregnant.").

B. *Right to Refuse Lifesaving Medical Treatment*

In addition to violating a woman's constitutional right to terminate her pregnancy, all state pregnancy exclusion laws violate the constitutional right of a competent person to refuse unwanted lifesaving medical treatment.¹⁶¹ In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court decided that a competent person has a constitutionally protected liberty interest in making their own health care decisions, including refusing unwanted lifesaving medical treatment.¹⁶² The Court acknowledged that an incompetent patient's health care surrogates may be required by the state to demonstrate clear and convincing evidence that the patient would have wanted to refuse lifesaving treatment;¹⁶³ however, advance directives expressly stating a patient would want to remove lifesaving treatment meet this burden of proof.¹⁶⁴ As a result of the *Cruzan* decision, advance directives became common tools to exercise the constitutional right to refuse lifesaving medical treatment.¹⁶⁵

Courts have further held that the right to refuse lifesaving medical treatment extends to family members and health care agents. In an influential case, *In re Quinlan*, the New Jersey Supreme Court held that a person's right to privacy under the U.S. Constitution can be asserted on their behalf by their guardian or family members, who may decide whether to remove life-sustaining treatment for that person in the absence of advance directives or a living will.¹⁶⁶ While the U.S. Supreme Court has ruled that a person does not have a "right to die" with active aid by physicians,¹⁶⁷ the right to refuse

¹⁶¹ Competence to sign legal testamentary documents is generally referred to as "mental capacity," which means one must have a sound mind to execute certain legal documents. See generally Robert Whitman, *Capacity for Lifetime and Estate Planning*, 117 PA. ST. L. REV. 1061 (2013) (discussing various capacity standards in legal transactions). The definitions of legal competence vary by jurisdiction, but generally focus on "cognitive aspects of decisions, especially the patient's abilities to comprehend information, to communicate choices, or to communicate rational choices." Allen C. Snyder, *Competency to Refuse Lifesaving Treatment: Valuing the Nonlogical Aspects of a Person's Decisions*, 10 ISSUES IN L. & MED. 299, 307 (1994).

¹⁶² 497 U.S. 261, 279 (1990) ("[F]or the purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.").

¹⁶³ *Id.* at 280.

¹⁶⁴ Schwager, *supra* note 30, at 600.

¹⁶⁵ See *id.* at 600–01.

¹⁶⁶ *In re Quinlan*, 355 A.2d 647, 661 (N.J. 1976) (holding a person's right to privacy could be asserted on her behalf by her guardian); Michele Yuen, Comment, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581, 597–98 (1992) (explaining the importance of *In re Quinlan* in allowing a guardian to exercise substituted judgment in making a decision to remove life support of a patient).

¹⁶⁷ *Washington v. Glucksberg*, 521 U.S. 702, 705–06, 709–10 (1997) (reasoning that history, traditions, and practice support the constitutionality of criminalizing physician-assisted suicide).

medical treatment outlined in *Cruzan* and *Quinlan* illustrates a constitutional right to die if the means are passive.¹⁶⁸

Similarly, the state's interest in preserving potential human life should never overcome a person's constitutional right to refuse unwanted lifesaving medical treatment.¹⁶⁹ At least one state has acknowledged that parents have the right to refuse life-sustaining treatment for infants born extremely prematurely who have terminal complications or diseases.¹⁷⁰ There are also numerous cases of courts holding that a pregnant woman has the right to refuse a cesarean section procedure needed to save the life of her viable fetus because forced medical treatment would unconstitutionally infringe on that woman's personal liberty.¹⁷¹ While there have been some cases where courts have ignored a pregnant woman's objections and subsequently forced her to submit to a cesarean section procedure, these cases based their analysis on weighing the state's interest in the potential life of a fetus against the right to an abortion.¹⁷² However, courts should be weighing the state's interest in the potential life of a fetus with the right to refuse lifesaving medical treatment—where no state interest in potential life should overcome this right—rather

¹⁶⁸ *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 284 (1990); *In re Quinlan*, 355 A.2d at 672 (1976).

¹⁶⁹ Several courts have held that this right to remove life-sustaining medical treatment, and subsequently die a natural death, cannot be overcome by the state's interests in preserving human life because forcing medical treatment infringes on personal liberty. *See, e.g.*, *Tune v. Walter Reed Army Med. Hosp.*, 602 F. Supp. 1452, 1456 (D.D.C. 1985) (holding a competent, terminally ill patient has the right to refuse life support); *In re Guardianship of Browning*, 568 So.2d 4, 14–15, 17 (Fla. 1990) (rejecting a judicial procedure requiring a surrogate to get court approval for health care decisions because the state's interests were not substantial enough to outweigh the constitutional right to refuse medical treatment through a surrogate); *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985) (stating the state's interest in preserving human life is typically outweighed by a person's right to refuse life-sustaining medical treatment); *Superintendent of Belchertown State Sch. v. Saikewic*, 370 N.E.2d 417, 425–26 (Mass. 1977) (contending the state has a significant interest in preserving human life, which is outweighed when the illness is incurable).

¹⁷⁰ *See HCA, Inc. v. Miller ex rel. Miller*, 36 S.W.3d 187, 191 (Tex. Comm'n App. 2000) (“[U]nless a child's need for life-sustaining medical is too urgent for consent to be obtained from a parent . . . a doctor's treatment of the child without such consent is actionable even if the condition requiring treatment would eventually be life-threatening . . .”).

¹⁷¹ *See e.g.*, *In re A.C.*, 573 A.2d 1235, 1240, 1252 (D.C. App. 1990) (acknowledging the right of a pregnant woman to refuse a cesarean section needed to save the potential life of her twenty-six-week-old fetus); *see also In re Baby Boy Doe*, 632 N.E.2d 326, 333–34 (Ill. App. 1994) (recognizing the right of a pregnant woman to refuse a cesarean section needed to save the life of her fetus, and finding the state's interest in potential life not compelling enough to override this right).

¹⁷² *See Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537, 538 (N.J. 1964) (directing trial court to issue order requiring blood transfusions to be performed on a pregnant mother in her thirty-second week of pregnancy if necessary to save the woman and the fetus); *see also Lynn M. Paltrow & Jeanne Flavin, Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. H. POL. POL'Y & L. 299, 317 (2013) (describing additional cases where pregnant women have been forced to submit to medical interventions).

than analyzing these types of cases under the abortion restriction framework that seemingly allows for more permissive restrictions after viability.¹⁷³

To illustrate the critical difference between weighing state interests under the abortion restriction framework and the right-to-refuse-medical-treatment framework, *In re A.C.* is instructive.¹⁷⁴ There, a patient with cancer was pregnant with a viable fetus and was very close to death.¹⁷⁵ The patient was forced to submit to a cesarean section procedure, and tragically the baby and mother died shortly after.¹⁷⁶ The D.C. Court of Appeals held that a near-death pregnant patient with a viable fetus has the right to decide whether to submit to a medical procedure under the principle that “courts do not compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person’s health.”¹⁷⁷ The court distinguished from other cases where courts have forced pregnant women with viable fetuses to submit to cesarean section procedures by explaining that these courts “have usually acted to vindicate the state’s interest in protecting third parties, even if in fetal state.”¹⁷⁸ The court instead held that the interest in protecting fetal life was not compelling enough to override the right to refuse medical treatment, explaining:

This right of bodily integrity belongs equally to persons who are competent and persons who are not. Further, it matters not what the quality of a patient’s life may be; the right of bodily integrity is not extinguished simply because someone is ill, or even at death’s door. To protect that right against intrusion by others—family members, doctors, hospitals, or anyone else, however well-intentioned—we hold that a court must determine the patient’s wishes by any means available, and must abide by those wishes unless there are truly extraordinary or compelling reasons to override them. When the patient is incompetent, or when the court is unable to determine competency, the substituted judgment procedure must be followed.¹⁷⁹

Thus, the requirement of competence does not create an opening for state lawmakers and physicians to void advance health care directives when a pregnant woman is in a persistent vegetative state. The court clarified that

¹⁷³ See *supra* note 169 and accompanying text; see also Villarreal, *supra* note 23, at 1067 (arguing that “the state’s interest may never be strong enough to justify violating a woman’s bodily autonomy, regardless of how far along she is in a pregnancy”).

¹⁷⁴ *In re A.C.*, 573 A.2d at 1238, 1252 (acknowledging the right of a pregnant woman to refuse a cesarean section needed to save the potential life of her twenty-six-week-old fetus).

¹⁷⁵ *Id.* at 1238.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 1243–44.

¹⁷⁸ *Id.* at 1246.

¹⁷⁹ *Id.* at 1247 (citation omitted).

even if a pregnant woman is declared incompetent and is unable to make an informed decision, the court must execute substituted judgment in making the decision.¹⁸⁰

While some scholars have argued that a pregnant woman in a persistent vegetative state who has advance directives to remove life-sustaining treatment has no current liberty interests at stake in that scenario,¹⁸¹ this position fundamentally ignores other legal schemes designed to allow individuals to exercise their liberty interest preemptively. For example, organ donation also involves a strong interest in keeping other people alive, yet the law in that arena demands that physicians only sustain people to prepare for organ donation with their previous consent.¹⁸² Furthermore, individuals are free to communicate their desires in advance about how their bodily remains should be handled and cared for, and these autonomous decisions are respected under the law even after an individual dies.¹⁸³ These legal schemes demonstrate that the principle of respecting a person's bodily autonomy and wishes, even after death, should prevent physicians from overriding a woman's clearly communicated treatment preferences to prioritize the potential life of a fetus.

¹⁸⁰ *Id.* at 1248–49.

¹⁸¹ See Bertha A. Manninen, *Sustaining a Pregnant Cadaver for the Purpose of Gestating a Fetus: A Limited Defense*, 26 KENNEDY INST. OF ETHICS J. 399, 404 (2016) (“An insentient pregnant woman cannot suffer the physical or emotional burdens of continued medical treatment or pregnancy, and thus arguably does not possess current interests in bodily integrity or procreative liberty.” (quoting Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER & L. 85, 116 (1997))).

¹⁸² David Orentlicher et al., *Organ Transplantation: The Control, Use, and Allocation of Body Parts*, in BIOETHICS & PUB. HEALTH L. 305 (3d ed., 2013). Some scholars who favor extinguishing rights at death, and thus support voiding the advance directives of pregnant women receiving life-sustaining treatment, also support organ donation for all patients who pass even if they do not consent because “[n]o one has the right to say what should be done to their body after death.” See H. E. Emson, *It Is Immoral to Require Consent for Cadaver Organ Donation*, 29 J. MED. ETHICS 125 (2003). An argument was made in Portugal that if a pregnant woman is designated as an organ donor, then that woman provides consent to sustain her fetus to term. See *Portugal Baby Born to Woman Brain Dead for Three Months*, *supra* note 19 (explaining that the decision to keep a fetus sustained in a brain-dead Portuguese woman was based on the fact that “she had never opted out of Portugal’s presumed-consent organ donation law,” and that “[b]eing a donor is not just about being in a position to donate a liver or heart or lung, but also being in a position to give yourself so a child can live”). This argument is flawed with respect to the U.S., given that sustaining a pregnant woman to develop a fetus, a genetically distinct life form that serves no specific function beyond its own individual development, is categorically different from sustaining a pregnant woman to preserve her organs, which are groups of cells and tissues that perform specific functions in a human body. Compare *Fetus* (Medical Definition), MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/fetus> [<https://perma.cc/3PK5-NVXW>], with *Organ* (Medical Definition), MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/organ> [<https://perma.cc/G9WE-JXDT>].

¹⁸³ See NORMAN L. CANTOR, *AFTER WE DIE: THE LIFE AND TIMES OF THE HUMAN CADAVER* 29 (2010) (explaining that human remains “receive[] a variety of entitlements and protections . . . such as decent disposal of a cadaver, quiet repose, and postmortem human dignity”).

Given that courts have recognized the right to refuse life-sustaining treatment as a fundamental right, it is never appropriate to void a pregnant woman's clearly communicated wishes to suspend life support, even after viability.¹⁸⁴ Therefore, in cases where a statute orders a physician to override a woman's clearly communicated advance directives to remove life-sustaining treatment in the case of pregnancy, *all* categories of state pregnancy exclusion laws violate the woman's right to refuse unwanted lifesaving medical treatment. Even in cases where the fetus is viable, placing the state's interest (under *Casey*) in protecting the fetus against the patient's right to die with dignity, the state must lose. First, there is no constitutional right to be born,¹⁸⁵ so the state's assertion of such a right must yield to the patient's recognized constitutional right to refuse treatment.¹⁸⁶ Second, to refuse to honor the patient's right is to turn her into an artificial womb for an unwanted fetus, reducing her to no more than an apparatus.¹⁸⁷ Such an affront to human dignity could not be consistent with a constitutional right to elect to die with dignity.¹⁸⁸

Furthermore, even if the woman's advance directives do not clearly state whether her end-of-life decisions would change in the case of pregnancy, that lack of clarification only means that the decision should be shifted to her health care agent or family members, who would then exercise "substituted judgment" in making a decision that the woman would have wanted given the circumstances.¹⁸⁹ Under no circumstances should the legislature's or physician's judgment override that of either the patient or her health care agent. Therefore, all pregnancy exclusion statutes violate the patient's constitutional right to refuse unwanted lifesaving medical treatment as recognized in *Cruzan*.

¹⁸⁴ Others may reasonably disagree that the state should never void a pregnant woman's express advance directives to remove life support after viability, and there may be some point where a state's interest in potential human life overrides a woman's right to refuse lifesaving medical treatment. See Elizabeth A. Marcuccio & Joseph P. McCollum, *Advance Directives Containing Pregnancy Exclusions: Are They Constitutional?*, 34 N.E. J. L. STUD. 22, 34–35 (2015) (noting that the fundamental right to refuse unwanted medical treatment is not absolute and can potentially be less compelling than the state's interest in potential human life). Consider, for example, a pregnant woman past her due date falling into a persistent vegetative state after an accident. In this exceptional circumstance, perhaps a state may be justified in removing a full-term fetus through a cesarean section procedure before the mother's life-support is removed, but not in maintaining the patient on life support to further develop the fetus.

¹⁸⁵ See *Roe v. Wade*, 410 U.S. 113, 162 (1973) ("[T]he unborn have never been recognized in the law as persons in the whole sense.")

¹⁸⁶ U.S. CONST. art. VI, cl. 2 (establishing the supremacy of constitutional rights).

¹⁸⁷ Youngsmith, *supra* note 60, at 442.

¹⁸⁸ See *id.*

¹⁸⁹ See *supra* note 40 and accompanying text.

III. BIOETHICAL CONSIDERATIONS OF STATE PREGNANCY EXCLUSION STATUTES

Even if pregnancy exclusion laws are found to be constitutional or are upheld in a narrow fashion, these laws raise serious ethical concerns about whether physicians should be required to void a woman's autonomous decision. These concerns are heightened when physicians are forced to maintain life support under state law even when the patient has clear directives expressing that she would not want continued treatment. In the absence of clear directives from the patient or her proxy, these laws still raise ethical concerns because physicians are required to maintain life-sustaining treatment, even if continued treatment would cause serious pain or physical harm to the woman, and even if the fetus would likely face deformities or complications if brought to term.¹⁹⁰ This Part explains general bioethical principles for resolving ethical issues, explains the current bioethics issues with pregnancy exclusion laws, and addresses how health care proxies can ease lawmaker concerns that a woman would have changed her mind if she knew she was pregnant.

The standard biomedical ethics approach to resolving ethical issues and determining the appropriate course of action is to balance four principles: (1) autonomy, (2) beneficence, (3) non-maleficence, and (4) justice.¹⁹¹ First, to balance autonomy, physicians should best determine what the wishes of the patient are in order to respect his or her autonomy.¹⁹² This principle reflects the “long tradition in medical care that the determination of the *inefficacy* of treatment lies in the hands of the physician [but] the determination of the *undesirability* of treatment lies with the patient,”¹⁹³ and also guides the concept of informed consent, where a physician may not treat a patient without the informed consent of the patient or her health care proxy, except

¹⁹⁰ See Taylor, *supra* note 181, at 87 (“Also deeply troubling is that the large majority of [pregnancy] restrictions legally compel the woman’s continued medical treatment *regardless* of such critical factors as her own pain and suffering, the fetus’s age, or its prognosis for either a live birth or a healthy life after birth.”).

¹⁹¹ TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 1–12 (5th ed. 2001); Theresa L. Chin et al., *Exploring Ethical Conflicts in Emergency Trauma Research: The COMBAT (Control of Major Bleeding After Trauma) Study Experience*, 157 *SURGERY* 10, 11 (2015); Nora Jacobson & Diego S. Silva, *Dignity Promotion and Beneficence*, 7 *J. BIOETHICAL INQUIRY* 365, 366 (2010); Christopher T. Le M. Rustom et al., *Ethical Issues in Resuscitation and Intensive Care Medicine*, 11 *ANAESTHESIA & INTENSIVE CARE MED.* 1, 1–2 (2010).

¹⁹² Le M. Rustom et al., *supra* note 191, at 1–2 (arguing the focus should be on maximal autonomy in resuscitation ethical dilemmas because full autonomy is an idealistic notion).

¹⁹³ California’s Natural Death Act—Medical Staff Conference, *supra* note 47, at 323 (emphasis added).

in very limited situations.¹⁹⁴ To balance beneficence and non-maleficence, physicians should best determine the patient's interests, further the patient's interests, and avoid harm to the patient.¹⁹⁵ Both beneficence and non-maleficence focus on what is in the patient's best interests.¹⁹⁶ Beneficence considers what courses of action would further the patient's interests, while non-maleficence considers what courses of action should not be taken because they are in conflict with the patient's interests—typically embodying the general medical principles of “do not kill” and “do not cause needless pain.”¹⁹⁷ Last, to balance justice, physicians are required to refrain from making “clinical decisions based on arbitrary social value judgments (age, race, sex, social status) as this would be unfair.”¹⁹⁸

Based on these basic bioethical principles, when a pregnant patient is incompetent, a physician should honor the prior expressed preferences of the patient in order to respect the patient's autonomy, by first consulting her living will. Physicians should do so not only because respecting a pregnant patient's directives best respects her autonomy, but also because physicians are ethically obligated to take actions that further the patient's interests, do no harm, and do not reflect an arbitrary social value judgment based on the fact that the patient is a pregnant woman. In the absence of a living will, a physician should consult the patient's health care proxy, who knows the patient's preferences and values and can exercise substitute decision-making on behalf of the patient. In the absence of clear directives from the patient or her proxy, physicians and health care proxies must make a judgment together based on the patient's past feelings, beliefs, and values.¹⁹⁹

In these scenarios, physicians and proxies should not be prohibited from considering all potential ethical issues and medical risks in making a decision about whether to void a pregnant woman's advance health care directives. Currently, physicians cannot consider *any* ethical factors under the pregnancy exclusion statutes of most states,²⁰⁰ or are limited in which ethical factors may be considered in states that do allow physicians to weigh some ethical considerations.²⁰¹ For example, many states have laws that only allow

¹⁹⁴ See generally STUART M. SPEISER ET AL., *The Doctrine of Informed Consent*, 4A AM. L. TORTS § 15:71, Westlaw (database updated March 2019).

¹⁹⁵ See Le M Rustom et al., *supra* note 191, at 2.

¹⁹⁶ See *id.*

¹⁹⁷ *Id.* (noting that “[b]eneficence is a *positive requirement* of action,” “relevant when the patient is unable to act autonomously and when considering the potential futility of treatment”; whereas “[n]on-maleficence . . . requires *refraining* from actions that may cause harm”).

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ See *supra* Sections I.A–I.B.

²⁰¹ See *supra* Section I.C.

consideration of the likelihood the fetus will develop to live birth, or consideration of whether continued treatment would cause pain or physical harm to the patient.²⁰² Instead, physicians and health care agents should be empowered to weigh *any* relevant ethical considerations and medical risks that could impact the woman or the fetus if the pregnant woman's life is prolonged on life support.

At least one scholar has argued that pregnancy exclusion laws can be ethically permissible when the woman is brain-dead because the psychological harms of compelling a woman to carry a fetus to term are absent when a woman is in that state—claiming that the lack of intimacy that can make forced pregnancy traumatic is absent in these rare scenarios.²⁰³ This argument rests on the premise that there is a unique relationship between a mother and her fetus, but once the mother is incapacitated, she will “never sense the burdens of gestation and will never have to rear the child in progress.”²⁰⁴ However, there are numerous reasons why a pregnant patient in a persistent vegetative state may not want to continue life-sustaining treatment for the purposes of gestating a fetus, such as “cultural or religious reasons,” “the pain and psychological stress of intrusive and long-lasting medical treatment,” or even “the financial burden that excess health care will put on their families after they die.”²⁰⁵ The bioethical principles described above suggest that the incapacity of a patient does not render the decision to continue life-sustaining treatment to the physician—the decision rests with the patient through her expressed advance directives, or with the patient's proxy in the absence of advance directives, based on the patient's wishes and values.

Furthermore, a concern that appears to underlie many existing state pregnancy exclusion laws is the idea that a pregnant woman who had previously drafted a living will or advance health care directives before she

²⁰² See KY. REV. STAT. ANN. § 311.629 (2018); N.H. REV. STAT. ANN. § 137-J:10 (2018); N.D. CENT. CODE ANN. § 23-06.5-09(5) (2017); 20 PA. STAT. AND CONS. STAT. ANN. § 5429 (2018); S.D. CODIFIED LAWS § 34-12D-10 (2018).

²⁰³ See, e.g., Manninen, *supra* note 181, at 403 (arguing that pregnancy is a unique experience between a woman and fetus that can render forced pregnancy traumatic for someone who wants an abortion; yet, brain-dead women receiving life-sustaining treatment are removed from these psychological harms).

²⁰⁴ CANTOR, *supra* note 183, at 225. Cantor also contends that a “pregnant woman's postmortem interests in parenthood (or its avoidance) are not the same as her premortem interests.” *Id.*

²⁰⁵ Villarreal, *supra* note 23, at 1057–58. “[J]ust the act of keeping a woman on life support can be dangerous for the fetus” because “ventilators and catheters are ‘major sources of infection’ that can harm a fetus's development.” *Id.* at 1060 (quoting Abuhasna Said et al., *A Brain-Dead Pregnant Woman with Prolonged Somatic Support and Successful Neonatal Outcome: A Grand Rounds Case with a Detailed Review of Literature and Ethical Considerations*, 3 INT'L J. CRITICAL ILLNESS & INJ. SCI. 220, 223 (2013)).

was pregnant would change her mind if she knew she were pregnant now.²⁰⁶ But the law cannot and should not account for every contingency or fear that women would amend their advance health care directives if they knew they were pregnant. Although it is reasonable to assume in some circumstances that a pregnant woman would make a different decision, having a law that outright voids a woman's previously expressed end-of-life instructions as a hard-and-fast rule, without any other considerations, is not a viable solution.²⁰⁷ Lawmakers have no knowledge of these patients' hearts and minds, and physicians' best resource to know the patients' wishes comes from the health care proxy. Therefore, the decision should ultimately remain with the proxy, and it is inappropriate to require physicians to void a pregnant woman's advance directives under the misguided assumption that the woman would necessarily change her mind.

IV. REFORMING STATE PREGNANCY EXCLUSION STATUTES TO BE CONSTITUTIONAL AND ETHICAL

Because all state pregnancy exclusion statutes are both unconstitutional and unethical,²⁰⁸ this Note concludes that state legislatures must reform their laws to create a pregnancy exclusion statute that both is constitutional and conforms to today's bioethical principles. Of course, one can question the value of pregnancy exclusions at all. One scholar has argued that the best option for states is to eliminate pregnancy exclusion laws and instead require physicians to have conversations with their pregnant patients about what their end-of-life wishes would be if they were to become incompetent during the pregnancy.²⁰⁹ The glaring lack of notice to both physicians and women of the existence and effect of pregnancy exclusion laws is certainly a problem that should be addressed by legislatures.²¹⁰ For example, on the federal level, Congress should implement the CWPS study recommendation to amend the Patient Self-Determination Act to require physicians to inform all women

²⁰⁶ See Villarreal, *supra* note 23, at 1053 ("One possible justification for excluding pregnant women from using living wills . . . may be that the state believes women are unlikely to think about how their preferences might change during pregnancy.").

²⁰⁷ See *id.* at 1059 ("The fact that they are pregnant, however, would not necessarily convince women who would be inclined to reject aggressive end-of-life medical care to accept it, and a pregnancy may make some women *less* likely to accept such care.").

²⁰⁸ Though Colorado's Category Five pregnancy exclusion law may appear at first glance to pass constitutional muster, this Note concludes it is likely unconstitutional. See *supra* Section II.A.5.

²⁰⁹ Villarreal, *supra* note 23, at 1075 (arguing that this option preserves patient autonomy by providing choices and allowing women to contemplate their end-of-life wishes should they become incompetent).

²¹⁰ See *id.* at 1053, 1076.

about the effect of state pregnancy laws on their advance directives;²¹¹ however, physicians themselves may not even be aware of their existence.²¹²

Nonetheless, there is value in having pregnancy exclusion laws that are both constitutional and ethical to provide physicians, patients, and courts with a clear procedure that respects patient autonomy and dignity within our constitutional frameworks. Some states that currently do not have pregnancy exclusion laws have “conscience clauses” in their advance directives legislation, which allow physicians to legally decline to follow a patient’s advance directives based on “reasons of conscience.”²¹³ Thus, in these rare and ethically complicated situations, the law must provide protections for patient autonomy with a clear procedure physicians must follow to decide the best course of action for a pregnant patient.²¹⁴ This would allow all parties to avoid litigating these decisions in courts, which could result in prolonged unwanted medical treatment.²¹⁵ Having clear legal procedures to follow is especially important to ensure physicians’ personal biases do not influence their judgments about the best course of action and to protect them from civil or criminal liability if they choose to withdraw lifesaving treatment.²¹⁶

Though in the ideal scenario women will clarify in their advance health care directives what their end-of-life wishes would be in the case of

²¹¹ GREENE & WOLFE, *supra* note 54, at 6, 7 (“One of the biggest problems with pregnancy exclusions is that there is virtually no public awareness that they even exist, in part because there is no uniformity in the way in which pregnancy exclusion clauses are written into state statutes and they often appear under ambiguous or unrelated titles.”).

²¹² See Letter from Katherine S. Kohari, *supra* note 54.

²¹³ See, e.g., HAW. REV. STAT. § 327E-7(e) (1999) (“A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience.”); MISS. CODE ANN. § 41-41-215(5) (1999) (“A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience.”); N.C. GEN. STAT. § 90-321(k)(1) (2007) (“An attending physician may decline to honor a declaration that expresses a desire of the declarant that life-prolonging measures not be used if doing so would violate that physician’s conscience . . .”).

²¹⁴ See GREENE & WOLFE, *supra* note 54, at 4 (explaining that courts must determine how to proceed in states with no pregnancy exclusion laws, which may result in a pregnant woman being “forced to endure prolonged treatment—for weeks or even months—before the provisions of her advance directive can be carried out”); Schwager, *supra* note 30, at 606 (arguing that states’ living will statutes that are silent on pregnancy create ambiguity that “breeds reliance on the courts which results in delays” because a woman in a vegetative state “may be forced to endure prolonged life sustaining treatment against her wishes, while the Court decides whether or not her advanced directive may be carried out”).

²¹⁵ See *id.*

²¹⁶ See Schwager, *supra* note 30, at 598 (“[A]dvance directives ideally prevent the need for family members or health care providers to go to court or have to otherwise resolve treatment disputes that may arise . . . and allow[] medical staff to act accordingly without fear of repercussion.”); Villarreal *supra* note 23, at 1058 (“Both families and medical providers want to avoid going to court to litigate end-of-life care decisions, and doctors want to ensure that they will be protected from civil or criminal liability if they forgo certain medical procedures.”).

pregnancy, the law must properly address situations in which they have not done so. There are three situations that must be addressed separately with regard to reforming pregnancy exclusion laws: (1) where a woman has advance directives that clearly communicate her wishes in the case of pregnancy; (2) where a woman has advance directives that direct removal of life-sustaining treatment but do not clarify her wishes in the case of pregnancy; and (3) where a woman does not have any advance directives at all indicating her wishes on whether to sustain or remove life support.²¹⁷

A. Advance Directives Communicating Wishes in the Case of Pregnancy

If a woman clearly communicates that her end-of-life wishes in the case of pregnancy are to remove life support, then state law should honor those wishes if the fetus is not viable.²¹⁸ This means physicians should follow directives to remove life-sustaining treatment—allowing the patient to die a natural death and the fetus to die as a byproduct of the medical decision.²¹⁹ Respecting this decision pre-viability would be consistent with the right to terminate a pregnancy without an undue burden under *Casey*, and even after viability would be consistent with the right to refuse lifesaving medical treatment under *Cruzan*. Accordingly, the states that currently have laws that force a physician to void a pregnant woman’s advance directives²²⁰—even when the woman states her wishes in the case of pregnancy—should take immediate action to reform their statutes in line with the above constitutional rights.

If a pregnant woman’s fetus is viable, a decision must be made about whether to induce birth since the fetus can survive outside the mother’s womb, or whether to continue life support to let the fetus further develop. In that scenario, the physician should inform the woman’s health care agent of all the relevant bioethical considerations and medical risks of prolonged treatment. These considerations would then guide the proxy in deciding

²¹⁷ See Manninen, *supra* note 181, at 407 (explaining that these three scenarios pose different ethical dilemmas).

²¹⁸ See *id.* at 409 (“If a pregnant woman has exercised her prospective autonomy to explicitly state that she does not want her body artificially sustained if she were to become brain-dead, even in the event of pregnancy, then her wishes should be respected to the *same extent* that her bodily autonomy takes precedence over the fetal interest in continued existence while she is living.”).

²¹⁹ See *id.*

²²⁰ The states that do not respect advance directives that clarify one’s wishes in the case of pregnancy include Alabama, Idaho, Indiana, Kansas, Michigan, Missouri, South Carolina, Texas, Utah, and Wisconsin. ALA. CODE § 22-8A-4(e) (2018); IDAHO CODE ANN. § 39-4510 (2019); IND. CODE § 16-36-4-8(d) (West 2017); KAN. STAT. ANN. § 65-28, 103(a)(4)(B) (2016); MICH. COMP. LAWS. § 700.5512(1) (2018); MO. ANN. STAT. § 459.025 (2018); S.C. CODE ANN. § 62-5-507 (2018); TEX. HEALTH & SAFETY CODE ANN. § 166.049 (West 2019); UTAH CODE ANN. § 75-2a-123(1) (2018); WIS. STAT. § 154.03(2) (2018).

whether the woman would want the physician to induce birth through a cesarean section, whether to keep the mother on life support to allow the fetus to further develop so it can be born with less risk,²²¹ or whether the health risks are so high as to justify removing treatment despite the consequences for the fetus. Thus, in the case of a viable pregnancy, the woman's right to refuse life-sustaining treatment under *Cruzan* would be delegated to her health care proxy who would be able to make an informed decision on her behalf about inducing birth or refusing further treatment.

B. Advance Directives Without Clarifying in the Case of Pregnancy

If a pregnant woman in a persistent vegetative state does not clarify in her advance directives what her end-of-life wishes would be in the case of pregnancy, but does state that her wish is to remove life-sustaining treatment, state law should not immediately void the advance directives. Instead, the law should impose a presumption that the woman would want to refuse medical treatment even with her current pregnancy. This presumption to refuse medical treatment, despite the woman's pregnancy, could then be overcome by presenting evidence that the woman would have changed her mind if she knew she would be pregnant at the time that a decision regarding suspension of life support must be made. Though the details of such a proposal should be worked out by state legislatures working with physicians to determine exactly what this would entail, such evidence could include OBGYN visits, any previous conversations regarding pregnancy or child-bearing, and other similar considerations that would help shed light on the woman's likely intent.²²² By imposing a presumption instead of immediately delegating the decision to the woman's health care agent or family members, the law is more likely to honor the woman's dignity and desires.

C. No Advance Directives

Finally, if a pregnant woman in a persistent vegetative state does not have advance health care directives expressing whether she would want to be sustained on life support, the decision should be delegated to the patient's

²²¹ See Manninen, *supra* note 181, at 409 (“The [viable] fetus, therefore should be sustained for the handful of weeks it would take to bring it to sufficient maturity so that it can be born with minimal [e]ffects to its health.”).

²²² See *id.* at 410 (“For example, if a pregnant cadaver belonged to a woman who knew about her pregnancy and embraced it, and who had in the past expressed a moral or religious objection to terminating fetal life, one could reasonably conclude that she would have conceded to the continual gestation of the fetus, even in absence of any clear directive, because this seems consistent with her preferences and values.”).

health care agent.²²³ The health care proxy is the best party to make the decision because they are likely most familiar with the pregnant woman's wishes and desires, whereas a physician probably lacks such insight.²²⁴ To guide the woman's health care agent in making an informed decision about whether to remove or sustain lifesaving treatment, the woman's physicians should inform those parties of bioethical considerations and medical risks.

CONCLUSION

Although cases of pregnant women in persistent vegetative states are exceedingly rare, when possible the law should seek to preserve the woman's wishes and respect her autonomy in deciding whether to continue life-sustaining treatment to develop the fetus. Because all current state pregnancy exclusion laws either violate constitutional rights or fall short of today's bioethical norms, it is imperative for states to reform their respective statutes to be both constitutional and ethical. A presumption model is the most appropriate framework for a state statute because it passes constitutional muster and respects the pregnant woman's autonomy—in situations where she would have continued life support and in situations where she would not. Given the glaring lack of notice about the existence of pregnancy exclusion laws, it is critical that women learn how the current pregnancy exclusion law in their state could have horrifying consequences for themselves, and ultimately call on lawmakers to adopt a constitutional and ethical solution.

²²³ This situation is particularly important to consider because many pregnant women are fairly young and may not have contemplated executing a living will. *See Villarreal, supra* note 23, at 1063.

²²⁴ This may not be true in all situations, such as where the patient is estranged from her family or even in an abusive relationship with her health care proxy. However, family and friends who are likely to be health care proxies are generally better positioned than a health care provider to exercise substitute decision-making in deciding what the woman would have wanted. Timothy J. Burch, *Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes*, 54 MD. L. REV. 528, 569–70 (1995).

APPENDIX: BRIEF FIFTY-STATE SURVEY

TABLE 1

Level of Restrictiveness	Count	States		
		Category 1	Category 2	Category 3
1 Void Per Se	10	Alabama Idaho Indiana	Kansas Michigan Missouri South Carolina	Texas Utah Wisconsin
2 Void if the Fetus Can Develop to Birth at Some Level of Certainty	11	<u>Probable Development</u> Alaska Delaware Montana Nebraska Nevada Rhode Island	<u>Possible Development</u> Arkansas Illinois Iowa Minnesota	<u>Unless Reasonable Medical Certainty That a Fetus Could Not Be Born</u> Ohio
3 Void Unless an Ethical Condition Is Met ^a	5	North Dakota South Dakota	Kentucky	Pennsylvania New Hampshire
4 Void Unless the Woman Specifically States "In the Case of Pregnancy"	9	Arizona Oklahoma Florida	Connecticut Georgia Maryland	New Jersey Vermont Washington
5 Honor If Pregnant, Unless the Fetus Is Viable	1	Colorado		
States with No Pregnancy Exclusion Law	14	California Hawaii Louisiana Maine Massachusetts	Mississippi New Mexico New York North Carolina	Oregon Tennessee Virginia West Virginia Wyoming

^a That is, physical harm to the woman or severe pain that cannot be alleviated by medication.

