THE IMPLICATIONS OF EXCLUSION: HOW PREGNANCY EXCLUSIONS DENY WOMEN CONSTITUTIONAL RIGHTS

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INTRODUCTION

In November 2013, a thirty-three year-old pregnant woman named Marlise Munoz was found unconscious and unresponsive in her Texas home.1 Munoz had suffered a pulmonary embolism, a blood clot

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in her lung. By the time paramedics arrived, Munoz’s brain had been without oxygen for at least thirty minutes. At the hospital, doctors were able to restart Munoz’s heart with electric shocks, and her heart continued beating with mechanical support. However, the young mother’s brain waves were nonexistent and doctors believed her brain had gone too long without oxygen to ever recover. It soon became clear that Ms. Munoz was brain dead. Munoz’s parents and husband prepared themselves to say goodbye and to remove Munoz from life support. Her family claimed that Munoz had made clear while she was living that she did not want to be kept alive by artificial means if the prognosis for recovery was low. Under Texas law, when a person without an advance directive is non-communicative and cannot make her own treatment options, her spouse and her parents have the legal right to make decisions for her, including the decision to withdraw life-sustaining treatment. However, the hospital refused to take her off of life support because she was 14 weeks pregnant.

Pursuant to Texas law, a pregnant woman, even one with a legally valid advance directive, cannot be taken off life support until her fetus is deemed non-viable; the mother’s body must be maintained until the child comes to term, or dies within her. Texas is one of twelve states that have laws which automatically invalidate a pregnant woman’s advance directive or end-of-life wishes, regardless of how far along the

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3 See Floyd, supra note 1.
4 Id.
5 See Fernandez, supra note 2.
6 See infra Part IV.
7 See Floyd, supra note 1.
8 See Fernandez, supra note 2.
9 See Tex. Health & Safety Code Ann. §166.039(b) (West 2013). “If the patient does not have a legal guardian or an agent under a medical power of attorney, the attending physician and one person, if available, from one of the following categories, in the following priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment: (1) the patient’s spouse; (2) the patient’s reasonably available adult children; (3) the patient’s parents[.]” If an advanced directive did not exist, Ms. Munoz’s husband and parents should have been legally entitled to make an end-of-life decision on her behalf.
10 See Floyd, supra note 1.
11 Tex. Health & Safety Code Ann. §166.049 (West 2013) (“A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient.”).
woman is in her pregnancy. A number of other states have different laws circumventing the advance directive of the pregnant woman. These laws, known for the purposes of this Note as “pregnancy exclusions,” are written into state advance directive statutes and, in most cases, provide that the woman’s end-of-life wishes must be ignored by the facility providing care in order to support the life of a fetus.

Ms. Munoz’s case highlights the reality that in thirty-seven states, the validity of a pregnant woman’s end-of-life wishes via an advance directive or family/spouse decisions, are voided or substantially limited. This Note will discuss only those end-of-life wishes that have been executed in an advance directive or a living will. An advance directive is a legal document specifying the type of medical and end-of-life care an individual would like to receive, should she be unable to verbally or competently express her choice at the time the care is executed. A living will is a specific type of advance directive which specifies the treatments an individual would want if she is terminally ill or in a permanent unresponsive state with little to no hope of cognitive recovery. Types of wishes outlined in living wills include an individual’s desire not to be kept alive on life support or breathing machines, the denial of tube feeding, and whether or not the individual would like her organs and tissues donated. In many states, execution of an advance directive such as a living will does not require preparation by an attorney: in New York State for example, an individual need only execute the document in front of two witnesses.

The ease of execution however, belies the extreme importance and intensely personal nature of these documents. An advance directive,
and living wills in particular, serve several critical purposes. First, a living will is the most effective means by which a person can maintain control over her health care decisions, even when rendered incompetent to make such decisions at the time the document is acted upon. By respecting a living will, health care providers are respecting the patient's wishes as well as the patient's right to bodily integrity. Additionally, advance directives ideally prevent the need for family members or health care providers to go to court or have to otherwise resolve treatment disputes that may arise. It should be noted that while an advance directive does not guarantee that a patient's wishes will be followed, it does "release physicians and others from liability if they follow the person's wishes." In other words, an advance directive, such as a living will, allows families and doctors to know exactly what the non-communicative patient wants, and allows medical staff to act accordingly without fear of repercussion. Furthermore, in cases like Ms. Munoz and her family, even where there is no legally executed advance directive, if the patient has made her wishes clear to family and friends, and care providers believe the proper course of action is to withhold life sustaining treatment, in most states they may do so via consent from the family or spouse of the patient.

Although the pregnancy exclusions vary among states, their existence implies that a patient's inherent right to refuse medical treatment, as well as her right to bodily privacy and integrity, are irrelevant when the woman asserting those rights is pregnant. This implication raises constitutional law questions surrounding issues such as the right to privacy, the right to bodily integrity, and the right to

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21 Id. at 332.
22 Id. at 612-613.
23 Id.
25 Id.
26 The (Un)Privileged Body: Living Wills are not for Incubators, supra note 24. See also supra note 9 for a discussion of Texas' statutory provision for family members and spouses making medical decisions on behalf of an incompetent patient.
27 See infra, Part I, discussing state pregnancy exclusions in detail.
equal protection.

While most Americans claim they would prefer a natural death to an artificially prolonged life, the right-to-die, as it has been categorized in recent years, is a topic steeped in political, ethical, practical, and constitutional difficulties. For example, legislatures and courts must distinguish between the refusal of medical care and promoting physician-assisted suicide. Moreover, state lawmakers are hesitant to legislate subjective conceptions of life and death especially when it comes to end of life care. The United States Supreme Court has held that an individual has the right to refuse medical treatment, but has left open the larger question of how this right is executed or protected. Theoretically, by executing an advance directive, explicitly directing kin and health care providers how she wishes to be treated medically, a person would be legally protecting themselves against the fickle nature of state legislatures. However, as this Note will discuss, this is not always the case.

The purpose of this Note is to examine state laws addressing pregnancy and living wills, as well as to argue that the most restrictive of these laws are unconstitutional and in need of immediate reform. Part I of this Note will discuss the state laws currently in effect across the country. Part II will identify the constitutional and public policy issues implicated by these laws. Part III will analyze how the state laws contradict standard interpretations of these constitutional rights. Part IV will provide concluding thoughts and suggest avenues for reform.

I. UNDERSTANDING THE STATE STATUTES

A. Background: Cruzan and the Patient Self-Determination Act of 1991

In 1990, the United States Supreme Court addressed the issue of patient’s right-to-die. The Court in Cruzan v. Director, Missouri Department of Health held that life-sustaining treatment could be withheld if an incompetent patient’s guardians or spouse (in this case, the patient’s

30 Id.
31 Id. at 865.
32 Id.
33 Wardle, supra note 29, at 865.
parents) could meet the burden of proof showing that the patient did not want such treatment.\textsuperscript{35} Nancy Cruzan was in a persistent vegetative state following a car accident and her parents requested that her life-sustaining treatment be ended, contending that Ms. Cruzan would not have wanted to be kept alive artificially.\textsuperscript{36} This case was pivotal because for the first time the Supreme Court recognized that a competent patient had a constitutionally protected right to refuse life-sustaining treatment and that this refusal must be honored by medical facilities and healthcare providers.\textsuperscript{37} The Court in \textit{Cruzan} stipulated that in the case of an incompetent patient the patient’s surrogates could (and in the majority of states would) be required by the state to meet a high burden of proof, showing that the patient would have indeed wanted to end the life-sustaining treatment.\textsuperscript{38} A patient who has executed an advanced directive indicating that she does not wish to be kept alive artificially will give her family or spouse an instrument with which to meet this burden of proof. Therefore, the \textit{Cruzan} decision stands as a clear marker of a patient’s right to protect her personal choice regarding end-of-life care, even in situations where she cannot express that choice.\textsuperscript{39}

In 1991, shortly after the \textit{Cruzan} decision was issued, Congress passed the Patient Self-Determination Act.\textsuperscript{40} The Act requires that health care providers, such as hospitals, nursing homes, and hospices receiving federal funding via Medicare or Medicaid, must inform all adult patients of their right to prepare an advance directive. However, the law does not specify how the information is given to patients, so “for women who live in states whose advanced directive statutes include pregnancy exclusions, there is no requirement for medical professionals to inform them that their wishes may be ignored if they are pregnant.”\textsuperscript{41}

The Supreme Court’s \textit{Cruzan} opinion and the subsequent passage

\textsuperscript{35} Id. at 278–80.
\textsuperscript{36} Greene & Wolfe, supra note 12.
\textsuperscript{37} \textit{Cruzan}, 497 U.S. at 279. (“[T]he United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”).
\textsuperscript{38} Id. at 280.
\textsuperscript{39} See Greene, supra note 12.
\textsuperscript{41} See Greene, supra note 12.
of the Patient Self Determination Act laid the foundation for many state legislatures to construct laws focusing on advance directives and end-of-life planning.\footnote{Id.}

B. \textit{Five Categories of Pregnancy Exclusions}

In 2012, the Center for Women’s Policy Studies studied the prevalence of pregnancy exclusion laws among the fifty states.\footnote{Id.} The study created five different categories of pregnancy exclusion laws based on the language and effect of the various state statutes.\footnote{Id.}

i. Category One: The Most Restrictive States

The first category includes states whose law dictates that pregnancy (at any stage) automatically invalidates a woman’s advanced directive.\footnote{Id.} As of 2014, eleven states adhere to this model of pregnancy exclusion: Alabama, Idaho, Indiana, Kansas, Michigan, Missouri, South Carolina, Texas, Utah, Washington, and Wisconsin.\footnote{See Ala. Code § 22-8A-4(e) (West, Westlaw through 2014 Reg. Sess. and 2015 Org. Sess.) (“The advance directive for health care of a declarant who is known by the attending physician to be pregnant shall have no effect during the course of the declarant’s pregnancy.”); Idaho Code Ann. § 39-4510 (West, Westlaw through 2014 Sec. Reg. Sess. of 62nd Idaho Legis.) (“The living will declaration of a person diagnosed as pregnant by the attending physician has no effect during the person’s pregnancy.”); Ind. Code Ann. § 16-36-4-8 (West, Westlaw through 2015 Reg. Sess. of 119th Ind. Legis.) (“The declaration to withdraw or withhold treatment by a patient diagnosed as pregnant by the attending physician shall have no effect during the course of the declarant’s pregnancy.”); Kan. Stat. Ann. § 65-28,103 (West Westlaw through 2014 Reg. Sess. and Ch. 1 of 2015 Reg. Sess. of Kan. Legis.) (“The declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient’s pregnancy.”); Mich. Comp. Laws Ann. § 700.5507 (West Westlaw through 2015 Reg. Sess. of the 98th Mich. Legis.) (“This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient’s death.”); Mo. Ann. Stat. § 459.025 (West Westlaw through 2014 Reg. Sess. of the 97th Mo. Legis.) (“The declaration to withdraw or withhold treatment by a patient diagnosed as pregnant by the attending physician shall have no effect during the course of the declarant’s pregnancy.”); S.C. Code Ann. § 62-5-504 (West Westlaw through Acts 1 and 3 2015 Reg. Sess.) (“If a principal has been diagnosed as pregnant, life-sustaining procedures may not be withheld or withdrawn pursuant to the health care power of attorney during the course of the principal’s pregnancy.”); Tex. Health & Safety Code Ann. § 166.049 (West Westlaw through 2013 3rd Sess. of 83rd Legis.) (“A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient.”); Utah Code Ann. § 75-2a-123 (West Westlaw through 2014 Gen. Sess.) (“A health care directive that provides for the withholding or withdrawal of life sustaining...
pregnant woman must remain on life support or life-sustaining treatment until she gives birth or the fetus dies within her. Notably, "none of these statutes make an exception for patients who will be in prolonged severe pain or who will be physically harmed by continuing life-sustaining treatment." This first category is the most constitutionally troubling and much of the subsequent analysis in this Note will focus on this group, referred to hereinafter as "Category One States".

ii. Category Two: The URTIA States

The second category contains state laws that have pregnancy exclusions similar to those outlined in the Uniform Rights of the Terminally Ill Act ("URTIA"), drafted by the National Conference of Commissioners on Uniform State Laws in 1985. Although it was not binding law upon the states, URTIA served as a legislative model for how to address the issue of end-of-life care when a patient is in a permanently comatose or vegetative state. Specifically, URTIA states that "the declaration of a patient known to the attending physician to be pregnant shall be given no force or effect as long as it is probable the fetus could develop to the point of live birth with the continued application of life-sustaining treatment." Currently, there are sixteen states adhering to this model: Alaska, Arizona, Arkansas, Illinois, Iowa, Kentucky, Montana, Minnesota, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Pennsylvania, Rhode Island, and South Dakota. These laws require a

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47 See Greene, supra note 12.

48 Id.


50 See Unif. Rights of the Terminally Ill Act, supra note 49, §5(d).

51 Id.; see also Greene, supra note 12.

52 See Alaska Stat. Ann. §13.52.055 (West Westlaw through 2014 2nd Reg. Sess. of 28th Alaska Legis.);[A]n advance health care directive by a patient . . . may not be given effect if (1) the patient is a woman who is pregnant and lacks capacity; . . . (4) it is probable that the fetus could develop to the point of live birth if the life-sustaining procedures were provided."); Ariz. Rev. Stat. Ann. § 36-3262 (West Westlaw through Apr. 6, 2015 of the 2015 1st Reg. Sess. of 52nd Ariz. Legis.); Ark. Code Ann. § 20-17-206 (West Westlaw through Mar. 27. 2015 of the
pregnant woman to be kept on life-sustaining treatment only if it is probable that her fetus will develop to the point of live birth. Unlike the first category, these laws base the continuation of life sustaining treatment on the viability of the fetus and the probability of a live birth.

These "Category Two" laws provide for more leeway in certain circumstances: the Kentucky, New Hampshire, North Dakota, Pennsylvania and South Dakota statutes "stipulate that an exception may be made if continuing treatment will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication." When a woman is terminally ill or in a permanently comatose state, however, the threshold for physical harm or severe pain

2015 Reg. Sess. of the 90th Ark. Legis.) ("The declaration of a qualified patient known to the attending physician to be pregnant must not be given effect as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment."); 755 ILCS 35/3 (West Westlaw through P.A. 99-2 of the 2015 Reg. Sess.) ("The declaration of a qualified patient diagnosed as pregnant by the attending physician shall be given no force and effect as long as in the opinion of the attending physician it is possible that the fetus could develop to the point of live birth with the continued application of death delaying procedures."); Iowa Code Ann. § 144A.6 (West Westlaw through 2015 Reg. Sess.) ("The declaration of a qualified patient known to the attending physician to be pregnant shall not be in effect as long as the fetus could develop to the point of live birth with continued application of life-sustaining procedures."); Ky. Rev. Stat. Ann. § 311.629 (West Westlaw through 2015 Reg. Sess.) ("Notwithstanding the execution of an advance directive, life sustaining treatment and artificially-provided nutrition and hydration shall be provided to a pregnant woman unless, to a reasonable degree of medical certainty, as certified on the woman's medical chart by the attending physician and one (1) other physician who has examined the woman, the procedures will not maintain the woman in a way to permit the continuing development and live birth of the unborn child, will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication."); Minn. Stat. Ann. § 145B.13 (West Westlaw through 2015 Reg. Sess.); Mont. Code Ann. § 50-9-106 (West Westlaw through 2015 Reg. Sess.) ("Life-sustaining treatment cannot be withheld or withdrawn pursuant to this section from an individual known to the attending physician or attending advanced practice registered nurse to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment."); Neb. Rev. Stat. § 20-408 (West Westlaw through end of 2014 Reg. Sess.); Nev. Rev. Stat. Ann. § 449.624 (West Westlaw through end of 2014 28th Special Sess.); N.H. Rev. Stat. Ann. § 137-J:10 (West Westlaw through end of 2014 Reg. Sess.); N.D. Cent. Code Ann. § 23-06.5-09 (West); Ohio Rev. Code Ann. § 2133.08 (West Westlaw through 2015 Files 1, 3 and 4 of the 131st GA (2015-2016)); 20 Pa. Cons. Stat. Ann. § 5429 (West Westlaw through end of 2014 Reg. Sess.); R.I. Gen. Laws Ann. § 23-4.10-5 (West Westlaw through Chapter 555 of the January 2014 Sess.); S.D. Codified Laws § 34-12D-10 (West Westlaw through 2014 Reg. Sess.).

53 See Greene, supra note 12; Unif. Rights of the Terminally Ill Act, supra note 49.
54 Id.
55 Greene, supra note 12; see also, notes on statutory language, supra note 52.
is ambiguous at best. Writing about the South Dakota pregnancy exclusion statute in 1992, Hope Matchan and Kathryn Sheffield explain:

It is difficult to envision actions which could be "physically harmful" to a pregnant woman in a "terminal condition". Under the statutorily provided definition of "terminal condition", she is already in an "incurable and irreversible condition." Additionally, if a pregnant woman is "unable to communicate verbally or nonverbally," whether or not severe pain has been "alleviated by medication" is a matter of sheer speculation by the physician. Consequently, while the pregnancy provision appears to provide several exceptions, the only reasonable exception for a pregnant woman in this condition is to have two physicians certify that her fetus is unhealthy. This operates as an abortion regulation statute.

One state that has seen legal challenges to its pregnancy exclusion law is North Dakota. The constitutional challenges brought by plaintiffs will be discussed in Parts II and III of this Note. In Gabrynowicz v. Heitkamp, a woman sought to execute a living will, which would remain in effect even if she later became pregnant. Plaintiff was denied the ability to execute such a document by state law, and argued that North Dakota’s pregnancy clause was unconstitutional because it deprived women of liberty without due process of law, it imposed undue burdens on the right to an abortion, it discriminated on the basis of gender in violation of the Equal Protection Clause of the Fourteenth Amendment, and it violated the First Amendment Establishment Clause and Free Exercise Clause. The United States District Court for the District of North Dakota dismissed plaintiff’s claim, however, due to issues of standing and ripeness: the plaintiff was not pregnant or in need of medical life sustaining technology at the time the case was brought. Thus, "the court did not see any 'realistic danger' that the statute in question would directly injure the plaintiffs . . .

57 Id. at 389-390.  
58 Sperling, supra note 20, at 339.  
60 Id. at 1063.  
61 Sperling, supra note 20, at 339-41.  
62 Id.
The court considered these questions to be abstract and non-justiciable. The dismissal of the case illustrates the catch-22 nature of the legal challenge: no one who would be deemed to have standing would actually be able to bring the claim. Gabrynowicz serves as an example of why it is so difficult for women in states with strict pregnancy exclusion laws to fight back against them in the court system.

iii. Category Three: Viability Standard States

The Category Three States include state laws that use the "Viability Standard" to determine the enforceability of an advanced directive. Four states use this viability standard: Colorado, Delaware, Florida and Georgia. The Center for Women's Policy Studies explains:

Essentially, viability standard statutes slightly modify the language of the URTIA model, making the relevant point of development of the fetus slightly different. For example, the Delaware statute states: "A life-sustaining procedure may not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of a life-sustaining procedure." The Georgia statute states that, to remove life-prolonging treatment, the fetus must not be viable and the woman must have written into her advance directive that the directive should be carried out in the event the fetus is not viable. If both of these criteria are not met, any directive stating that she should be removed from life-sustaining treatment

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63 Id.
64 See Greene, supra note 12.
65 See Colo. Rev. Stat. Ann. § 15-18-104 (West Westlaw through 2015 1st Reg. Sess.) ("In the case of a declaration of a qualified patient known to the attending physician to be pregnant, a medical evaluation shall be made as to whether the fetus is viable. If the fetus is viable, the declaration shall be given no force or effect until the patient is no longer pregnant."); Del. Code Ann. tit. 16, § 2503 (West) ("A life-sustaining procedure may not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of a life-sustaining procedure."); Fla. Stat. Ann. § 390.0111 (West Westlaw through 2015 1st Reg. Sess. of the 24th Fla. Legis.) ("If a termination of pregnancy is performed during viability, no person who performs or induces the termination of pregnancy shall fail to use that degree of professional skill, care, and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted."); Ga. Code Ann. § 31-32-9 (West).
will be ignored.\textsuperscript{66}

iv. Category Four: The Silent States

This category encompasses states whose living will statutes are silent on the issue of pregnancy.\textsuperscript{67} Thirteen states (and the District of Columbia) are considered to be in this category: California, Hawaii, Louisiana, Maine, Massachusetts, Mississippi, New Mexico, New York, North Carolina, Oregon, Tennessee, Virginia, West Virginia, and Wyoming.\textsuperscript{68}

In these states, the courts are most often issued the task of determining how to proceed when an incompetent, pregnant patient’s surrogate brings an action against the health care providers.\textsuperscript{69} Understandably, this ambiguity breeds reliance on the courts which results in delays.\textsuperscript{70} Thus, a terminally ill woman, or a woman in an unresponsive vegetative state, may be forced to endure prolonged life sustaining treatment against her wishes, while the Court decides whether or not her advanced directive may be carried out.\textsuperscript{71}

Although the legislature is silent in these states on the issue of the validity of a pregnant woman’s advance directive, some of state statutes include “conscience clauses.”\textsuperscript{72} These clauses allow medical care providers to continue life-sustaining treatment against the wishes of the patient and her family, if removal of life support goes against the conscience of the doctor providing care, or against the proffered public policy of the health care institution.\textsuperscript{73} Circumventing a pregnant woman’s advance directive in order to protect the ethical and moral considerations of the person or institution providing care, muddles the purpose of the legal document. These laws put a pregnant woman at

\textsuperscript{66} See Greene, supra note 12.
\textsuperscript{67} Id.
\textsuperscript{68} Id.
\textsuperscript{69} Id.
\textsuperscript{70} Id.
\textsuperscript{71} Id.
\textsuperscript{73} See Greene, supra note 12.
risk by subordinating her end-of-life wishes to the subjective belief of others.

Finally, there are four state statutes which explicitly explain that a woman can specify in her advance directive what type of medical treatment she wishes to have if she is pregnant at the time her advance directive is executed. These states are Maryland, New Jersey, Oklahoma, and Vermont. These laws are the most progressive and inclusive of a woman's right to her own bodily integrity. Additionally, these laws adequately inform a woman that "a pregnancy could complicate the execution of [her] advance directive." The issue of notice will be discussed in greater detail in Part II and Part III of this Note.

Part II and Part III of this Note will discuss the constitutional issues implicated by the various types of pregnancy exclusion laws discussed in Part I. Understandably, the most constitutionally suspect laws are those in Category One and Category Two states. As such, the focus of the remainder of this Note will be on these states, but there will also be discussions of Category Three and Four states.

II. CONSTITUTIONAL PROVISIONS IMPlicated

A. The Fundamental Right to Privacy

Unfortunately, the crossroads between the right-to-die and the right to abortion is often overlooked or maligned by critics and Courts. Only through understanding the foundation of the right to privacy can we thoroughly analyze how those two rights intersect.

Griswold v. Connecticut, decided by the Supreme Court in 1965, laid the framework for later precedent and defined the fundamental right to privacy. Although the right to privacy never appears explicitly within the Constitution, the Court constructed it from a "penumbral guarantees emanating from the Bill of Rights." The Supreme Court

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74 Id.
76 See Greene, supra note 12.
78 Griswold, 381 U.S. at 489; Matchan & Sheffield, supra note 56 at 392.
found that two Connecticut statutes were unconstitutional: one prohibiting the use of "any drug, medicinal article or instrument for the purpose of preventing conception" and the second providing for the prosecution of any person who "assisted or counseled another in the use of a contraceptive device." The Court wrote, "such a law cannot stand in light of the familiar principle, so often applied by this Court, that a 'governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep and thereby invade the area of protected freedoms." Six years later, the right held by married persons to use contraceptive devices was expanded by Eisenstadt v. Baird, to unmarried persons. Famously, the Court wrote that, "it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to whether to bear or beget a child."

The Griswold and Eisenstadt opinions are fundamental in understanding the role of government in reproductive rights. This precedent illustrates the Court's desire to allow individuals the right to make decisions in the privacy of their own homes and relationships. This privacy right would be expanded further in the decades following.

In 1973, the Supreme Court issued its landmark Roe v. Wade decision. The Court held that women across the country had a right to have an abortion under the Due Process Clause of the Fourteenth Amendment. This decision has been heralded by pro-choice advocates as establishing the right to an abortion as a fundamental right. Most notably, the decision in Roe established a trimester framework, which balanced the state interest in prenatal life and maternal health with the woman's right to maintain control over her own body. The strength of the state's interest increases, and the strength of the mother's rights decreases, as the prenatal life develops.

79 Griswold, 381 U.S. at 480.
80 Id.; Matchan & Sheffield, supra note 56 at 392.
83 Id. at 453.
85 Id.
86 See Greene, supra note 12.
87 Id.; Roe, 410 U.S. 113.
88 See Greene, supra note 12; Roe, 410 U.S. 113, 163.
Based upon the framework established in *Roe*, a woman had an unfettered right to an abortion during her first trimester (weeks one through twelve of pregnancy). During her second trimester (weeks thirteen through twenty-eight of pregnancy), a woman had the right to receive an abortion in an authorized clinic and under certain conditions. Finally, in her third trimester of pregnancy (weeks twenty-nine through forty of pregnancy), a woman could legally be denied an abortion by the state, as the state's interest in the health of the unborn child as well as the health of the mother (late term abortions are riskier for the mother) now outweighed the mother's interest in having her pregnancy terminated.

This trimester framework stood as precedent for nearly twenty years until 1992 when the Supreme Court once again took up the issue of a woman's right to an abortion. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court upheld *Roe* by reaffirming that the right to an abortion was constitutionally protected. However, the decision in *Casey* eliminated *Roe*'s trimester framework due to an increased understanding of pregnancy and neo-natal care. In the nineteen years separating *Roe* and *Casey*, the medical community had come to understand that viability was a more accurate indicator of prenatal life than trimesters. Additionally, doctors were now able to deem a fetus as viable (able to live outside of the mother with life-sustaining medical support) at twenty-two or twenty-three weeks, rather than at twenty-eight weeks (which was widely believed to be the beginning of viability when *Roe* was decided). The plurality in *Casey* held that in determining a fetus to be viable, the state interest in the life of the fetus would outweigh the rights of the woman to terminate the pregnancy, and the abortion may be deemed illegal. An exception was noted, however, where an abortion was necessary for the preservation of the life and the long-term health of the pregnant woman.

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89 See Greene, supra note 12; *Roe*, 410 U.S. 113, 163.
90 See Greene, supra note 12; *Roe*, 410 U.S. 113, 145.
91 See Greene, supra note 12; *Roe*, 410 U.S. 113, 165.
93 See generally id.
94 Id. at 860; Greene, supra note 12.
95 *Casey*, 505 U.S. 833, 862.
96 Id.; Greene, supra note 12.
97 Greene, supra note 12. See generally *Casey*, 505 U.S. 833.
In the context of this Note, the decision in Casey is important because it established the “undue burden” standard.\textsuperscript{99} When assessing the constitutionality of a state’s abortion laws, a court should consider whether the law poses an undue burden on the woman seeking the abortion.\textsuperscript{100} A law is considered unduly burdensome when that law has “the purpose and effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”\textsuperscript{101} Part III of this Note will discuss this undue burden test and how it applies to a pregnant woman who wishes to have life-sustaining treatment withheld.

At the source of both the right to privacy and the right to abortion lies the fundamental right to bodily integrity.\textsuperscript{102} This right, as illustrated in Cruzan, includes an individual’s right to refuse medical treatment.\textsuperscript{103} Even before Cruzan, the courts around the country had been grappling with this recognized autonomy; the New Jersey Supreme Court decided In re Quinlan in 1976.\textsuperscript{104} The Court wrote that, “[p]resumably the right to privacy is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman’s decision to terminate pregnancy under certain conditions.”\textsuperscript{105} This right to bodily integrity requires that the state regulation infringing it pass a strict scrutiny analysis:

Although the fundamental right to bodily integrity has been recognized, if a state regulation infringing this right survives strict scrutiny, it will be allowed to abridge the fundamental right in question. In other words, the state interests asserted must be sufficiently compelling while simultaneously utilizing the least restrictive means available for achievement. When attempting to abridge the fundamental right to bodily integrity, the asserted state interests include the preservation of life, the prevention of suicide, the protection of innocent third parties and the maintenance of the ethical integrity of the medical profession.\textsuperscript{106}

\textsuperscript{99} See generally Casey, 505 U.S. 833.
\textsuperscript{100} Casey, 505 U.S. 833 at 874-75.
\textsuperscript{101} Id.
\textsuperscript{102} See infra Part III(B).
\textsuperscript{103} See Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261 (1990); see supra Part I(A).
\textsuperscript{104} In re Quinlan, 355 A.2d 647 (N.J. 1976).
\textsuperscript{105} Id. at 663.
\textsuperscript{106} Matchan & Sheffield, supra note 56 at 393-394.
Many advocates argue that in the context of advance directives such as living wills and medical proxies, none of these interests reach the level of sufficiently compelling, as the patient has explicitly outlined her treatment decisions beforehand.\textsuperscript{107} Therefore, a pregnant woman with an advance directive in place has a right to bodily integrity that can never be abridged because end-of-life wishes have been clearly expressed.\textsuperscript{108}

B. Gender Classification and Discrimination

There is no doubt that certain classifications based on gender are constitutionally permissible, however, such classifications must be judged using an intermediate level of scrutiny.\textsuperscript{109} The Court explained intermediate scrutiny in \textit{Craig v. Boren}\textsuperscript{110} as such: “Classifications by gender must serve important governmental objectives and must be substantially related to achievement of those objectives.”\textsuperscript{111} Moreover, classifications based on pregnancy are inherently gender classifications, since women are the only gender who may be diagnosed with pregnancy. The Supreme Court has decided cases challenging certain classifications based upon pregnancy. In 1974 \textit{Cleveland Board of Education v. LeFleur}, a pregnant woman challenged a school district’s mandatory maternity leave policies that required pregnant mothers take unpaid maternity leave from teaching for five months before the birth of the child.\textsuperscript{112} The school district also delayed the mother’s return to teaching until the “next regular semester after the child was three months old.”\textsuperscript{113} Justice Stewart wrote the majority: “While the regulations no doubt represent a good-faith attempt to achieve a laudable goal, they cannot pass muster under the Due Process Clause of the Fourteenth Amendment, because they employ irrebuttable presumptions that unduly penalize a female teacher for deciding to bear a child.”\textsuperscript{114}

In 1978, Congress enacted the Pregnancy Discrimination Act,

\textsuperscript{107} Id. at 395.

\textsuperscript{108} Id.

\textsuperscript{109} Id. at 396-397.


\textsuperscript{111} Id. at 197.

\textsuperscript{112} Cleveland Bd.of Educ. v. LeFleur, 414 U.S. 632 (1974); Matchan & Sheffield, \textit{supra} note 56 at 399.

\textsuperscript{113} LeFleur, 414 U.S. at 635; Matchan & Sheffield, \textit{supra} note 56 at 399.

\textsuperscript{114} LeFleur, 414 U.S. at 648.
which amended Title VII of the Civil Rights Act of 1964 and prohibited employment discrimination on the basis of pregnancy.\textsuperscript{115} Subsequently, in \textit{Newport News Shipbuilding \& Dry Dock v. EEOC}, the Supreme Court held that “[t]he Pregnancy Discrimination Act ("PDA") has now made clear that, for all Title VII purposes, discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex.”\textsuperscript{116} Even though the Supreme Court’s ruling in \textit{Newport News} was limited to the Title VII context, “most commentators agree that pregnancy-based classifications are in fact gender-based classifications,” as women are the only gender who can become pregnant.\textsuperscript{117} The inherent pregnancy classification regarding advance directives infringes on a fundamental right: a man cannot become pregnant and therefore, his living will can never be invalidated because of his pregnancy.\textsuperscript{118} Although the challenges to a state’s pregnancy exclusion law would not be brought pursuant to Title VII, the decision in \textit{Newport News} is important because it creates the presumption that discrimination based on pregnancy is per se gender discrimination, thus possibly violating a woman’s right to Equal Protection under the 14\textsuperscript{th} Amendment.\textsuperscript{119}

\textbf{C. The First Amendment Establishment Clause}

The Establishment Clause of the First Amendment states simply that Congress “shall make no law respecting an establishment of religion.”\textsuperscript{120} At its heart, the Establishment Clause is a prohibition against government religious preference and against the government placing a particular religious dogma over that of another.\textsuperscript{121} In 1971, the Supreme Court’s decision in \textit{Lemon v. Kurtzman}\textsuperscript{122} created a three-pronged test for determining whether a state or Federal action had

\begin{itemize}
\item \textsuperscript{117} Matchan & Sheffield, \textit{supra} note 56 at 401.
\item \textsuperscript{118} \textit{Id}.
\item \textsuperscript{120} See generally U.S. CONST. amend. I.
\item \textsuperscript{121} Dr. Robert L. Maddox & Blaine Bortnick, \textit{Webster v. Reproductive Health Services: Do Legislative Declarations That Life Begins at Conception Violate the Establishment Clause?}, 12 Campbell L. Rev. 1, 3 (1989).
\item \textsuperscript{122} \textit{Lemon v. Kurtzman}, 403 U.S. 602 (1971).
\end{itemize}
violated the Establishment Clause. To avoid violating the Establishment Clause, a government action must have a clear secular purpose, it must not have the effect of advancing or inhibiting religious freedom, and it must not excessively or unnecessarily entangle government in religious affairs. In 1984, this three-pronged test was narrowly refined in *Lynch v. Donnelly*. In her concurring opinion, Justice Sandra Day O’Connor proposed her “endorsement test”: this test would determine whether the government action being challenged had the effect of endorsing one religion over another. In 1989, O’Connor’s test was adopted by the majority in *County of Allegheny v. A.C.L.U.*: “[W]hen evaluating the effect of government conduct under the Establishment Clause, we must ascertain whether the challenged governmental action is sufficiently likely to be perceived by adherents of the controlling denominations as an endorsement, and by the non-adherents as a disapproval, of their individual religious choices.”

The application of this Establishment Clause analysis to the issue of abortion came to a head in 1989, with Justice Steven’s dissenting opinion in *Webster v. Reproductive Health Services*. The case centered around a Missouri abortion statute which stated that life began at conception. Justice Stevens, in his dissent, argued that this declaration violated the Establishment Clause under the tests discussed above. Justice Stevens opined that the preamble to the abortion statute violated the Establishment Clause because it focused on the beginning of life and when life actually begins. When life begins is a concept deeply embedded in religious belief, argued Stevens. The *Webster* dissent illustrated what many already know: determining when life begins is a quest mired in religious and scientific animosity. By setting standards such as “viability” and “probability of live birth”, with

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123 Id. See also Matchan & Sheffield, *supra* note 56 at 402.
126 *Id.* at 705-08.
130 *Webster*, 492 U.S. at 647-49.
131 *Id.;* Matchan & Sheffield, *supra* note 56, at 402.
132 *Webster*, 492 U.S. at 647-49.
no scientific evidence or guidance, Category Two and Category Three state pregnancy exclusions, entangle the government in religious doctrine and violate the Establishment Clause.\textsuperscript{134}

III. CONSTITUTIONAL AND PUBLIC POLICY CONCERNS

Now that the bases for the Constitutional issues that are implicated by pregnancy exclusions have been established, Part III will explore how the Constitutional provisions are violated or weakened by the various pregnancy exclusion laws.

A. Right to Privacy and Abortion

The right to privacy and abortion, discussed in Part II (A), are implicated by Categories One, Two, Three and Four statutes. 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. Thus, we can analyze the Constitutionality of these pregnancy exclusions by using Supreme Court abortion law precedent.

After the Supreme Court's decision in \textit{Casey},\textsuperscript{135} the legality of abortion rests on viability: when the fetus is deemed be viable (able to live outside of the mother), this is the point at which the state's interest in the fetus will outweigh the right of the woman to have an abortion, and thus any obstacle the state imposes (i.e. criminal liability, barring access to facilities, etc.) is constitutional.\textsuperscript{136} The Court in \textit{Casey} made it easier for states to impose restrictions on a woman's access to abortion, but maintained that states could not ban abortions completely or impose restrictions that acted as "undue burdens" to women seeking an abortion.\textsuperscript{137} Opponents of pregnancy exclusions argue that the exclusions violate the female patient's right to abortion, especially those statutes which automatically invalidate a woman's advance directive upon a pregnancy diagnosis.\textsuperscript{138} These Category One statutes fail to take viability of the pregnancy into account at all, as many only require the presence of a fetal heartbeat in order to keep the mother alive.

\textsuperscript{134} \textit{See supra} Part I for discussion of Category 1 and Category 2 state legislation.
\textsuperscript{135} \textit{See supra} Part I.
\textsuperscript{136} Greene, \textit{supra} note 12.
\textsuperscript{138} Greene, \textit{supra} note 12.
artificially. Therefore, these statutes blatantly violate the undue burden and viability standards of *Casey*. The Category One living will statutes have two adverse affects:

[F]irst, women already in an incapacitated state cannot communicate their choice to have what, in other circumstances, would be a perfectly legal abortion; second, women who are capable of voicing their decision are still ignored because the law prohibits any termination of the pregnancy if that termination is done to carry out the removal of life-sustaining treatment.

In the case of an early term pregnancy, in which the fetus has not yet reached viability, a competent pregnant woman in a Category One state would be able, pursuant to the Supreme Court’s decision in *Casey*, to legally terminate the pregnancy. However, if the pregnant woman is not legally competent and cannot make her wishes clear verbally, her right to a legal abortion is diminished.

*Roe, Casey* and *Webster* established that the state’s interest in the potential life of the fetus is not compelling enough to override the rights of the mother until the fetus has reached viability. It flows from this precedent that the state therefore cannot regulate the enforcement of the living will of a pregnant woman, until the fetus has become viable. That is, the State has no legal basis for denying a pregnant woman’s right-to-die, until it has been established that the fetus could survive outside of the womb. However, because these Category One states void the advance directives of all terminally ill, comatose, or vegetative pregnant women, regardless of the stage of the pregnancy, the state statutes run contrary to established Supreme Court precedent.

The largest problem with automatic statutes, as well as states that adhere to the URTIA model (Category Two states), is the ambiguity of statutory language. URTIA states that “life-sustaining treatment must not be withheld or withdrawn pursuant to a declaration from an

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139 Id. See also supra note 45.
140 Greene, supra note 12.
141 Id.
142 Id.
143 Roe v. Wade, 410 U.S. 113, 163 (1973); See supra Part II(A).
144 Matchan & Sheffield, supra note 55 at 403-404.
145 Id.
146 Greene, supra note 12.
individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with the continued application of life-sustaining treatment.”\textsuperscript{147} The “probability of a live birth” is an extremely vague and subjective standard: This standard could easily be used to cover any pregnancy as a fetus is likely to develop to a live birth “as long as the woman carrying it continues to receive life-prolonging treatment . . . .”\textsuperscript{148} Thus, the constitutionality of these statutes is highly questionable: “No doctor, judge or legislative body can possibly determine with any certainty when a fetus has reached a point in development at which it will ‘probably’ reach live birth.”\textsuperscript{149} The “probability of live birth” standard, runs afoul of the \textit{Casey} precedent discussed above, because if a competent pregnant woman sought an abortion before viability, she would legally be able to receive one regardless of whether the fetus was likely to develop to the point of live birth or not.\textsuperscript{150} Much like Category One pregnancy exclusions, Category Two exclusions fail to take into account the viability of the fetus. Thus, a pre-viability abortion is legal when the woman is competent to express her wish to terminate the pregnancy, but illegal when the pregnant woman is unable to verbally express her wishes, even though she has provided for her end of life care via an advance directive.

Category Three State statutes that use a viability standard, are no less mired in ambiguity. The point at which viability begins is hotly contested within the medical, religious and legal communities.\textsuperscript{151} Courts have yet to specifically define viability and the term is especially susceptible to politics and social movements:

Its definition varies among political agendas, and is malleable by the individual, including the doctors who are in charge of determining the fate of their patients. Further, it is impossible for doctors to avoid relying on their own ideological beliefs to some extent, particularly as the definition of “viability” is fluid and deliberated within science and medicine. However, no individual right, especially one with a history of constitutional protection, should be subject to the ever-changing landscape of politics and public

\textsuperscript{147} Id.
\textsuperscript{148} Id.
\textsuperscript{149} Id.
\textsuperscript{150} See Dyke, supra note 28.
\textsuperscript{151} See supra note 133.
opinion.\footnote{\textsuperscript{152} Greene, supra note 12.}

The Category Four states, which include conscience clauses, allow medical staff to choose not to perform medical procedures they find morally troubling, expose a woman to the subjective belief of those providing her care.\footnote{\textsuperscript{153} See supra Part I for discussion of Category 2. See also Part I supra for discussion of conscience clauses.}

A woman who is in a permanent comatose or vegetative state cannot speak on her own behalf, lending more complexity to the issue. A woman in this situation cannot appear in court or sign an affidavit attesting to her wishes, and so she must rely on an advanced directive, which now may be automatically or implicitly invalidated.\footnote{\textsuperscript{154} Greene, supra note 12.}

Furthermore, a terminally ill or comatose woman, by definition suffers from both an incurable and irreversible condition, and so the state’s interest in the health of the mother is irrelevant, regardless of how developed the fetus is.\footnote{\textsuperscript{155} See supra Part I(A).} Thus, the importance of a woman’s right to privacy and her right to abort a fetus as collateral to ending her own life outweighs the interest of the state.\footnote{\textsuperscript{156} Id.}

B. Right to Bodily Integrity

The Supreme Court has held that a competent patient has the right to refuse medical treatment.\footnote{\textsuperscript{157} Elizabeth Carlin Benton, \textit{The Constitutionality of Pregnancy Clauses in Living Will Statutes}, 43 \textit{VAND. L. REV.} 1821, 1826 (1990). (“When a pregnant woman is terminally ill or comatose, the only state interest that justifies interference with the directives of the living will is the interest in fetal life.”).} The state may impose a burden upon this right in order to protect a sufficiently compelling state interest.\footnote{\textsuperscript{158} Matchan & Sheffield, supra note 56 at 394.}

This state interest cannot be unnecessarily broad or sweeping and must be balanced against the interests of the individual.\footnote{\textsuperscript{159} Id.}

The state’s interest can be in three main categories: 1) the preservation of life; 2) the prevention of suicide; and 3) the protection of innocent third parties.\footnote{\textsuperscript{160} Id.}

When a woman is pregnant, and the fetus is not yet viable, these interests are not compelling enough to overcome the woman’s wish to
refuse life-sustaining treatment, whether by verbal expression or expression through her advance directive.

First, in most instances a state's interest in preserving the life of a man or non-pregnant woman would not be compelling enough to overcome an applicable living will. Where a woman has made clear her wishes not be kept alive artificially, the state must adhere to this wish. Similarly, the state's interest in the prevention of suicide is not implicated in cases such as these because the pregnant woman is terminally ill or in a permanent state of unresponsive comatose.

The state's interest in preventing harm to innocent third parties (here, the unborn child), is irrelevant: Based on Planned Parenthood v. Casey precedent, the state may assert an interest in the right of an unborn fetus in an instance of a pregnant woman having a living will, but only after it has reached the point of viability. Thus, "while it may be within the confines of the Constitution for a pregnancy clause to abrogate the living will of an individual carrying a viable fetus," Category One statutes are too broad and inclusive of all stages of pregnancy.

Moreover, pregnancy exclusions place the rights of an unborn child above the rights of its mother. This extends to the fetus the rights of a "born-alive child." The decision in Roe made it clear that the rights of a fetus are nonexistent in the eyes of the law until a specific developmental stage. These laws therefore extend rights where there are none and open the door to troubling legal questions and responsibilities: "For example, could a parent whose child needs a transplant and is a donor match be forced to give up an organ? This completely rails against our legal system which has never forced one person to give up their own rights or safety to save another."

It is important to take into account the simple ethical argument that individuals have rights regarding the treatment of their own bodies and corpses:

161 Id. at 395.
162 See supra Part I(A).
163 Matchan & Sheffield, supra note 56 at 404.
164 See supra Part I(B).
165 Matchan & Sheffield, supra note 56 at 404.
166 Greene, supra note 12.
167 Id.
168 Id.
[W]e may grant the ability to make decisions about the treatment of one's own corpse because living people care about what happens to their bodies after death and we want to give them confidence that their wishes will be respected after death. On this view, the dead need not have rights. The reason for respecting people's wishes, even after they are dead, is to give comfort to the living. This is uncontroversial: we want to give the living confidence that their wishes will be respected, regardless of whether we also view the dead as having interests and rights in their own right.169

At its core, respect for the body of a dead or nonresponsive patient, reflects our values as a society and "as a society, we wish to see ourselves as people who respect the wishes of the dead."170 Americans who are living have a protected interest in bodily integrity, namely through laws prohibiting battery, assault and non-consensual touching.171 When it comes to the treatment of dead or unresponsive bodies, "few interferences with a corpse . . . are permitted without consent — either the prior consent of the deceased or substitute consent of the next of kin."172 It is clear that by requiring this prior consent, society has deemed the body of a dead individual to still maintain some semblance of personal bodily integrity.173 This bodily integrity should extend to posthumous reproduction or fetal incubation especially since the competing interests are unbalanced: the patient's right to bodily integrity and personal autonomy versus the rights of the unborn fetus or the family and friends of the patient.174 Take autopsy for example: Autopsy is usually prohibited without consent from the patient or from next of kin.175 In New York, "[N]o . . . autopsy shall be performed over the objection of a surviving relative . . . of the deceased that such procedure is contrary to the religious belief of the decedent, or, if there is otherwise reason to believe that a[n] . . . autopsy is contrary to the

169 Hilary Young, The Right to Posthumous Bodily Integrity and Implications of Whose Right it Is, 14 Marq. Elder's Advisor 197, 201 (2013).
170 Id.
171 Id.
172 Id. at 202.
173 Id.
174 Id. at 232 ("Prior consent should, therefore, be required, especially since competing interests are weaker than in the organ donation context, for example. The competing interest primarily involves the deceased's partner's interest in having a child with the deceased.").
175 Id.
decedent’s religious beliefs.\textsuperscript{176} Laws like this one illustrate a legal right to posthumous bodily integrity.\textsuperscript{177} However, pregnancy exclusions fundamentally undermine this right to bodily integrity, especially in cases where the mother is legally deceased.\textsuperscript{178}

C. Gender Discrimination

The goal of advance directives are to allow the wishes of a patient to be carried out, even when she cannot make those decisions explicitly. The pregnancy exclusion statutes around the country, however, treat the preferences of patients differently depending on their ability to carry a fetus to term. This differential treatment places women in a different class than men “based solely upon the woman’s risk of becoming pregnant . . . [and] expressly contravenes a woman’s right to have her living will carried out in the event that she is pregnant.”\textsuperscript{179} Thus, the Equal Protection Clause of the Fourteenth Amendment is implicated because classes of similarly situated persons are being treated disparately.\textsuperscript{180} Using the standard of intermediate scrutiny, the state interest must be balanced against the interest of the woman who is seeking to have her living will enforced.\textsuperscript{181} The state interest in the rights of the unborn child is weakened in the early stages of pregnancy, when the fetus is the least viable and it is not clear it would survive until a live birth.\textsuperscript{182} Assuming the state’s interest was found to be sufficiently important, (i.e. in later stages of pregnancy) a determination that the state has an important interest does not end an Equal Protection analysis.\textsuperscript{183} A state’s pregnancy provision must also be substantially related to achieving the asserted important interest.\textsuperscript{184} This substantial relationship test has caused confusion and disagreement, but appears to require that the classification be both effective and necessary.\textsuperscript{185} If a pregnant woman’s condition is deemed terminal and she has executed an advance directive indicating that she wishes to refuse life-sustaining

\textsuperscript{176} N.Y. Pub. Health Law § 4210(c) (McKinney 2015).
\textsuperscript{177} Young, \textit{supra} note170, at 232-34.
\textsuperscript{178} \textit{Id}.
\textsuperscript{179} Matchan & Sheffield, \textit{supra} note 56, at 406.
\textsuperscript{180} See Schair, \textit{supra} note 120, at 18.
\textsuperscript{181} See generally \textit{supra} Part II(B).
\textsuperscript{182} Matchan & Sheffield, \textit{supra} note 56, at 407-408. See also supra Part II(B).
\textsuperscript{183} Matchan & Sheffield, \textit{supra} note 56, at 407.
\textsuperscript{184} \textit{Id}. at 408.
\textsuperscript{185} \textit{Id}.
treatment, the “potential life of the fetus would be lost.”\textsuperscript{186} Pregnancy exclusions prevent this loss of the fetus by circumventing the living will until the fetus can develop to a live birth:\textsuperscript{187}

In addition, the statute is tailored so that if the fetus will never develop to the point of live birth . . . the mother's living will declaration will be enforced. While this pregnancy provision appears to be substantially related to the asserted interest in protecting potential life, the statute may sweep too broadly . . . . \textsuperscript{188} It covers a fetus at any stage of development . . . . \textsuperscript{188} While the state may have an important interest at some stage of fetal development, that interest is not necessarily absolute at all stages of development. Thus, the substantial relationship test may not be met by this provision.

Additionally, many of these pregnancy exclusions burden a woman's constitutional right to terminate a pre-viable pregnancy.\textsuperscript{189} No state has a compelling governmental interest in the life of the fetus pre-viability.\textsuperscript{190}

\textbf{D. Establishment Clause}

In order for a pregnancy clause within a state statute to be acceptable under the Establishment Clause of the First Amendment, it must pass the test created in \textit{Lemon v. Kurtzman} and refined in \textit{County of Allegheny v. A.C.L.U.}\textsuperscript{191} The statute must have a secular purpose, must not inhibit, advance or endorse any religion, and must not excessively entangle the government in religious affairs.\textsuperscript{192} Many of the state statutes described in previous sections of this Note, however, do not pass this constitutional analysis. Specifically, the Category One states, and a number of the Category Two states, impose religious views of conception and life into the legal world of advance directives and end-of-life planning.\textsuperscript{193} For example, South Dakota's pregnancy exclusion clause states that life begins at conception, regardless of the stage of the

\textsuperscript{186} Matchan & Sheffield, supra note 56, at 408.
\textsuperscript{187} Id.
\textsuperscript{188} Id. (citing Russell W. Galloway, Jr., Basic Equal Protection Analysis, 29 SANTA CLARA L. REV. 121, 123 (1989)).
\textsuperscript{189} Id. at 408-409.
\textsuperscript{190} See supra Part II(A).
\textsuperscript{191} See supra Part II (C).
\textsuperscript{192} Id.
\textsuperscript{193} See supra Part I (B) for legislative language and statutory citations.
woman’s pregnancy, the fetus is considered an unborn child, “worthy of greater protection.” This type of statutory language illustrates how a state has incorporated the religious definition of when life begins into the state’s laws. If a woman within the state disagrees with this determination of the beginning of life, she may feel alienated by the state and discriminated against by its laws because of her personal beliefs about when life begins and the morality of abortion. Thus, the state pregnancy clause implicitly endorses a particular religious belief and excludes all other, religious or non-religious, beliefs. Therefore, the state law fails to pass the endorsement test of the Establishment Clause. Furthermore, using this same logic, the state statutes would violate the additional prongs of the Lemon Test: the statutes both advance and inhibit religious beliefs by promoting one religious view of conception over another. Additionally, in her concurring opinion in Lynch, Justice O’Connor wrote that “political divisiveness is admittedly an evil addressed by the Establishment Clause. Its existence may be evidence that institutional entanglement is excessive or that a government practice is perceived as an endorsement of religion.”

These pregnancy exclusion clauses highlight issues of abortion and right-to-die, both hotly contested political issues within the United States. In a recent Gallup Poll, when asked whether a person considers themselves pro-choice or anti-abortion, 45% responded pro-choice and 48% responded as anti-abortion advocates. Also, if the response to Ms. Munoz’s case and others like it is any indication, many social issue groups have rallied around the issue of a person’s right-to-die.

Finally, it is worth re-iterating the concern that Category Four states, those states that have “conscience clauses” allowing medical staff to refuse to perform a medical procedure they find morally troubling, expose women to the subjective religious views of their health care providers. Do not hallucinate.

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194 Matchan & Sheffield, supra note 56, at 410 (quoting SDCL § 34-12D-10).
195 Id.
196 Id.
197 See supra Part II for further discussion of Lemon Test.
providers. These statutes put the validity of a woman’s advanced directive in the hands of health care workers who may have differing religious or moral beliefs than the patient.

IV. RECOMMENDATIONS FOR REFORM

At the end of January 2014, a Texas District Court Judge ordered that Ms. Munoz be taken off life support. The Judge, responding to papers filed by Ms. Munoz’s husband, acknowledged that Ms. Munoz had been brain dead since late November 2013 and that the fetus was no longer viable. According to the Texas Advance Directive Statute, life-sustaining treatment cannot be withdrawn from a patient who is pregnant. However, once the fetus is deemed non-viable, life-sustaining treatment may cease. Additionally, the North Texas Court ruled that since Ms. Munoz was legally brain dead, and had been for over two months, the statute could not apply to her. This landmark legal battle raises many questions for the future of pregnancy exclusion clauses and reform efforts. Specifically, the lines between natural death and artificial life support are further blurred: Ms. Munoz was legally dead for over two months before a Court was willing to recognize her right to die.

Many states are moving towards more progressive pregnancy clauses within their own advance directive statutes. These states, referred to in this paper as Category Five states, allow a woman to circumscribe the pregnancy exclusion with specific language written into her advance directive. Although this reform addresses many of the main concerns raised by pregnancy exclusions in this Note, one could argue that it still unduly burdens a woman’s right to privacy, as

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201 See supra Part II (B); see also supra note 72.
202 Neuman, supra note 180.
203 Id. Note: Because the Court found Ms. Munoz to be brain dead, it ruled the pregnancy exclusion statute did not apply to her, because she was already technically dead. Although this raises separate issues that could be discussed in a completely separate note, the issues apparent in pregnancy exclusions and the exclusions’ ability to circumvent the last wishes of a pregnant woman are still valid.
205 Dyke, supra note 28.
207 See supra Part I (B).
well as violates Equal Protection. Although a woman would be able to, in a sense, contract around the pregnancy exclusion statutory language, the fact that the language exists is troubling. Furthermore, there is little public knowledge about the issue of pregnancy exclusions within states, making reform efforts particularly difficult. This also raises the issue of notice and the necessity for women to understand that their legal documents may be compromised in the future. Unfortunately, many women and their families do not discover the existence of these pregnancy exclusions until it is too late.

CONCLUSION

A woman’s right to safe, accessible abortion has been protected by the Supreme Court since 1974. However, this constitutional right has been slowly eroding in many subtle ways including the existence of pregnancy exclusions. While many may not equate abortion with a woman’s end-of-life wishes, it is the unfortunate truth that the two often intersect. Women who do not wish to have their lives extended artificially, via life support mechanisms, when it is clear that there is little hope for any cognitive or physical recovery, have the right to have their wishes respected when they are not pregnant. However, when a pregnant woman has the same inclination, even before that pregnancy becomes a viable one, her rights are quashed. This disparity highlights distressing issues of constitutional inequality and intrusive state control. By educating state citizens about the insipid ways in which their legislators are contravening women’s constitutionally protected rights, hopefully people can make their voices heard.

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208 See supra Part I (B).
209 See supra Part I (B).
210 See supra Part I (B).