

THE MUDDLED MILIEU OF PREGNANCY EXCEPTIONS AND ABORTION RESTRICTIONS

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INTRODUCTION

Marlise Muñoz was fourteen weeks pregnant when she collapsed in her Texas home. Her husband called an ambulance upon finding her. After her arrival at the hospital and doctors’ attempts at treatment, Muñoz’s heart and certain other organs could only function with the assistance of life support machines. Between her initial collapse and her eventual connection to a ventilator, Muñoz had spent an extended period of time without oxygen. Despite efforts by hospital staff to revive her, doctors determined she was brain dead. Her other organs continued to function solely with mechanical assistance.

Muñoz’s medical situation and her family’s anguish were on public display following her brain death in November 2013.¹ Muñoz and her husband were both paramedics.² Although she left no written instructions regarding her wishes for treatment post-competence, Muñoz had expressed her desire not to be resuscitated in the event of brain death.³ Texas law states that if an individual does not have a written directive concerning their treatment wishes post-competence,⁴ the patient’s attending physician and spouse may make such decisions, including the decision to withhold life-sustaining treatment.⁵ Therefore, in accordance with Muñoz’s wishes and state law, her family informed the hospital that doctors should withdraw her life support.⁶ The hospital refused.⁷

The hospital relied upon a Texas statute, Texas Health & Safety Code Section 166.049, which dictates that “[a] person may not

1. For further details surrounding the Muñoz case, see 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> (on file with the *Columbia Human Rights Law Review*).

2. Ed Lavandera et al., *Texas Judge: Remove Brain-Dead Woman from Ventilator, Other Machines*, CNN (Jan. 24, 2014), <https://www.cnn.com/2014/01/24/health/pregnant-brain-dead-woman-texas/> [<https://perma.cc/BD8S-8NB9>].

3. Tom Dart, *Texas Hospital Acknowledges Brain-Dead Status of Pregnant Woman*, GUARDIAN (Jan. 24, 2014), <https://www.theguardian.com/world/2014/jan/24/texas-hospital-acknowledges-brain-dead-pregnant-woman> [<https://perma.cc/H34N-2TQR>].

4. Throughout this Note, the term “competence” is used to describe the state in which individuals are conscious and able to make and communicate their wishes.

5. TEX. HEALTH & SAFETY CODE ANN. § 166.039(b)(1) (2015).

6. Fernandez & Eckholm, *supra* note 1.

7. *Id.*

withdraw or withhold life-sustaining treatment . . . from a pregnant patient.”⁸ There are no exceptions to this rule.⁹ The hospital staff based their decision to maintain Muñoz’s treatment on an interpretation of the law that would require the hospital to artificially keep Muñoz’s organs functioning until she was no longer pregnant. They made this determination—and kept Muñoz alive—despite the express wishes of Muñoz and her family.¹⁰ In essence, the hospital staff intended to artificially maintain the functionality of the heart in Muñoz’s brain-dead body in order to allow the continued development of the fetus inside of her. Muñoz’s body was to be treated merely as a host or a tool—a test tube inside of which a fetus could grow. Texas ignored Muñoz’s express wishes and those of her family because she was pregnant.

After several months of litigation, a Texas judge eventually ordered that the hospital cease the artificial maintenance of Muñoz’s organs.¹¹ What was not addressed in the judge’s ruling, and has not yet been addressed fully by federal or state courts, is whether or not laws that overrule the wishes of a pregnant woman or her family in the event of incompetence infringe on the constitutional rights of the woman in question. The Texas judge determined that Section 166.049 of the Texas Health and Safety Law did not apply in this instance because Muñoz was legally dead.¹² But what would happen if a pregnant woman, who had previously made clear to friends or family or expressed in writing her desire to not be kept alive artificially, suffered an accident or illness that caused her to fall into a comatose state with limited but existing brain function and little to no chance of ever regaining consciousness? According to Texas law, and certain other states’ laws, the pregnant woman’s wishes would quite simply be ignored and she would be forced to carry the fetus to term. This broad-brush disregard for the bodily autonomy of pregnant women is reminiscent of the statutory restrictions on abortions that exist in many states.¹³ But, as this Note will illustrate, pregnancy-based

8. TEX. HEALTH & SAFETY CODE ANN. § 166.049 (2016).

9. See TEX. HEALTH & SAFETY CODE ANN. § 166.039(b)(1) (2015) (providing no exceptions to the Texas law).

10. TEX. HEALTH & SAFETY CODE ANN. § 166.039(a) (2015).

11. Manny Fernandez, *Texas Woman Is Taken Off Life Support After Order*, N.Y. TIMES (Jan. 26, 2014), https://www.nytimes.com/2014/01/27/us/texas-hospital-to-end-life-support-for-pregnant-brain-dead-woman.html?_r=0 (on file with the Columbia Human Rights Law Review).

12. See *infra* Appendix I (reprinting the court order).

13. See TEX. HEALTH & SAFETY CODE ANN. § 171.012(4)(A)–(C) (West 2015) (requiring any woman seeking an abortion to undergo an ultrasound at least

infringements on advance directives and abortion restrictions are discrete legal issues and should be treated as such.

This Note addresses pregnancy exceptions to advance directives. Although these are distinct from abortion restrictions, pregnancy exceptions similarly concern the right of pregnant women to control what happens to their bodies in the face of governmental regulations that seek to infringe on the bodily integrity that a woman is guaranteed by the Fourteenth Amendment.¹⁴ Because the ideological motivations behind pregnancy exceptions are similar to the motivations behind abortion restrictions, much of the scholarship examining pregnancy exceptions relates the right of incompetent pregnant women to have agency over their bodies with the right of pregnant women to choose to terminate their pregnancies.¹⁵ This approach may be misguided—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.

This Note will examine these pregnancy exceptions, the constitutional protections provided for bodily autonomy and physical integrity, and the ways in which state pregnancy exceptions and abortion regulations have become blurred in case law and scholarship. Muñoz's case exemplifies the muddled interrelation between pregnancy exceptions, bodily autonomy, and existing abortion-related jurisprudence. First, the Texas statute is just one of a number of state laws that limit or annul advance directives if the patient is pregnant.¹⁶

twenty-four hours before the procedure); WIS. STAT. § 253.10(1)(b)(3) (2016) (mandating that, "prior to the performance or inducement of an elective abortion, the woman . . . receive personal counseling by the physician and be given a full range of information regarding her pregnancy, her unborn child, the abortion, the medical and psychological risks of abortion and available alternatives to the abortion"); S.D. CODIFIED LAWS § 34-23A-56 (2015) (requiring women to wait at least seventy-two hours after consultation with a physician before they can obtain an abortion).

14. At the time of publication, the author is not aware of any instances in which pregnant individuals who do not identify as women have been directly affected by pregnancy exceptions to advance directives. If this were to happen, the author believes the bodily autonomy and constitutional implications discussed in this Note would be the same.

15. See *infra* note 153 and accompanying text (noting the discussion of the rights of pregnant women, whose degrees of consciousness range from death to a vegetative state).

16. See *infra* notes 28–29 and accompanying text (citing TEX. HEALTH & SAFETY CODE ANN. § 166.049 (1999) and other state statutes that limit or annul advance directives).

While the Texas law is among the most restrictive in the nation, it is an apt example of the devices that state legislatures employ when seeking to limit the ability of pregnant women to control their bodies.

Second, the highly restrictive nature of the Texas statute reflects the common thread that 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. Pregnancy exceptions and abortion restrictions are both 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.¹⁷ This shared motivation, in turn, leads to a fusion of thought surrounding pregnancy exceptions and abortion when in fact there should exist a distinction. There is an essential difference between pregnancy exceptions and abortion restrictions: abortion restrictions stop women from getting the health care that they want or need; pregnancy exceptions forcibly subject women to health care that they neither require nor desire. This distinction is vital.

Finally, because of this artificial interrelation between pregnancy exceptions and abortion, legal thought concerning pregnancy exceptions is confused. Few courts have directly addressed the constitutionality of pregnancy exceptions, often avoiding the matter by citing standing issues.¹⁸ But in the instances where courts have been confronted with pregnancy exceptions, as in the case of *Muñoz* and others, the application of law has been inconsistent. Similarly, scholarship surrounding pregnancy exceptions has conflated their morality and legality with that of abortions, which leads to further inconsistency in the discussion surrounding the exceptions.¹⁹

17. See *infra* Section I.B “Ideological Motivations Behind Pregnancy Exceptions” for an examination of the political overlap between abortion restrictions and pregnancy exceptions.

18. See Joan Mahoney, *Death With Dignity: Is There an Exception for Pregnant Women?*, 57 UMKC L. REV. 221, 225 (1989) (relating the details of a case wherein a woman sought review of Washington’s pregnancy exception, but the “Washington Supreme Court held that the issue was not justiciable, since the plaintiff was neither pregnant nor terminally ill”); Hannah Schwager, Note, *The Implications of Exclusion: How Pregnancy Exclusions Deny Women Constitutional Rights*, 13 CARDOZO PUB. L. POL’Y & ETHICS J. 595, 604–05 (2015) (describing *Gabrynowicz v. Heitkamp*, 904 F. Supp. 1061 (D.N.D. 1995), wherein a federal court determined that a plaintiff’s constitutional challenge to North Dakota’s pregnancy exception lacked standing because the plaintiff was neither pregnant nor in need of life-sustaining treatment).

19. See *infra* Part V “The Legal Confusion Surrounding Pregnancy Exceptions” for further discussion.

Throughout this Note, the proposition that a fetus is alive from conception—a structure that has been accepted by state and federal courts—will not be disputed. This is a controversial point.²⁰ However, for purposes of showing the inconsistency of the state “interest in life” jurisprudence surrounding pregnancy decisions, adopting a similar definitional framework is essential. By focusing specifically on pregnancy exceptions and comparing them more broadly to the governmental regulations concerning abortions, this Note will analyze inconsistencies in enforcement of pregnancy exceptions.

Part I will examine the background of advance directives and pregnancy exceptions that exist in the various states. It will show the difference between the exceptions as they exist across the country and illustrate how some are significantly more intrusive on Fourteenth Amendment rights to bodily autonomy and integrity than others. Surveying the differing approaches amongst the states and the motivations behind these exceptions will provide context as to why pregnancy exceptions and abortion jurisprudence have become interlaced.

Part II will focus on existing autonomy and abortion jurisprudence to show the state’s purported interests in life and how that interest is reflected in governmental regulation. It will examine the state’s interest in protecting fetal life and in protecting the health of pregnant women. This section will look closely at existing abortion jurisprudence in order to show that the state does not value the health of a fetus and the health of a pregnant woman equally. It will further show the extent to which states can limit abortion in order to protect fetuses. Abortion jurisprudence will be explored to this extent to clarify the distinction between abortion restrictions and pregnancy exceptions.

Part III will examine established constitutional rights to bodily integrity and autonomy. It will explore how bodily autonomy is valued by courts, and when and why it can be infringed.

Part IV will compare and contrast abortion regulations and pregnancy exceptions. By looking at the similarities and differences between these two types of regulations, this Part will show how the abortion framework is often improperly applied to pregnancy exceptions and why the distinction between the two is important.

20. See generally Jed Rubenfeld, *On the Legal Status of the Proposition that “Life Begins at Conception,”* 43 STAN. L. REV. 599 (1991) (concerning the legal, moral, and scientific debate surrounding the question of when life begins).

Part V will describe the inconsistencies that have arisen as a result of the confusion over the distinction between pregnancy exceptions and abortion restrictions. Two cases in particular that concern pregnancy exceptions will be examined to demonstrate how the fusion of pregnancy exceptions and abortion restrictions has led to confusion and contradiction amongst courts and scholars, leaving the legal questions surrounding pregnancy exceptions unsettled and uncertain.

I. BACKGROUND ON PREGNANCY EXCEPTIONS TO ADVANCE DIRECTIVES

An advance directive is a legal document prepared by an individual that seeks to guide the medical treatment that person will receive if and when they become unable to make or communicate those decisions to a health care provider.²¹ An advance directive may be an “anticipatory decision,” illustrating specific treatments in the event of certain occurrences, or it may involve the appointment of a “medical treatment attorney” to make those decisions on behalf of the patient.²² The Code of Federal Regulations states that “[t]he patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.”²³ In 1991, Congress passed the Patient Self-Determination Act, which mandated that any facilities receiving funds from Medicare or Medicaid inform patients of their right to establish an advance directive.²⁴ One of the purposes of these advance directives is to give individuals the ability to plan for their end-of-life care.²⁵

However, advance directive statutes in a number of states, including Texas, “require that life-prolonging medical care not be withheld or withdrawn from an incompetent pregnant woman, regardless of her own wishes previously expressed in a living will, or, in many states, the wishes of her designated proxy decisionmaker.”²⁶ In essence, while advance directives are full and respected legal documents that are given weight by the United States Code and the

21. 42 C.F.R. § 489.100 (1992).

22. Kristina Stern, *Advance Directives*, 2 MED. L. REV. 57, 57 (1994).

23. 42 C.F.R. § 482.13(b)(3) (1986).

24. 42 U.S.C. § 1395cc(f) (2012).

25. Vanessa Cavallaro, Comment, *Advance Directive Accessibility: Unlocking the Toolbox Containing Our End-of-Life Decisions*, 31 TOURO L. REV. 555, 556 (2015).

26. Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER & L. 85, 93 (1997).

Code of Federal Regulations, they can be unilaterally gutted by a state statute simply if the individual is pregnant.

A. The Status of Pregnancy Exceptions in the Various States

Currently, only sixteen states and the District of Columbia have no statutory limits regarding the enforcement of advance directives of pregnant women.²⁷ In the other thirty-four states, laws either mandate that a pregnant woman's advance directive be disregarded entirely due to her pregnancy²⁸ or require a woman to take

27. For state statutes that outline advance directive procedures but make no mention of pregnancy, *see* CAL. PROB. CODE §§ 4670–4806; D.C. CODE § 7-626 (2000); HAW. REV. STAT. § 327E-3 (2017); ME. STAT. ANN. TIT. 18 § 5-802 (2017); 130 MASS. CODE REGS. 450.112 (2017); MISS. CODE ANN. §§41-41-203–211, 215(9) (1998); N.M. STAT. ANN. §§ 24-7A-1–18; N.Y. COMP. CODES R. & REGS. tit. 10, § 400.21 (2006); N.C. GEN. STAT. §§ 90-320–323 (2007); OR. REV. STAT. §§ 127.505–127.660 (2015); TENN. CODE ANN. §§ 68-18-1801–1815 (2010); VA. CODE ANN. §§ 54.1-2981–2993.1 (2017); W. VA. CODE ANN. §§ 16-30-1–25 (2000); WYO. STAT. ANN. §§ 35-22-401–16 (2008). For others that contemplate the possibility of pregnancy in the creator of an advance directive and provide space for a woman to specify her wishes should she become incapacitated while pregnant, *see* ARIZ. REV. STAT. §§ 36-3201, 36-3262 (2016) (allowing for the creation of advance directives (“living wills”) in Arizona, and providing a sample document that lets a pregnant woman choose to nullify her directive if she is pregnant); MD. CODE ANN., HEALTH-GEN. § 5-603 (West 2007) (making optional a section on an advance directive form for a pregnant patient to communicate what she would like to happen in the event of incompetency in Maryland); N.J. STAT. ANN. § 26:2H-56 (2013) (stating that in New Jersey, a “female declarant may include in an advance directive executed by her, information as to what effect the advance directive shall have if she is pregnant”); VT. STAT. ANN. tit. 18, § 9702(8) (2010) (allowing but not requiring patients with advance directives in Vermont to specify their wishes for post-competence treatment should they be pregnant).

28. For state laws wherein an end-of-life wish of a pregnant woman in an advance directive is immediately nullified, *see* ALA. CODE § 22-8A-4(e) (2001) (noting that, in Alabama, “[t]he 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”); ALASKA STAT. § 13.52.055 (2004) (stating that an advance directive may not be given effect in Alaska if the fetus could reasonably be expected to develop to term without the directive’s enforcement); ARK. CODE ANN. § 20-17-206(c) (2003) (disallowing an advance directive of a pregnant woman from taking effect in Arkansas if “it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment”); COLO. REV. STAT. § 15-18-104(2) (2017) (mandating that, if a Colorado doctor determines that a woman is pregnant with a viable fetus, her advance directive cannot be carried out); CONN. GEN. STAT. § 19a-574 (1993) (prohibiting the enforcement of the advance directives of pregnant women in Connecticut); DEL. CODE ANN. tit. 16, § 2503(j) (1996) (banning removal of life support in accordance with an advance directive in Delaware if the patient is pregnant and it is probable the fetus will

reach viability with continued treatment); IDAHO CODE § 39-4510 (2012) (requiring any advance directive in Idaho to include a provision that blocks the directive from taking effect if the woman is pregnant); 755 ILL. COMP. STAT. 35/3(c) (2007) (nullifying the advance directive of a pregnant patient in Illinois if “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”); IND. CODE ANN. § 16-36-4-8(d) (1993) (invalidating an advance directive in Indiana if the patient is pregnant); IOWA CODE § 144A.6 (1985) (mandating that an advance directive of a pregnant patient in Iowa be ignored if the fetus could develop to viability); KAN. STAT. ANN. § 65-28,103(a) (1994) (declaring that a pregnant patient’s advance directive will have no effect in Kansas “during the course of the qualified patient’s pregnancy”); KY. REV. STAT. ANN. § 311.625 (1994) (requiring that an advance directive in Kentucky include a provision to require life sustaining treatment to be continued for pregnant patient during the course of the pregnancy); LA. STAT. ANN. § 40:1151.9(E) (2014) (mandating that an advance directive of a pregnant patient in Louisiana not be enforced if an obstetrician determines that the fetus is at least twenty weeks developed, and that that determination be communicated to the patient’s family); MICH. COMP. LAWS § 700.5512 (2005) (stating that treatment cannot be withheld or withdrawn from a pregnant patient in Michigan); MO. REV. STAT. § 459.025 (1985) (declaring that a pregnant patient’s advance directive will have no effect in Missouri while the patient is pregnant); MONT. CODE ANN. § 50-9-106(7) (2007) (barring the removal of life-sustaining treatment in Montana if “it is probable that the fetus will develop to the point of live birth”); NEB. REV. STAT. § 20-408(3) (1992) (requiring that a Nebraska advance directive of a pregnant patient be given no effect if the fetus will likely develop to a point of live birth); NEV. REV. STAT. ANN. § 449.624(4) (2018) (requiring an advance directive in Nevada to be ignored so long as the fetus will likely develop to viability); N.H. REV. STAT. ANN. § 137-J:5 (2017) (allowing the enforcement of the advance directive of a pregnant patient in New Hampshire if the fetus will not develop to a live birth, or if the continued development of the fetus will be physically harmful to the patient, or cause her severe pain that cannot be alleviated by medicine); N.D. CENT. CODE § 23-06.5-09(5) (2005) (requiring that health care be provided to a pregnant patient in North Dakota despite her advance directive to the contrary unless the fetus will not develop to a live birth or continued fetal development will be “physically harmful or unreasonably painful”); OHIO REV. CODE ANN. § 1337.13(D) (2016) (nullifying a pregnant patient’s advance directive in Ohio unless a doctor determines that the fetus will not develop to a live birth); 23 R.I. GEN. LAWS § 23-4.11-6 (1992) (voiding the advance directives of pregnant women in Rhode Island so “long as it is probable that the fetus could develop to the point of live birth with continued application of life sustaining procedures”); S.C. CODE ANN. § 44-77-70 (1988) (declaring simply that in South Carolina, “[i]f a declarant has been diagnosed as pregnant, the Declaration is not effective during the course of the declarant’s pregnancy”); S.D. CODIFIED LAWS § 34-12D-10 (1992) (disallowing the enforcement of a pregnant woman’s advance directive in South Dakota unless a doctor believes that continued treatment will not lead to a live birth of the fetus, or that treatment would be physically harmful or extremely painful to the woman); TEX. HEALTH & SAFETY CODE ANN. § 166.049 (1999) (stating that a person may not withdraw or withhold life-sustaining treatment for a pregnant patient in Texas); UTAH CODE ANN. § 75-2a-123 (2008) (voiding the advance directives of pregnant women in Utah); WASH. REV. CODE § 70.122.030 (1992) (providing that any advance

some further affirmative step beyond creating an advance directive in order for her wishes to be carried out.²⁹ These state laws vary in degrees of restrictiveness.³⁰ But every state that does have a pregnancy exception shows a willingness, as a matter of public policy, to infringe on the rights of pregnant women.

Texas's pregnancy exception is among the most prohibitive laws, but it is not particularly unusual when compared to other states. For example, in its text, Connecticut Section 19a-575 provides a model advance directive for use by individuals in the state.³¹ However, Connecticut law also states simply that "[t]he provisions of

directive in Washington should include a provision that blocks the directive from taking effect if the woman is pregnant); WIS. STAT. § 154.03 (2008) (invalidating the advance directives of pregnant women in Wisconsin).

29. For state laws wherein a woman must take some affirmative step beyond creating an advance directive in order for there to be a chance that her end-of-life wishes will be carried out if she is pregnant at the time of incompetence, *see* FLA. STAT. § 765.113 (1996) (requiring an explicit statement that an advance directive should be enforced even in the event of pregnancy in Florida); GA. CODE ANN. § 31-32-9(a)(1) (2007) (prohibiting the cessation of life sustaining treatment in Georgia for a pregnant woman unless her fetus is not viable and she had previously specifically requested that her advance directive be enforced even if she was pregnant); MINN. STAT. ANN. § 145C.10 (1998) (announcing a presumption that a pregnant patient Minnesota would want to be kept on life support, though this presumption can be rebutted by the patient's advance directive or "clear and convincing evidence that the patient's wishes, while competent, were to the contrary"); OKLA. STAT. ANN. tit. 63, § 3101.8(C) (2006) (allowing for the enforcement of a pregnant patient's advance directive in Oklahoma only if the patient specifically authorized the directive's enforcement even in the case of pregnancy); 20 PA. CONS. STAT. § 5429 (2006) (mandating that health care providers maintain medical treatment of a pregnant patient in Pennsylvania unless an advance directive provides otherwise).

30. *See supra* notes 28–29.

31. CONN. GEN. STAT. § 19a-575 (2017):

I . . . request that, if my condition is deemed terminal or if it is determined that I will be permanently unconscious, I be allowed to die and not be kept alive through life support systems. . . . By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: Artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

sections . . . 19a-575 and 19a-575a shall not apply to a pregnant patient.”³² With no exception based on the stage of pregnancy or prognosis for survival of the fetus, the wishes of a pregnant woman for her end-of-life care will be dismissed. Numerous other states join Texas and Connecticut in this most restrictive form of pregnancy exception.³³

Some states will ignore a pregnant woman’s advance directive so long as a doctor determines that her fetus will likely reach viability. For example, Arkansas law allows for a “qualified patient . . . [to] make decisions regarding life-sustaining treatment as long as the patient is able to do so,” but goes on to state that the directive “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.”³⁴ Even if a fetus is not viable at the time of a woman’s loss of competence, a doctor’s declaration that the fetus may become viable will determine whether her advance directive is enforced.

Some states limit the exception for instances in which continuing life support to a pregnant woman will harm her. The New Hampshire statute disallows the removal of life support functions from a pregnant woman—regardless of the wishes of the woman or her family—unless a doctor determines that continued medical treatment will not allow for the “live birth of the fetus or will be physically harmful to the [pregnant woman] or prolong severe pain which cannot be alleviated by medication.”³⁵ In these states, if keeping a pregnant woman alive solely to serve as a host for a fetus causes physical harm or “severe” pain to the woman, her advance directive will be followed and life support will be withheld.

Finally, some states will invalidate a pregnant woman’s advance directive if it does not specifically address what to do in case of pregnancy. For example, Florida’s “Restrictions in providing consent” statute states that “[u]nless 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.”³⁶ If the creator of the advance directive has not predicted the potential that she may

32. CONN. GEN. STAT. § 19a-574 (2017).

33. See Schwager, *supra* note 18, at 601–07 (providing a full examination of the differing levels of restrictiveness found in states’ pregnancy exceptions).

34. ARK. CODE ANN. § 20-17-206(c) (2012).

35. N.H. REV. STAT. ANN. § 137-J:5 (2015).

36. FLA. STAT. ANN. § 765.113 (2017).

be pregnant at the time of loss of competency—or may not have imagined that she may become pregnant post-competency³⁷—and has not accounted for such a possibility in writing, state law will not enforce her advance directive.³⁸ It will instead require her to act as a host for the fetus until it can be delivered.

Examining the various pregnancy exceptions across the United States is important. By seeing how states tailor their pregnancy exceptions, one can understand just how truly restrictive many of them are. The fact that some states uphold an advance directive if a woman has been unequivocal that it should apply despite pregnancy shows that, by contrast, the most restrictive states care nothing at all for the wishes of these women, regardless of how explicitly they express their intentions. Some states will not invalidate an advance directive and subject a woman to harm or pain in order to maintain a pregnancy; others require it by law.

For the purposes of this Note, the strictest type of pregnancy exception will be assumed. Under this understanding, the pregnant woman whose rights are at issue is imagined to reside in a state like Texas or Connecticut. The state will require that a hospital or doctor ignore her advance directive if she is pregnant. This will happen regardless of how early or advanced the pregnancy is, whether the woman requested specifically a cessation of life support even in the event of pregnancy, the harm that will be done to her by the continuance of life support, and any pain she may suffer.

B. Ideological Motivations Behind Pregnancy Exceptions

The primary reason pregnancy exceptions and abortion restrictions are conflated is that both aim to ensure that as many fetuses are carried to term as possible. Proponents of pregnancy exceptions and proponents of abortion restrictions seek the same

37. The rape of unconscious hospital patients is uncommon but not unheard of. In 1996, staff at a Rochester hospital discovered that a twenty-nine-year-old patient who had been comatose for a decade was pregnant. In another instance in 2015, an Argentinian woman in a coma became pregnant after being raped. Frank Bruni, *Woman, 29, Still in Ten-Year Coma, Is Pregnant by a Rapist*, N.Y. TIMES (Jan. 25, 1996), <http://www.nytimes.com/1996/01/25/nyregion/woman-29-still-in-10-year-coma-is-pregnant-by-a-rapist.html> (on file with the *Columbia Human Rights Law Review*); *A Woman in Argentina Became Pregnant in a Coma After Being Raped*, VICE (May 15, 2015), https://www.vice.com/en_au/article/a-woman-became-pregnant-after-being-in-a-coma-for-over-a-year-430 (on file with the *Columbia Human Rights Law Review*).

38. FLA. STAT. § 765.113 (2017).

goal—the birth of fetuses that without government intrusion on the choices of the pregnant women would likely not be born at all. Supporters of pregnancy exceptions “believe that if [a] fetus is viable, it should be able to be born as if its mother was still alive.”³⁹ Legislators who sponsor abortion restrictions often cite similar motivations, claiming that their proposed laws give fetuses “the most important opportunity of all—the opportunity to live.”⁴⁰ Backers of pregnancy exceptions and abortion restrictions alike couch their support in terms of providing the fetuses the ability or opportunity to be born. The results of either an abortion or an enforced advance directive would be the same: the cessation of fetal development. So, morally, the acts must be the same and must warrant the same restrictions. This is where the jumbling of pregnancy exceptions and abortion restrictions begins—in the ideological motivations that frame the state laws.

But in fact, the two practices are not the same. Part IV of this Note will delve further into a comparison between the enforcement of advance directives and abortion. For now, however, it is important to see that while the practices are indeed distinct, they are not viewed as such by legislators. This mixed-up framing of these issues contributes to the confusion surrounding the laws as they are drafted, passed, enforced, and litigated.

II. THE STATE’S INTEREST IN PROTECTING LIFE

One of the chief responsibilities of a government is to ensure the safety and survival of the people under its protection.⁴¹ This protection principle justifies many government actions that limit the freedoms of citizens. An individual may be prohibited from selling certain foods that the government has determined are unsafe for consumption.⁴² A driver may not take a shortcut by driving the wrong

39. Katie Rinkus, *The Pregnancy Exclusion in Advance Directives: Are Women’s Constitutional Rights Being Violated?*, 19 PUB. INT. L. REP. 94, 98 (2014).

40. Jackie Borchardt, *Ohio Senate Approves ‘Heartbeat Bill’ Abortion Ban as Part of Unrelated Bill*, CLEVELAND.COM (Dec. 8, 2016, 3:19 PM), http://www.cleveland.com/politics/index.ssf/2016/12/ohio_senate_republicans_pass_6.html [<http://perma.cc/MV6L-RKJQ>].

41. CONG. GLOBE, 39th Cong., 2d Sess. 101 (“The first duty of the Government is to afford protection to its citizens.”) (remarks of Rep. Farnsworth debating the Reconstruction Act of 1867), quoted in Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 DUKE L.J. 507, 508 (1991).

42. 21 U.S.C. § 610 (2018).

direction on a one-way street.⁴³ Famously, a person may not shout “fire” in a crowded theater.⁴⁴ The ability of citizens to do whatever they want, whenever they want, is limited in order to keep the general public safe.

But a government must determine whether the risk to public safety posed by a certain behavior warrants the imposition of limitations. There is no simple solution to the puzzle of where, when, and how a state should limit freedom in order to protect life. This balancing test is a constant point of debate and source of tension in a free society. However, the Supreme Court has found that “a [s]tate may . . . simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.”⁴⁵ In essence, the preservation of life is an incredibly strong state interest and can be asserted by the state as a justification for an infringement of constitutional rights. It is up to the courts to determine if this infringement oversteps the mark.

The state’s interest in protecting life extends to fetuses. Over the course of a series of contentious rulings, the Court has recognized that the state has an “important and legitimate interest in protecting the potentiality of human life.”⁴⁶ This “potentiality of human life” includes unborn fetuses. State restrictions on individual freedoms thus extend to measures meant to protect unborn human life, as well as the lives of those already born.

In the case of pregnancy exceptions, there are legally two lives at issue. The first is that of the pregnant woman and her health and safety.⁴⁷ The second is the “potentiality of life,”⁴⁸ the protection of the continued development of the fetus.⁴⁹ States with the strictest pregnancy exceptions show a clear priority for the health and life of the fetus over the health and life of the pregnant woman.

A. The State’s Interest in Protecting the Life of the Fetus

The Supreme Court first determined that a woman has a constitutionally protected right to an abortion in the landmark decision *Roe v. Wade*, in which the Court held that the right to an abortion was

43. N.Y. VEH. & TRAF. LAW § 1127(a) (2012).

44. See *Schenck v. United States*, 249 U.S. 47, 52 (1919).

45. *Cruzan v. Dir., Mo. Dep’t. of Health*, 497 U.S. 261, 282 (1990).

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

47. See *supra* notes 28–29.

48. *Roe*, 410 U.S. at 162.

49. For an overview of the pregnancy exceptions in each state, including which ones make provision for the likelihood of the continued development of the fetus, see *supra* notes 27–29.

found within the constitutionally protected right to privacy.⁵⁰ The Court stated that:

This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.⁵¹

This right was reaffirmed in later Court decisions.⁵² Additionally, the Court further clarified the origin of the right to an abortion "[t]he c]onstitutional protection of the woman's decision to terminate her pregnancy derives from the Due Process Clause of the Fourteenth Amendment."⁵³

For any right derived from the Fourteenth Amendment's Due Process Clause, a state may impose limitations only where there is a compelling state interest.⁵⁴ The Supreme Court has determined that the protection of fetal life can, at certain stages in the pregnancy, be a compelling enough state interest to impose limits on the practice of abortions.⁵⁵ The Supreme Court has upheld some state-imposed limitations on abortion,⁵⁶ while it has struck down others.⁵⁷ In sum, however, the Court has determined that the state has a compelling interest in keeping its citizens and residents safe and healthy and in promoting the general welfare.⁵⁸ This idea is the foundation for governmental regulations on abortion practices.⁵⁹ It is also a principle

50. *Roe*, 410 U.S. at 152.

51. *Id.* at 153.

52. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 871 (1992) ("The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce.").

53. *Id.* at 846.

54. *Reno v. Flores*, 507 U.S. 292, 301–02 (1993).

55. *Casey*, 505 U.S. at 879 (quoting *Roe v. Wade*, 410 U.S. at 164–65 (1973)) ("[S]ubsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.").

56. See *id.* at 879–87 (upholding a series of restrictions on abortion).

57. See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (invalidating restrictions that the Court determined posed an undue burden on pregnant women seeking abortions).

58. U.S. CONST. pmbl.

59. See *Roe*, 410 U.S. at 150 ("[A]s long as at least *potential* life is involved, the State may assert interests beyond the protection of the pregnant woman

that can be found weaving through pregnancy exceptions,⁶⁰ which may lead to the natural but misguided conclusion that pregnancy exceptions and abortion restrictions should be treated similarly by the courts.

In *Roe*, the Court determined that despite the constitutional right to an abortion, the protection of fetal life was a sufficiently compelling interest for the state to impose certain limitations on that right.⁶¹ Stating that “the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation,”⁶² the Court formally adopted the idea that the state has an interest (“some phrase it in terms of duty”) in protecting prenatal life.⁶³ This interest in fetal life was reaffirmed in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁶⁴ though this stated interest is noticeably harder to locate in the more recent *Whole Woman’s Health v. Hellerstedt* decision.⁶⁵

B. The State’s Interest in Protecting the Health of the Pregnant Woman

In addition to the preservation of fetal life, the principal cases governing abortion regulations make clear that the state also has an interest in the health and safety of the pregnant woman. *Roe* declares that “the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman . . . and that it has still *another* important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct.”⁶⁶ According to *Roe*, and reaffirmed in *Casey*, regardless of the stage of pregnancy, a state’s restrictions on the practice of abortion must allow an exception for the safety of the pregnant woman.⁶⁷

However, the Supreme Court has in fact moved away from the determination in *Roe* and in *Casey* that an exception for the health of the pregnant woman is required in all abortion limitations. In 2003,

alone.”) (emphasis in original); *Casey*, 505 U.S. at 871 (“On the other side of the equation is the interest of the State in the protection of potential life.”).

60. See generally *supra* notes 28–29 (detailing the thirty-four states that pose conditions on a pregnant woman’s advance directives).

61. *Roe*, 410 U.S. at 163.

62. *Id.* at 154.

63. *Id.* at 150.

64. *Casey*, 505 U.S. at 871.

65. *Whole Woman’s Health*, 136 S. Ct. at 2326 (Thomas, J., dissenting).

66. *Roe*, 410 U.S. at 162 (emphasis in original).

67. *Casey*, 505 U.S. at 879.

Congress passed legislation to ban intact dilation and extraction procedures (termed “partial birth abortions” by opponents of the practice) throughout the United States.⁶⁸ The Partial-Birth Abortion Ban Act did not include an exception for the health or safety of pregnant women. Justice Anthony Kennedy, writing in *Gonzales v. Carhart*, found that the “Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman’s health, given the availability of other abortion procedures that are considered to be safe alternatives.”⁶⁹ Because there was some debate over whether or not the procedure was necessary to preserve a woman’s health, the Court determined that no exception was needed. Evidently, the interest in the life of the fetus outweighs the interest in the life and health of the woman when there is uncertainty over whether the woman’s life is at risk. The Court showed that there exists a presumption against preserving the health of the woman in the case of uncertainty.

There are other instances, outside the realm of abortion jurisprudence, where the Supreme Court has made it clear that the state has a compelling interest in protecting life, distinct from the “potentiality of life” referred to in *Roe*. In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court upheld a Missouri rule that mandated that without explicit evidence of what a brain-dead patient wanted regarding her treatment, the patient’s parents could not have her life support terminated.⁷⁰ The Court found that the Due Process Clause of the Fourteenth Amendment “protects an interest in life as well as an interest in refusing life-sustaining medical treatment.”⁷¹ The presumption that without any evidence to the contrary a person would want to be kept on life support is a further illustration of the judicial deference to the state’s declared interest in protecting and preserving life.

Certain legal protections are afforded to pregnant women, ostensibly to protect their health. The Family and Medical Leave Act of 1993 (“FMLA”) states that a pregnant woman “is entitled to [twelve weeks of unpaid] FMLA leave for incapacity due to pregnancy, for prenatal care, or for her own serious health condition following the

68. See 18 U.S.C. § 1531 (2018) (“Any physician who . . . knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both.”).

69. *Gonzales v. Carhart*, 550 U.S. 124, 166–67 (2007).

70. *Cruzan*, 497 U.S. at 284.

71. *Id.* at 281.

birth of the child.”⁷² But the twelve weeks provided for pregnant women, presumably to ensure the health and safety of the woman and the fetus, is exactly the same amount of leave that the FMLA requires for any qualifying employee in the United States, regardless of whether they are pregnant or not, who requires time off for medical reasons.⁷³ No further legislative protection is provided for pregnant women to protect fetal health, even though state legislatures seek to infringe on their rights by disregarding their advance directives.

Cruzan demonstrates that preserving and protecting human life is a compelling state interest in the United States. The abortion cases also declare a strong state interest in preserving fetal life. Many of these cases, including *Roe* and *Casey*, recognize the state’s compelling interest in preserving the life and health of the pregnant woman as well as the fetus.⁷⁴ But *Carhart* shows that this interest is unequal, in the eyes of the Court, to the state’s interest in the “potentiality of life.”⁷⁵ The Court weighs the state’s interest in the fetus more heavily than the state’s interest in the health of the mother and society provides little additional protection for the health of pregnant women, as shown by the FMLA.

C. Where the State’s Interest in Protecting Fetal Life Ends

The essence of *Roe* and its progeny is that while the protection of fetal life is indeed a compelling state interest, it does not totally outweigh the rights to personal and bodily security found in the penumbra of the Constitution, “a right of privacy older than the Bill of Rights—older than our political parties.”⁷⁶ In *Casey*, the Court recognized that restrictions on abortion were unconstitutional if they posed an “undue burden” on a woman’s ability to make a decision about terminating a nonviable fetus.⁷⁷ An undue burden may include requiring a pregnant woman to notify her spouse prior to terminating a pregnancy,⁷⁸ requiring a doctor who provides an abortion to have admitting privileges to a local hospital,⁷⁹ or mandating that facilities that provide abortion services meet strict regulatory standards beyond

72. 29 C.F.R. § 825.120(4) (1993).

73. 29 U.S.C. § 2612(a) (2018).

74. *Casey*, 505 U.S. at 875–76; *Roe*, 410 U.S. at 162.

75. *Carhart*, 550 U.S. at 166–67.

76. *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965).

77. *Casey*, 505 U.S. at 877. A nonviable fetus is one who cannot survive outside of the womb.

78. *See id.* at 898.

79. *Whole Woman’s Health*, 136 S. Ct. at 2300.

those necessary for the termination of a pregnancy.⁸⁰ According to the Court, 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.”⁸¹ The state’s interest in protecting fetal life runs up against the state’s interest in protecting bodily autonomy, which is discussed more fully in Part III.

Notably, some state governments place certain restrictions on abortion practices in an effort to protect fetal life, but none mandate actions by pregnant women in order to protect the health of the fetus. Pregnant women are not required by law to retain the services of an obstetrician in preparation for birth. They are not forced to take prenatal vitamins under penalty of law, nor are they legally forbidden from using saunas or eating high-mercury fish—behaviors that doctors may advise pregnant women to avoid for the sake of the health of the fetus.⁸² Pregnant women do face significant pressure from health care providers to make certain decisions during the pregnancy process, which often do little or nothing in the way of protecting the health of pregnant women or fetuses,⁸³ but the state’s interest in protecting life does not result in legally-mandated treatment practices for pregnant women.

The exception to this pattern, of course, is incompetent pregnant women with advance directives. Unlike all other pregnant women in the United States, comatose women in states like Texas are forced to submit to treatment that seeks to save the life of the fetus, regardless of the stated treatment preferences in their advance directives. The justification for pregnancy exceptions is the same as the justification for restricting abortion—protection of fetal life. But unlike abortion restrictions, pregnancy exceptions require that pregnant women receive treatment against their express wishes.⁸⁴

Pregnancy exceptions represent an unprecedented and extraordinary step beyond abortion restrictions. They do not proscribe

80. *Id.*

81. *Casey*, 505 U.S. at 877.

82. *See Health Tips for Pregnant Women*, NAT’L INST. OF DIABETES & DIGESTIVE & KIDNEY DISEASES (June 2013), <https://www.niddk.nih.gov/health-information/weight-management/health-tips-pregnant-women> [<https://perma.cc/DHP6-6MMM>].

83. *See* Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016) (examining the prevalence of obstetric violence against pregnant women in the United States).

84. *See supra* notes 28–29 (listing state statutes with pregnancy exceptions).

action that a pregnant woman wishes to take. Rather, they mandate action that a pregnant woman must take despite her clearly indicated intentions.

III. CONSTITUTIONAL RIGHTS TO BODILY AUTONOMY

Like abortion restrictions, pregnancy exceptions infringe on the Fourteenth Amendment autonomy rights of pregnant women. In the case of some abortion restrictions, courts have determined that the infringement is permissible in order to protect the fetus.⁸⁵ But balance must be sought between the rights of the pregnant woman and the rights of the fetus. And it is still unclear if the advance directives of pregnant women do warrant as significant an infringement upon autonomy as abortion restrictions impose.

The Supreme Court held that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."⁸⁶ This idea is the essence of the informed consent doctrine, wherein a doctor must provide a patient full knowledge of the potential benefits and consequences of a medical procedure before obtaining the patient's permission to begin treatment.⁸⁷ American courts have recognized the importance of patient autonomy in the face of unwanted medical treatment. Judge Benjamin Cardozo of the New York Court of Appeals wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."⁸⁸ As such, if the informed consent doctrine is ignored, there must be a significantly compelling reason. This section will show the strength of constitutional protections for bodily autonomy.

85. *Carhart*, 550 U.S. at 145 (declaring that the government's "legitimate and substantial interest in preserving and promoting fetal life" would be "repudiated" if the Supreme Court were to affirm the district court in striking down Texas's ban on intact dilation and extraction procedures); *Casey*, 505 U.S. at 886 (noting that "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion").

86. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

87. Martin R. Studer, *The Doctrine of Informed Consent: Protecting the Patient's Right to Make Informed Health Care Decisions*, 48 MONT. L. REV. 85, 85 (1987).

88. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

A. State Protections of Bodily Autonomy

In 1990, the *Cruzan* Court “assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”⁸⁹ This assumption is necessary for advance directives to continue functioning as they do. Without assuming that competent persons can refuse life support, end-of-life decisions found in advance directives would have no weight at all. When it comes to pregnancy exceptions, the question is whether this constitutionally protected right outweighs the state interest in the protection of life.

The Supreme Court has found that the Due Process Clauses of the Fifth and Fourteenth Amendments significantly limit the state’s ability to interfere with these personal, life and death decisions. Indeed, in *Cruzan*, the Court quotes *In re Conroy*,⁹⁰ a New Jersey case that stated that,

[o]n balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient’s competency to make a rational and considered choice.⁹¹

This Note concerns, in general, the second clause of the second sentence of that quotation: the instances where personal autonomy is infringed in order to protect innocent third parties—in the case of pregnancy exceptions, fetuses. However, for the purposes of Part III, it is crucial to emphasize the importance of personal autonomy rights and how rarely they are infringed.

This interest in bodily autonomy is especially strong where the wishes of an individual are made explicit. In *Cruzan*, Missouri was allowed to disregard the wishes of the patient’s parents because of the absence of an express request to end medical treatment made by the patient herself. The Court stated that “[a]ll of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient’s wishes lead us to conclude that the State may choose to defer only to those wishes.”⁹² The Court found that the

89. *Cruzan*, 497 U.S. at 279.

90. *In re Conroy*, 486 A.2d 1209, 1225 (N.J. Sup. Ct. 1985).

91. *Id.*

92. *Cruzan*, 497 U.S. at 286–87.

explicit wishes of the competent party whose autonomy will be infringed is a compelling factor for the state to weigh in determining how and when to restrict bodily autonomy in the name of protecting life.⁹³ Cruzan was unable to express her wishes due to her vegetative state and her parents were not permitted to make decisions on her behalf. But the Court explicitly stated that Cruzan's expressed desire could have overcome the state interest in protecting life.

Indeed, there have been cases outside of the realm of advance directives that implicate the autonomy rights of pregnant women and their ability to determine the type and amount of medical treatment to which they are subjected. In the Illinois case *In re Baby Boy Doe*, the Illinois Supreme Court affirmed the right of a pregnant woman to refuse a cesarean section that doctors claimed was for the benefit of her fetus.⁹⁴ The Cook County State's Attorney's office had sought a court order to appoint the hospital as ward of the fetus and to mandate a cesarean section.⁹⁵ The Court ruled that although "the State has an interest in the preservation of the potential life of the fetus, courts have traditionally examined the refusal of treatment as it impacts upon the preservation of the life of the maker of the decision."⁹⁶ The Court went on, "[t]he proposed cesarean section was never suggested as necessary, or even useful, to the preservation of Doe's life or health. . . . Further, even in cases where the rejected treatment is clearly necessary to sustain life, these factors alone are not sufficiently compelling to outweigh an individual's right to refuse treatment."⁹⁷ Three years later, in a different case, the Illinois Supreme Court again addressed a similar issue.⁹⁸ A pregnant woman refused a blood transfusion on religious grounds.⁹⁹ The court declared again that "the State may not override a pregnant woman's competent treatment decision, including refusal of recommended invasive medical procedures, to potentially save the life of the viable fetus."¹⁰⁰

However, despite this language that seems to lend significant support to the autonomy of pregnant women, Illinois law surrounding advance directives still declares that "if you are pregnant and your health-care professional thinks you could have a live birth, your living

93. *Id.*

94. *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. 1996).

95. *Id.* at 327.

96. *Id.* at 334.

97. *Id.*

98. *In re Brown*, 689 N.E.2d 397 (Ill. 1997).

99. *Id.* at 399.

100. *Id.* at 405.

will cannot go into effect.”¹⁰¹ This is further proof that the legal status of pregnancy exceptions—and their aims and motivations—remain confused and ill-defined.

Protections of bodily autonomy run throughout the legal system for those who are not pregnant. As the *Casey* Court pointed out, reproductive decisions,

involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.¹⁰²

Language of this nature makes it abundantly clear that bodily autonomy is a right deeply enmeshed in the fabric of the Due Process Clause of the Constitution. Indeed, protecting the sanctity of the human body from unwanted intrusion even goes beyond death. Organs cannot be taken from a body—no matter how much need there is for them—without the consent of the donor.¹⁰³ This is true regardless of the lives that the donated organs could save. And, in fact, humans have an interest in what will become of their corpses.¹⁰⁴ This includes one's organs, as well as the manner in which one's body is disposed of.

In sum, great weight is given to the right of an individual to be secure in his or her body, to choose what happens to it and what does not. While this protection is not inviolable, it is immense. It exists in living humans and in dead ones. And, even when infringing on it by harvesting organs could save lives, the right is respected. *In re Baby Boy Doe* and *In re Fetus Brown* show that, in certain cases, pregnant women are provided with the same autonomy over their bodies as other adults in the United States. However, cases like these are rare and no reasoning similar to the Illinois Supreme Court has been applied to a case involving advance directives, even in the State of Illinois.

101. *Statement of Illinois Law on Advance Directives and DNR Orders*, ILL. DEPT OF PUB. HEALTH (Aug. 2, 2011), <http://www.idph.state.il.us/public/books/advdir4.htm> [<https://perma.cc/YRS8-RMYF>].

102. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

103. Hayley Cotter, Note, *Increasing Consent for Organ Donation: Mandated Choice, Individual Autonomy, and Informed Consent*, 21 HEALTH MATRIX 599, 602 (2011).

104. RONALD DWORKIN, *LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 201–02 (1993).

B. Where the State's Protections of Bodily Autonomy End

The state will infringe on a person's bodily autonomy in certain instances. As described above, the protection of third-party life—often the life of a fetus—is one of the chief reasons the state puts limitations on what someone can do with their body.¹⁰⁵ Further, an individual convicted of a crime can be sentenced to serve time in prison.¹⁰⁶ Even without a criminal conviction, an individual may be held against his or her will if the state determines, through constitutional procedures, that their civil detainment is necessary for the health and safety of the individual or of the community at large.¹⁰⁷ Through conscription, the state may compel an individual to risk life and limb in defense of the United States.¹⁰⁸ Furthermore, the state, in order to protect the health and safety of the general population, may compel its citizens to be vaccinated against communicable diseases.¹⁰⁹

These actions by the state all share a particular feature: protection of third parties. Society at large is meant to be protected when a criminal is convicted and imprisoned or when a dangerous individual is committed in a civil proceeding.¹¹⁰ The drafted soldier protects the nation.¹¹¹ A vaccinated population creates herd immunity, limiting the spread of dangerous diseases amongst human populations.¹¹² In the case of abortion restrictions and pregnancy exceptions, the protected third party is the fetus.

Most of these limitations of bodily autonomy focus on the protection of a large group of people, whether a community, a city, a state, or the United States as a whole. Abortion restrictions and

105. *Casey*, 505 U.S. at 879 (quoting *Roe v. Wade*, 410 U.S. 113, 164–65 (1972)) (“[S]ubsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”).

106. See U.S. CONST. amend. V (outlining the conditions under which an individual can be deprived of liberty as “presentment or indictment of a grand jury . . . [and] due process of law”).

107. *Kansas v. Hendricks*, 521 U.S. 346, 357 (1997).

108. *Arver v. United States*, 245 U.S. 366, 385 (1918).

109. See *Jacobson v. Massachusetts*, 197 U.S. 11, 37 (1905) (expressing incredulity that “compulsory vaccination could not, in any conceivable case, be legally enforced in a community, even at the command of the legislature, however deep and universal was the belief of the community and of its medical advisers, that a system of general vaccination was vital to the safety of all.”).

110. *Hendricks*, 521 U.S. at 373.

111. *Arver*, 245 U.S. at 390.

112. *Jacobson*, 197 U.S. at 34.

pregnancy exceptions, however, look to protect individual fetuses. By focusing only on protecting fetal life, abortion restrictions and pregnancy exceptions are distinct from other instances in which the state's imposition upon an individual's Fourteenth Amendment freedom is accepted as warranted by the courts. They seek far more specific and limited ends.

IV. COMPARING PREGNANCY EXCEPTIONS AND ABORTION RESTRICTIONS

Pregnancy exceptions are meant to advance the compelling state interest of protecting the life of a fetus at the cost of a pregnant woman's constitutional right to bodily autonomy. The specter of the decades-old political and legal battle over abortion arises when the life to be protected is that of a fetus and where the trampled rights belong to a pregnant woman. The purpose of this Part is to show that pregnancy exceptions, while often tied in current legal discourse to existing abortion jurisprudence, actually represent an infringement on bodily autonomy beyond the already substantial limits of current abortion regulations.

A. The Similarity Between Pregnancy Exceptions and Regulating Abortion Restrictions

One main characteristic ties abortion restrictions and pregnancy exceptions together: they both represent an infringement on the bodily autonomy rights of pregnant women in an effort to protect the life of a fetus. As such, abortion restrictions and pregnancy exceptions are often regarded as interrelated.¹¹³ Some opponents of pregnancy exceptions argue that they "violate the female patient's right to abortion, especially those statutes which automatically invalidate a woman's advance directive upon a pregnancy diagnosis."¹¹⁴ But pregnancy exceptions are not just another instance in a long line of attempts by opponents of abortion to regulate the practice. They reach beyond abortion regulations, legally forcing women to essentially act as hosts, supporting a fetus which would not survive without modern medicine.

113. Schwager, *supra* note 18, at 607.

114. *Id.* at 614.

B. The Differences Between Enforcing the Advance Directives of Pregnant Women and Abortions

When a woman seeks an abortion, either she is seeking a medical procedure that is a medical necessity, or she is seeking to exert control over the size and timing of her family. When a pregnant woman or her legal proxy seeks to have her advance directive enforced, she is looking to avoid state-mandated medical practices that she may have explicitly rejected. This is the essential difference: in the first instance, the state is barring a medical practice; in the second, the state is forcing one.

Quite simply, an abortion is a decision that a pregnant woman makes, alone or in consultation with her family or health care provider, to terminate a pregnancy. The enforcement of a pregnant woman's advance directive, on the other hand, is a decision that she has made, alone or in consultation with her family or health care provider, to avoid unwanted medical treatment and die in a manner that she has determined would be best for her and her loved ones. There is a distinction between these two practices legally, medically, and perhaps morally.

In 1971, two years before *Roe v. Wade*, Barnard- and Columbia-educated moral philosopher Judith Jarvis Thomson published her now-famous article *A Defense of Abortion*. Thomson took the position that even if a fetus is considered a human life from conception—a conclusion that was not then, and is not now, accepted by many scholars¹¹⁵—it did not logically follow that abortion should be disallowed.¹¹⁶ Through a series of thought experiments, Thomson pointed out that an individual's right to bodily autonomy could outweigh the state's interest in protecting life.¹¹⁷ In her hypotheticals, Thomson posits that actions meant to protect one's life or one's bodily integrity—like abortion—were morally permissible decisions, even if not legal in a number of states at the time.¹¹⁸ One of Thomson's hypothetical examples includes a scenario in which an individual is kidnapped by a fictional Society of Music Lovers and surgically connected to a world-

115. See generally Rubinfeld, *supra* note 20 (examining the debate over whether a fetus is alive from conception).

116. Judith Jarvis Thomson, *A Defense of Abortion*, 1 PHIL. & PUB. AFF. 47, 48 (1971).

117. *Id.* at 48 (providing a number of hypotheticals throughout her article).

118. *Id.*

class violinist in order to keep the violinist alive.¹¹⁹ At a hospital, a doctor tells the kidnap victim:

Look, we're sorry the Society of Music Lovers did this to you—we would never have permitted it if we had known. But still, they did it, and the violinist now is plugged into you. To unplug you would be to kill him. But never mind, it's only for nine months. By then he will have recovered from his ailment, and can safely be unplugged from you.¹²⁰

Thomson believes that this hypothetical, if effectuated in reality, would be outrageous and that the kidnapping victim would be under no moral obligation to keep the violinist alive by remaining connected to him for nine months.¹²¹ The extension of Thomson's argument leads to the conclusion that in cases where terminating a pregnancy is also meant to protect a pregnant woman's life or bodily integrity, abortion is similarly morally acceptable.¹²²

Responses to Thomson's conclusion that abortion is morally defensible included that of John Finnis, who claimed that abortion is active—killing the fetus within the womb of the mother—whereas the examples in many of Thomson's thought experiments would be passive, simply allowing the "victim" to die of natural causes.¹²³ For Finnis, allowing the violinist to die would be a passive act, as the violinist likely would have died anyway had he not been surgically linked to the kidnap victim, while terminating a pregnancy is choosing to end the development of a fetus that would probably be born in the future. But the contrast that he draws between active and passive action is particularly relevant to the distinction between pregnancy exceptions and abortion restrictions. Enforcement of advance directives inhabits the same land of passive results as Thomson's hypotheticals. The moral distinction between actively terminating a pregnancy and passively allowing an ailing person to die is thoroughly erased when the state insists on keeping pregnant women alive in order to carry a fetus to term. In effect, Thomson's thought experiments, criticized by Finnis as unrepresentative of the treatment of pregnant women, are now played out in real life in hospitals across the country.

119. *Id.* at 48–49.

120. *Id.* at 49.

121. Thomson, *supra* note 116, at 49.

122. *Id.* at 53.

123. John Finnis, *The Rights and Wrongs of Abortion: A Reply to Judith Thomson*, 2 PHIL. & PUB. AFF. 117, 124 (1973).

In the states with the most severe pregnancy exceptions, incompetent women are required to carry a fetus to term even if they have made advance directives with an express authorization to discontinue medical treatment in the event of their incompetence.¹²⁴ Many patients in comas who are “minimally conscious” can still feel pain.¹²⁵ In some of these states, these women are required to act as unwilling hosts, even if keeping the women alive for the purposes of their pregnancy will cause pain or harm.¹²⁶

Despite the wishes of women being made expressly clear in legal documents, the state mandates that the will of these women be ignored in the case of pregnancy. Despite the strong state interest in respecting people’s autonomous choices, state legislatures and courts that uphold these statutes have determined that the state’s interest in protecting the life of the fetus outweighs the bodily integrity rights of the mother. But unlike in abortion cases—*Roe* and *Casey* in particular—in pregnancy exception cases, the state is not protecting the life of the fetus against an affirmative decision by a pregnant woman to end her pregnancy. Rather, these governmental bodies are forcing women to act as hosts to developing fetuses against the express wishes of the woman, in an instance where, without the interference of medical technology, both the woman and the fetus would naturally die. The state’s interest in protecting the fetus surpasses the decision of the pregnant woman to abort and, instead, the state now requires the woman to defy both her own wishes and the natural outcomes of illness and death.

Pregnancy exceptions inhibit the natural course of events from taking place, i.e., the advance directive holder from dying in a manner they prefer and view as dignified, and instead force the patient to adhere to an unnatural and unwanted path. As Katherine Taylor rightly points out, it is “deeply troubling . . . that the large majority of these 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.”¹²⁷ The main purpose of an advance directive—allowing an individual to make a decision as foundational

124. See *supra* notes 28–29.

125. Andy Coghlan, *Some Coma Patients ‘Feel Pain,’* NEW SCIENTIST (Oct. 7, 2008), <https://www.newscientist.com/article/dn14891-some-coma-patients-feel-pain/> [<https://perma.cc/8M4P-QUV6>].

126. See *supra* notes 28–29 (detailing state laws that ignore a pregnant woman’s advance directive due to her pregnancy).

127. Taylor, *supra* note 26, at 87 (emphasis in original).

and personal as the manner of one's end-of-life care—is not only ignored, it is actively rejected when the patient happens to be pregnant.

In order for an infringement of rights so powerful and intimate to take place, the state's interest to the contrary must be overwhelmingly compelling. As stated above, the Supreme Court has established that the state has the ability to regulate how and when a woman terminates a pregnancy in order to protect fetal life.¹²⁸ But pregnancy exceptions have nothing to do with abortions. In many cases, they mandate that an incompetent pregnant woman incubate a fetus against her express wishes, solely to protect the life of a third party.¹²⁹ As Thomson points out, "nobody [else in society] is morally *required* to make large sacrifices, of health, of all other interests and concerns, of all other duties and commitments . . . in order to keep another person alive."¹³⁰ Pregnancy exceptions are inconsistent with the way that non-pregnancy-related American law functions. Society does not require invasive medical procedures that are against the will of the incompetent patient when the alternative to the procedure would lead to the death of a third party.

For those who support pregnancy exceptions and oppose abortion rights, the cessation of life support functions for a pregnant woman and an abortion may continue to be morally indistinguishable, despite the medical and legal differences between the practices. In both cases, a fetus will not be brought to term. However, this view continues to fail to recognize how the enforcement of the advance directive of a pregnant woman differs from an abortion. For some staunch opponents of abortion rights—the Catholic Church, for example—the Principle of Double Effect may provide a lens through which to view the differences between abortions and enforced advance directives. The Principle of Double Effect is the idea that one

is permitted to produce an otherwise forbidden result . . . by means of an act itself innocent. In such a case the evil effect is said not to be intended by the agent, but rather only permitted by him. It should be clear that the distinction between doing something and

128. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 879–87 (1992).

129. See sources cited *supra* note 27 (describing the statutes of the sixteen states where advance directives can be enforced during pregnancy).

130. Thomson, *supra* note 116, at 61–62 (emphasis in original).

only bringing the effect about as a consequence is crucial.¹³¹

In essence, the Principle “may be employed when one is considering an action that is morally good, yet the action involves one or more unintended bad consequences. Because these consequences are side effects, and not directly willed, the choice that brings them about is morally acceptable.”¹³² A morally acceptable choice with morally unacceptable consequences may not be ethically wrong.

The United States Conference of Catholic Bishops has published moral and religious rules for Catholic health care providers entitled the Ethical and Religious Directives for Catholic Health Care Services (hereinafter the “Directives”).¹³³ The Directives provide guidance on the ethical ramifications of certain practices.¹³⁴ They specifically direct that Catholic health care providers “make available to patients information about their rights, under the laws of their state, to make an advance directive for their medical treatment.”¹³⁵ They also state that “[a]bortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion”¹³⁶ The Directives prohibit abortions, as defined in the United States. But the fingerprints of the Principle of Double Effect are all over this definition of abortion. Only acts which are “directly intended” to terminate a pregnancy, or whose “sole immediate effect” is such a termination, are considered abortions.¹³⁷ Further, medical practices that result in the termination of fetuses can be morally acceptable to the Church if ending the pregnancy is not the reason for the procedure. For example, “[o]perations, treatments, and medications that have as their direct purpose the cure of a

131. Philip E. Devine, *The Principle of Double Effect*, 19 AM. J. JURIS. 44, 44 (1974).

132. CATHOLICS UNITED FOR THE FAITH, THE PRINCIPLE OF DOUBLE EFFECT (1997), <http://studylib.net/doc/18476033/the-principle-of-double-effect---catholics-united-for-the...> [<https://perma.cc/E8KV-EKCA>].

133. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (U.S. Conference of Catholic Bishops, 5th ed. 2009), <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf> [<https://perma.cc/PK77-T32V>].

134. *Id.* at 4.

135. *Id.* at 19.

136. *Id.* at 26.

137. *Id.*

proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child.”¹³⁸ And though the Church generally opposes birth control,¹³⁹ a rape victim “may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization.”¹⁴⁰ Accordingly, there are situations in which the Church believes that practices that would otherwise be morally unacceptable should be allowed because their direct purpose is not to end a pregnancy or because the circumstances of the case are so extreme.

The Principle of Double Effect shows how, for opponents of abortion and proponents of pregnancy exceptions, there should be a moral distinction between choosing to terminate a pregnancy and removing life support from an incompetent pregnant woman. The latter is not an abortion because it is not an active, direct choice to end the pregnancy. Rather, the end of the pregnancy is a related effect that accompanies the end of a woman’s life.

Legal, medical, and moral distinctions exist between the enforcement of advance directives and abortions. But, because of a dearth of jurisprudence on the subject and because public policy that affects the autonomy of pregnant women is so tangled up with the political fights that surround abortion, the differences between the two may be easy to overlook.

V. THE LEGAL CONFUSION SURROUNDING PREGNANCY EXCEPTIONS

Because so few courts have addressed the issue of pregnancy exceptions to advance directives, the moral opposition of legislators to abortion, which seeps into the advance directive debate, has been allowed to establish itself as the prevailing narrative surrounding pregnancy exceptions. Where public policy implicates the well-being of a fetus or infringes on the rights of pregnant women, the debate over abortion rights springs to mind for many. But this conflation leads to confusion both amongst courts and in the literature. This means that the issue of the constitutionality of pregnancy exceptions has not been properly considered on its own basis distinct from the preformed and ill-fitting structure of abortion jurisprudence.

138. U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 133, at 26.

139. *Id.* at 24.

140. *Id.* at 22.

The few courts that have gotten beyond standing issues to consider pregnancy exceptions to advance directives have displayed the muddled nature of pregnancy exceptions and abortion jurisprudence. An early case that was adjudicated in Georgia bears a striking resemblance to the more recent Muñoz case in Texas. In 1986, a pregnant woman named Donna Piazza fell unconscious and was brought to a hospital.¹⁴¹ Eventually, hospital staff determined that Piazza was brain dead.¹⁴² Piazza's husband wanted her life support to be terminated, a request that a guardian ad litem, who the court appointed on behalf of Piazza's fetus, opposed.¹⁴³ Noting that the question as to whether a court should order the cessation of life support to a pregnant woman when the fetus may develop to viability was one of first impression, the court ruled that Piazza's body must be artificially maintained until the fetus could reach viability.¹⁴⁴ The court began its order by citing *Roe*, declaring that Piazza's privacy rights were "not a factor" since she was brain dead and that *Roe* gave the state the power to "assert an interest in protecting potential life."¹⁴⁵ By immediately turning to *Roe*, the court showed that, like other players in this arena, it instinctively linked the rights of incompetent pregnant women to the issue of abortion. The court noted that while Georgia had a living will (advance directive) law, the statute had a pregnancy exception.¹⁴⁶ Based on *Roe* and other Georgia case law, the court determined that "public policy in Georgia requires the maintenance of life support systems for a brain-dead mother so long as there exists a reasonable possibility that the fetus may develop and survive."¹⁴⁷ The court viewed this case through the lens of abortion and was able to use *Roe*'s allowance for state protection of potential life to justify infringing on Piazza's constitutional autonomy rights.

The Muñoz case is another one of the few cases to address pregnancy exceptions to advance directives. Judge R.H. Wallace, Jr., who decided the Muñoz case, came to the opposite conclusion as the court in *Piazza*. He determined that the Texas statute prohibiting the cessation of life-sustaining treatment was inapplicable, as Texas law declares that that "[i]f artificial means of support preclude a

141. See *Order in the Piazza Case*, 2 ISSUES IN L. & MED. 415, 415 (1987) (containing a reprint of *Univ. Health Servs. Inc. v. Piazza*, No. CV86-RCCV-464 (Ga. Super. Ct. Aug. 4, 1986)).

142. *Id.*

143. *Id.* at 416.

144. *Id.* at 418.

145. *Id.* at 417.

146. *Order in the Piazza Case*, *supra* note 141, at 417-18.

147. *Id.* at 418.

determination that a person's spontaneous respiratory and circulatory functions have ceased, the person is dead when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function."¹⁴⁸ In effect, Texas law declares that brain death is the legal definition of death. Because there was no dispute that Muñoz was brain dead, Texas law considered her completely dead and the statute mandating life-sustaining treatment was therefore inapplicable because it only applied to living pregnant women.¹⁴⁹ Like the court in *Piazza*, Wallace determined that the question turned on whether the pregnant woman was legally alive or not. But where the *Piazza* court found that legal death stripped the woman of her legal rights and forced her to remain a host to a growing fetus, Wallace found cause to remove Muñoz from life support precisely because of her death. Nowhere in the order does Wallace mention abortion, or any abortion-related jurisprudence.

However, just because Wallace did not mention *Roe* or its progeny does not mean that abortion laws were not intrinsic to his understanding of the case. The confusion surrounding the Muñoz case continued beyond the court order to cease her treatment. In 2016, Wallace sought reelection as a judge in Tarrant County's District 96.¹⁵⁰ The Republican primary race, in which Wallace ran, was "was one of the most contentious in county."¹⁵¹ Though Wallace was reelected, "[o]ne of the main issues in the race was Wallace's decision to have life support removed in the case of Marlise Muñoz."¹⁵² After the campaign, Wallace claimed that "his opposition tried to paint him as a candidate who does not oppose abortion because of his ruling in the Muñoz case."¹⁵³ In Wallace's mind and the mind of his opponent, there was a relationship between the Muñoz case and abortion.

The dearth of jurisprudence on the subject of pregnancy exceptions means that courts are left without guidance when addressing challenges to pregnancy exceptions. At best, this leads to confusion regarding what standards courts should impose in

148. TEX. HEALTH & SAFETY CODE ANN. § 671.001(b) (2017).

149. See *infra* Appendix I (showing the final judgment on Eric Muñoz and Marlise Muñoz v. John Peter Smith Hospital).

150. Ryan Osborne & Mitch Mitchell, *Updated: Judge Wallace victorious in bid to retain 96th District Court seat*, FORT WORTH STAR TELEGRAM (Mar. 1, 2016), <http://www.star-telegram.com/news/politics-government/election/article63489872.html> [<https://perma.cc/EZW9-39KA>].

151. *Id.*

152. *Id.*

153. *Id.*

constitutional challenges to pregnancy exceptions. At worst, this lack of definition allows courts to misappropriate the language of *Roe* and other cases and characterize these cases as abortion-related in an effort to limit—rather than expand, or even protect—the constitutional rights of pregnant women. Abortion jurisprudence provides for significant limitations on the autonomy rights of pregnant women. Applying this framework to pregnancy exceptions gives the state a head start when it comes to limiting the rights of pregnant women. If 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.

The judiciary is not the only venue where the lines between pregnancy exceptions and abortion restrictions are blurred. Although there is scholarship on the subject of pregnancy exceptions to advance directives, most of it compares pregnancy exceptions to abortion restrictions—not to clarify the distinction between the two, as is the purpose of this Note, but to show similarities between the two governmental impositions on the rights of women.¹⁵⁴ These articles make compelling points and strong arguments based on abortion jurisprudence can be made to argue that pregnancy exceptions violate constitutional rights.¹⁵⁵ But lumping pregnancy exceptions together with abortion restrictions not only generates confusion and

154. See Schwager, *supra* note 18, at 614 (“By invalidating a pregnant woman’s living will for the sake of an unborn child, pregnancy exclusions are in effect anti-abortion measures: A woman is seeking to end her own life, and thus the life of the unborn child as well.”); Taylor, *supra* note 26, at 118 (“[T]he abortion cases do not settle the question of the restrictions’ constitutionality after fetal viability, though abortion jurisprudence does offer the important lesson that the pregnant woman should not be made to suffer for the survival of even a viable fetus.”); Kristeena L. Johnson, Note, *Forcing Life on the Dead: Why the Pregnancy Exemption Clause of the Kentucky Living Will Directive Act Is Unconstitutional*, 100 KY. L.J. 209, 212 (2011) (“[P]regnancy exemptions effectively violate [reproductive] rights as established by *Roe v. Wade* and its progeny.”); Mahoney, *supra* note 18, at 231 (“[T]he only limits that *Roe* allows on those decisions are based on the state interest in the health of the woman after the first trimester, and on the state interest in the life of the fetus after viability. If . . . the fetus is viable, there is no reason to keep a woman alive against her will—the fetus can be delivered, and the mother can be allowed to die.”); James M. Jordan III, Note, *Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 GA. L. REV. 1103, 1165 (1988) (“The existing bodies of common law governing natural death and abortion must also be reconciled, so that a vegetative or brain-dead pregnant woman will not be subject to state interference with her freedom of choice until the fetus is viable.”).

155. See generally Johnson, *supra* note 154 (examining the constitutionality of Kentucky’s pregnancy exception through the lens of abortion jurisprudence).

inconsistent decisions on the part of the courts, it fails to acknowledge that pregnant women with advance directives are not seeking abortions at all. The decision to terminate a pregnancy is limited by Supreme Court precedent, and infringement on the rights of women seeking abortions is an accepted limitation on constitutional rights.¹⁵⁶ Applying the abortion framework to advance directives may allow a court to impose those same restrictions—restrictions based on moral protestations—on women who simply seek to die in peace.

CONCLUSION

Drawing a distinction between arguments surrounding abortion regulations and those surrounding pregnancy exceptions is not meant to imply that existing state limitations on abortion are anything but onerous. Severe restrictions have led to the closure of a significant number of reproductive health care providers in certain states, making access to safe abortion extremely limited in broad regions of the United States and putting the lives of thousands of women—and fetuses—at risk.¹⁵⁷ This distinction is meant, however, to illustrate an essential point: women seeking the enforcement of their advance directives are not seeking abortions and should not be treated by the state as though they are, especially when the Supreme Court has allowed states to impose significant restrictions on the rights of women simply because those women may be seeking abortions.¹⁵⁸

In both instances—pregnancy exceptions and abortion restrictions—the bodies of women are treated as arenas of public policy, with legislatures seeking to promote and protect the lives of fetuses above the autonomy rights of pregnant women. Because the medical decisions in advance directives implicate pregnant women, a false equivalency has arisen between abortion limitations and advance directives. Imposing pregnancy exceptions on advance directives is, based on the courts' historical respect for bodily autonomy, a sharp divergence with societal practice. The protections for fetal life imposed by abortion restrictions are meant to limit the choices of women who seek to terminate a pregnancy. Pregnancy exceptions completely deny

156. *Casey*, 505 U.S. at 879–87.

157. Sarah McCammon, *For Many Women, the Nearest Abortion Provider Is Hundreds of Miles Away*, NPR (Oct. 3, 2017), <http://www.npr.org/sections/health-shots/2017/10/03/555166033/for-many-women-the-nearest-abortion-clinic-is-hundreds-of-miles-away> [https://perma.cc/SB7U-8M7Y] (last visited Feb. 25, 2018).

158. See, e.g., *Casey*, 505 U.S. at 879–87 (discussing the constitutionality of several restrictions on a woman's right to seek and have an abortion).

the rights of incompetent women, regardless of the viability of the fetus, and force medical treatment on women. And at the end of the day, when life's most personal and intimate choices are presented, including ending a pregnancy or choosing when and how to die, "women themselves are best able to decide what is at stake."¹⁵⁹

Wherever issues of life and death arise, ethical, moral, religious, and legal questions will follow. But in the case of advance directives, anti-abortion ideological zealotry has overshot its mark, gone beyond the decisions of women to terminate their pregnancy, and seeped into the realm of end-of-life discussions.

159. CAROL SANGER, *ABOUT ABORTION* 23 (Harvard Univ. Press 2017).

APPENDIX I

CAUSE NO. 096-270080-14

ERICK MUÑOZ, AN INDIVIDUAL	§	IN THE DISTRICT COURT
AND HUSBAND, NEXT FRIEND OF	§	
MARLISE MUÑOZ, DECEASED	§	
	§	TARRANT COUNTY, TEXAS
VS.	§	
	§	
JOHN PETER SMITH HOSPITAL,	§	
AND DOES 1 THROUGH 10, INCLUSIVE	§	96 TH JUDICIAL DISTRICT

JUDGMENT

On this date came on to be heard *Plaintiff's First Amended Motion to Compel Defendants to Remove Marlise Muñoz from "Life-Sustaining" Measures and Application for Unopposed Expedited Relief* in conjunction with *Platntiff's First Amended Original Petition for Declaratory Judgment and Application for Unopposed Expedited Relief*.

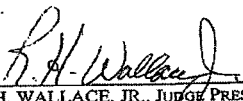
Having considered those matters, the Court finds:

1. The provisions of § 166.049 of the Texas HEALTH AND SAFETY CODE do not apply to Marlise Muñoz because, applying the standards used in determining death set forth in § 671.001 of the Texas HEALTH AND SAFETY CODE, Mrs. Muñoz is dead.
2. In light of that ruling, the Court makes no rulings on the Plaintiff's constitutional challenges to § 166.049.

IT IS THEREFORE ORDERED that *Plaintiff's First Amended Motion to Compel Defendants to Remove Marlise Muñoz From "Life-Sustaining" Measures* is granted and that the Defendants are ordered to pronounce Mrs. Muñoz dead and remove the ventilator and all other "life-sustaining" treatment from the body of Marlise Muñoz no later than 5:00 p.m., Monday, January 27th, 2014.

All relief not expressly granted herein is denied.

SIGNED this 24th day of January 2014.


R. H. WALLACE, JR., JUDGE PRESIDING

