A TIME TO BE BORN AND A TIME TO DIE

A Pregnant Woman's Right to Die with Dignity

"For everything there is a season, and a time for every matter under heaven: a time to be born and a time to die; a time to plant and time to pluck up what is planted." Ecclesiastes 3:1,2

Since the beginning of time man has been faced with the inevitable fact that he must die. In recent years our technology has devised ways to put off that eventuality, at least temporarily. For many, the technological advances have added productive and meaningful time to their lives. For others, it has only prolonged the agony of the dying process. The right to end this process in a humane way has been the subject of numerous articles, books and court decisions.[1] This Note focuses on one dying person in particular, the pregnant woman.

Because of technological improvements in both cardiopulmonary resuscitation and life-support systems, there will be an increasing number of pregnant women who are brain dead or chronically vegetative.[2] In addition, the advances in medical science will sustain pregnant women who previously would have rapidly succumbed to terminal illnesses. It is estimated that cancer and pregnancy will occur simultaneously in 3,472 women per year.[3] One out of every 118 women who have cancer are pregnant.[4] Physicians and the court systems will be faced with new legal, medical and ethical problems inherent in this situation.

The legislature and courts have developed means by which a terminally ill person may arrange to forego or discontinue medical treatment which only serves to prolong the process of dying.[5] This is recognized

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[1]*See generally* DEATH, DYING AND EUTHANASIA (Horan & Mall ed. 1980); LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS (Doudera & Peters 1982); P. RIGA, RIGHT TO DIE OR RIGHT TO LIVE? LEGAL ASPECTS OF DYING AND DEATH (1981); R. VEATCH, DEATH, DYING AND THE BIOLOGICAL REVOLUTION (1976); Bryan, *How Dignified a Death? Living Wills*, 1985 MED. TRIAL TECH. Q. 209; Bryn, *Compulsory Lifesaving Treatment for the Competent Adult* 44 FORDHAM L. REV. 1, (1975); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973); Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741 (1984); Schwartz, *Patients' Right to Refuse Treatment: Legal Aspects, Implications and Consequences*, 1986 MED. TRIAL TECH. Q. 430; and Note, *The Right to Die — A Current Look*, 30 LOY. L. REV. 139 (1984).

[2]Hill, Parker, & O'Neill, *Management of Maternal Vegetative State During Pregnancy*, 60 MAYO CLINIC PROC. 471 (1985) [hereinafter *Maternal Vegetative State*].

[3]Iochim, *Non-Hodgkin's Lymphoma in Pregnancy*, 109 ARCHIVES OF PATHOLOGY AND LABORATORY MED. 803 (1985).

[4]Excluding basal cell carcinoma and in situ lesions. *Id.*

[5]*See infra* notes 9-13, 18-37, and 127-29 and accompanying text.

as humane and necessary by both the legal and medical communities. The Supreme Court of the United States has also recognized an interest in the potential life of a viable fetus.[6] When confronted with a woman who is both dying and pregnant there is a clash between these two interests. Because the right to die has been recognized by many courts as an aspect of the constitutional right of privacy,[7] a balancing test must be performed to determine if concern for the fetus compels state intervention. This no-win situation will be influenced by the facts of the case, such as state of fetal development and maternal condition. This Note will attempt to identify those factors which a decision-maker may find relevant in making this difficult choice.

I. The Right to Die

> *"Wherefore death is indeed . . . good to none while it is actually suffered, and while it is subduing the dying in its power."* St. Augustine, City of God, Book VI, Chpt. XIII.

A. The Common Law

The common law foundation for the right to die is the right to be free from unwanted bodily invasion. The courts have long recognized the importance of a person's bodily integrity. This fundamental concept was articulated by Justice Gray:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law . . . . "The right to one's person may be said to be a right of complete immunity; to be let alone."[8]

Another who violates that right without consent commits a battery.[9] This includes a physician who performs any procedure, no matter how beneficial or necessary,[10] without first obtaining the informed consent of the patient. Justice Cardozo stated, "Every 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

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[6]Roe v. Wade, 410 U.S. 113 (1973).

[7]*See infra* note 18.

[8]Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) (quoting T. Cooley, A Treatise on the Law of Torts 29 (2d ed. 1888)).

[9]Prosser, Handbook of the Law of Torts § 9 (4th ed. 1971).

[10]Mohr v. Williams, 95 Minn. 261, 268, 104 N.W. 12, 16 (1905).

patient's consent commits an assault, for which he is liable in damages."[11]

This doctrine of informed consent protects both the patient and the physician. Because of this safeguard, the patient may not be required to submit to unwanted procedures. By withholding or withdrawing his consent he may decline even life saving medical treatment.[12] By the same mechanism, the physician is relieved of liability from the consequences of honoring the patient's decision.[13]

Some jurisdictions base the right to die solely on this common law right of self-determination.[14] The New York Court of Appeals, in the case *In re Storar*,[15] expressed an unwillingness to recognize a constitutional basis for this right since the Supreme Court had repeatedly refused to grant certiorari in a number of similar cases.[16] In addition, it found the patient adequately protected by the common law.[17]

B. The Right of Privacy

Despite the Supreme Court's unwillingness to address the matter, most courts that have decided cases on this issue have recognized the right to die as having a basis in the constitutional right of privacy.[18] This right is not explicitly mentioned anywhere in the Constitution.[19] The Supreme Court in *Griswold v. Connecticut*[20] "found" the right of privacy in the penumbras of the Bill of Rights.[21] This newly discovered right was further expanded and solidified in subsequent cases.[22]

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[11]Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

[12]*In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied sub nom.* Storar v. Storar, 454 U.S. 858 (1981).

[13]*In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (1981).

[14]*See, e.g.*, *In re* Storar, 52 N.Y.2d 363, 377-78, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272-73 (1981).

[15]52 N.Y.2d 363 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied sub nom.* Storar v. Storar, 454 U.S. 858 (1981).

[16]*Id.* at 377-78, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73.

[17]*Id. See also* Winters v. Miller, 446 F.2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971); Jones v. Director of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964); *In re* Quinlin, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

[18]*See, e.g.*, Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); Satz v. Perlmutter, 379 So.2d 359 (Fla. 1980); Superintendent of Belchertown State School v.Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlin, 70 N.J. 10, 355 A.2d 647 (1976); Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

[19]Roe v. Wade, 410 U.S. 113, 153 (1973).

[20]381 U.S. 479 (1965) (the right of privacy encompasses the right of married persons to use contraceptives).

[21]*Id.* at 484.

[22]*See* Stanley v. Georgia, 394 U.S. 557 (1969) (the right to possess obscene materials

The right of privacy does not concern privacy in the conventional sense. Rather, it provides a more far reaching right to personal autonomy or freedom from government regulation.[23] It allows an individual to make certain decisions without interference from the government. The types of decisions falling into this zone of privacy are personal decisions involving one's self or one's family, which must be important decisions which affect one's life.[24] The Supreme Court stated, "'[O]nly personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' . . . are included in this guarantee of personal privacy.'"[25] The cases in which courts have upheld this right of privacy have involved decisions concerning marriage, procreation, contraception, family relationships, child rearing and education.[26]

Although the Supreme Court has never considered a case involving euthanasia, the right to refuse treatment, or the right to die, a number of state and lower federal courts have decided that these types of cases are controlled by the constitutional right of privacy.[27] The New Jersey Supreme Court in its highly publicized case, *In re Quinlin*,[28] referred to the Supreme Court's decision in *Roe v. Wade*[29] and equated the right to die with the right to have an abortion.[30]

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is included in the right of privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (the right of privacy extends to the distribution of contraceptives to unmarried persons); Roe v. Wade, 410 U.S. 113 (1973) (the right of privacy encompasses a woman's decision to terminate her pregnancy).

[23]This concept is explained fully in Henkin, *Privacy and Autonomy*, 74 COL. L. REV. 1410, 1411 (1974).

[24]Andrews v. Ballard, 498 F.Supp. 1038, 1046 (S.D. Tex. 1980) (paraphrasing Carey v. Population Services, 431 U.S. 678, 684-85 (1977)).

[25]Roe v. Wade, 410 U.S. 113, 152 (1973) (quoting Palko v. Connecticut, 302 U.S. 319, 325 (1937)).

[26]Roe v. Wade, 410 U.S. 113, 152 (1973) (citing Loving v. Virginia, 388 U.S. 1, 12 (1967) (marriage); Skinner v. Oklahoma, 316 U.S. 535, 541-42 (1942) (procreation); Eisenstadt v. Baird, 405 U.S. 438, 453-54 (1972) (contraception); Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (family relationships); Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925) (child rearing and education)). *But see* Bowers v. Hardwick, 106 S. Ct. 2841 (1986) (constitutionally protected right of privacy does not include right to engage in acts of homosexual sodomy in one's own home). The author of one article argues that the emphasis on the intimacy of these decisions leads to a conclusion that the right of privacy extends to other intimate matters. He views the list of marriage, procreation, and family life as only examples of the constitutionally protected zones of privacy. Delgado, *Euthanasia Reconsidered: The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474, 477 (1975).

[27]*See supra* note 18.

[28]70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

[29]410 U.S. 113 (1973).

[30]"Presumably this right 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

An analogy may be made between the decision to die and the decision to terminate a pregnancy. Both involve highly personal and intimate matters. The right to die may be even more personal if the patient is not pregnant. The termination of life-sustaining treatment involves only consideration of the life of the patient with no question of the life or potential life of anyone else. Both situations involve detrimental effects on the person's future.[31] The Court in *Roe* took into account the serious effects the birth of an unwanted child might have on the mother.[32] Similarly, the life of a terminal patient is detrimentally affected by forcing him to undergo unwanted treatment and prolong a hopeless existence.[33]

Once it was established that a right to die exists,[34] further cases refined the list of those instances in which that right may be exercised. The obstacles confronted in each instance are varied. An important common denominator, however, is the moral and emotional burden on the decision-maker. Various state courts have addressed the problem of who shall decide whether or not to discontinue life support for an incompetent patient who has not formally expressed his desires.[35] A California court has been faced with the decision of whether a patient who is hopelessly ill but not yet terminal may order the withdrawal of necessary treatment.[36] In a number of cases the definition of extraordinary or ordinary treatment is in question. In addition, a state court recently decided whether feeding may be withheld to facilitate the dying process.[37]

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enough to encompass a woman's decision to terminate pregnancy under certain conditions." 70 N.J. at 40, 355 A.2d at 663. This line of reasoning was also followed in other states to support a constitutionally based right to die. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

[31]Delgado, *supra* note 26, at 479.

[32]410 U.S. at 154. These included damage to mental and physical health by child care, the distress of bringing an unwanted child into a family which is unable to care for it and the stigma of unwed motherhood.

[33]Delgado, *supra* note 26, at 479. The author also compared the societal ramifications of both abortion and the right to die decisions. For example, he discussed population growth and allocation of scarce social and personal resources.

[34]That is, established by state courts, not the U.S. Supreme Court. *See supra* notes 16-18 and accompanying text.

[35]*See, e.g.*, John F. Kennedy Memorial Hosp. Inc. v. Bludsworth, 452 So. 2d 921 (Fla. 1983) (if a patient is chronically vegetative, the decision may be made by family members or guardian); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (the decision is to be made by substituted judgment, that is the choice must be that which the patient would have made if competent); *In re* Quinlin, 70 N.J. 10, 355 A.2d 647 (1976) (the choice must be the best interests of the patient made by the patient's family together with a hospital ethics committee); *In re* Colyer, 99 Wash.2d 114, 660 P.2d 738 (1983) (requires the appointment of a guardian for the patient).

[36]Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1985).

[37]*In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

Each new wrinkle sharpens the focus on this newly created right.

C. Compelling State Interest

Whether the right to die is based on a constitutional right of privacy or a common law right to be free from unwanted bodily invasion, that right must be balanced against state interests.[38] Because the decision to die is deemed "fundamental" by many courts and therefore protected from government regulation by the right of privacy, it can only be overcome if the state interest is considered "compelling".[39] The interests which are traditionally focused upon in right to die cases are (1) the preservation of life, (2) the protection of innocent third parties, (3) the prevention of suicide and (4) the maintenance of the ethical integrity of the medical profession.[40] None of these interests directly address the situation of a terminally ill pregnant patient. This traditional litany is not, however, exclusive of any additional interests.[41]

The state interest in preserving the life of a person decreases where treatment is intrusive and only prolongs the dying process.[42] Where the illness is incurable the value of life is not diminished by allowing the patient to refuse life-sustaining treatment.[43] The Supreme Court of Massachusetts stated in *Superintendent of Belchertown State School v. Saikewicz:*

> The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.[44]

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[38]*See In re* Quinlin, 70 N.J. 10, 40-41, 355 A.2d 647, 663-64 (1976), *cert. denied*, 429 U.S. 922 (1976); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 740, 370 N.E.2d 417, 424-25 (1977); *In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (1981), *cert. denied sub nom.* Storar v. Storar, 454 U.S. 858 (1981).

[39]Roe v. Wade, 410 U.S. at 156.

[40]Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *In re* Conroy, 98 N.J. 321, 348-49, 486 A.2d 1209, 1223 (1985); Saunders v. State, 129 Misc. 2d 45, 50, 492 N.Y.S.2d 510, 514 (1985); *In re* Colyer, 99 Wash. 2d 114, 122, 660 P.2d 738, 743 (1983).

[41]*See, e.g.*, Cantor, *supra* note 1, at 242-54.

[42]70 N.J. at 41, 355 A.2d at 664; *In re* Colyer, 99 Wash. 2d 114, 122, 660 P.2d 738, 743 (1983).

[43]Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741-742, 370 N.E.2d 417, 425-426 (1977).

[44]Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 424 (1977).

The interest in the protection of third parties traditionally extends to minor children who will be emotionally and financially harmed by losing their parents.[45] One case which found this interest compelling stressed the abandonment of the patient's child.[46] Some might argue that this interest should encompass the protection of the fetus. This enlargement, however, would be beyond the established concept of this state interest.[47]

It is well accepted that there is a difference between refusing life-sustaining treatment and committing suicide.[48] This is a distinction between allowing a fatal illness to run its natural course and actively seeking death.[49] Unlike suicide, the discontinuance of treatment is not irrational self-destruction.[50] It is an acceptance of death, not a desire for it that motivates the terminal patient.

The court in *Quinlin* stated that there is evidence "that physicians distinguish between curing the ill and comforting the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable."[51] Surveys of physicians show that a majority favor passive euthanasia and believe that it is widely practiced in the medical community.[52] The American Medical Association issued this statement: "The cessation of the employment of extraordinary means to prolong the life of the body where there is irrefutable evidence that biological death is imminent is the decision of the patient and-or his immediate family."[53]

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[45]*Id.*

[46]*In re* Presidents and Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (the court ordered the mother of a seven month old infant to submit to blood transfusions although it was against her religious beliefs).

[47]The nature of the third party interest discussed here is not one where the decision has clear, immediate, and adverse effects on the third party such as in *Raleigh Fitkin-Paul Morgan Memorial Hosp.*, *supra*, where a blood transfusion was necessary to preserve the life of a child in utero, as well as the mother. Clearly, different considerations are presented in such a case.

373 Mass. at 743, 370 N.E.2d at 426 n.10. For a discussion of the *Raleigh Fitkin* case see *infra* notes 72-75 and accompanying text.

[48]373 Mass. at 743, 370 N.E.2d at 246 n.11; *In re* Quinlin, 70 N.J. at 43, 355 A.2d at 665.

[49]Byrn, *supra* note 1, at 18.

[50]*Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 426 n.11.

[51]70 N.J. at 47, 355 A.2d at 667.

[52]Passive euthanasia involves withholding life-sustaining measures or "letting the patient go." This is distinguishable from active euthanasia which is taking an active role in helping the person die. Fletcher, *Ethics and Euthanasia* in DEATH, DYING, AND EUTHANASIA 293 (Horen & Mall ed. 1980). *In re* Storar, 52 N.Y.2d 363, 385-86, 420 N.E.2d 64, 75-76, 438 N.Y.S.2d 266, 277-78 n.3 (1981), *cert. denied sub nom.* Storar v. Storar, 454 U.S. 858 (1981).

[53]*Id.*

Although it is probably not a violation of medical ethics to discontinue life-support for a hopelessly ill, dying patient, there might be an ethical problem if that patient is pregnant. A physician who treats a pregnant woman views himself as having two patients, the mother and developing fetus.[54] Therefore, a physician who might have chosen to discontinue treatment if the patient were not pregnant may have to make a contrary decision so as not to violate his obligation to the fetus-patient. Although probably not a decisive factor,[55] this should be considered in balancing the state interest with the woman's right to bodily integrity.

II. Expanding Fetal Rights

Treatment of the fetus by our judicial system today provides some insight into the weight a decision-maker might accord the interest of the fetus in a right to die balancing test. In recent years there has been a trend toward expanding the rights of the fetus. One example is in the law of torts. Within a span of twenty years there was a complete change in the law concerning prenatal injury. Prior to 1946 nearly every jurisdiction denied recovery for injuries to a pregnant woman which resulted in damage to her subsequently born child.[56] In 1946 there was an abrupt reversal of the existing law. By 1967 every jurisdiction held that if the child is born alive he may maintain an action for prenatal injuries.[57] Some courts have even held that if her actions are unreasonable, a mother can be held liable for injuries inflicted on a child due to the mother's negligent pre-natal conduct.[58]

Criminal law has also witnessed a broadened recognition of the fetus. Under common law, in order to sustain a prosecution for homicide the

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[54]Haycock, *Emergency Care of the Pregnant Traumatized Patient*, 2 Emergency Med. Clinics N. Am. 843, 851 (1984), Mahowald, *Obgynethical Issues - Present and Future*, 12 Advances Psychosomatic Med. 166, 168 (1985).

[55]A number of courts have given this state interest little weight. *See* In re Conroy, 98 N.J. 321, 352-53, 486 A.2d 1209, 1225 (1985) (stating, "Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the value of the medical profession as a whole."). Also, the Massachusetts Supreme Court stated: "[I]f the doctrines of informed consent and right of privacy have as their foundations the right to bodily integrity . . . and control of one's own fate, then those rights are superior to the institutional considerations [of the medical profession]." Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 744, 370 N.E.2d 417, 427 (1977).

[56]Prosser, *supra* note 9, § 55.

[57]*Id.*

[58]*See, e.g.*, Grodin v. Grodin, 102 Mich. App. 396, 301 N.W.2d 869 (1980). (a child may sue his mother to recover for discolored teeth allegedly caused by the mother's use of tetracycline while pregnant).

"born alive requirement" must be met.[59] That is, the fetus must be fully brought forth and independent circulation must be established.[60] A number of states have, however, passed statutes which give the fetus greater protection by recognizing the killing of a fetus as a crime separate from homicide.[61] California's legislature went yet beyond these feticide statutes. Under the California Code murder is defined as the "unlawful killing of a human being, *or a fetus*, with malice aforethought."[62] In addition, California also applies its criminal child abuse statutes to fetuses: "A child conceived but not yet born is to be deemed an existing person insofar as this section is concerned."[63]

Unless the statute specifically includes a fetus, courts have always defined the word "person" to exclude an unborn child.[64] The Supreme Court of Massachusetts recently broke that well accepted rule when it became the first jurisdiction to include a viable fetus in its judicial definition of the word "person" for purposes of a penal statute.[65]

These are just a few examples of the nature of the expansion of the recognition of the fetus in the law today. They represent a change in perception. Generally, in the past, the law was viewed as protecting the interests of the subsequently born child. These changes have now granted rights to the fetus as a fetus. This may indicate that courts have a greater interest in protecting the fetus from its mother's decision to die.

III. Prior Balancing Tests

In order to determine whether state interest in the fetus is sufficient to prevail over a woman's fundamental right to die, the two interests must be balanced.[66] The most highly publicized and controversial cases involving the balancing of a woman's rights with fetal rights are the abortion cases. In *Roe v. Wade*,[67] the Court examined the woman's right of privacy, and although the Court found that the constitutional right of privacy was broad enough to encompass her decision to have

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[59]LaFave & Scott, Criminal Law 530-31 (1972). *See also* Keeler v. Superior Court, 2 Cal.3d 619, 470 P.2d 617, 87 Cal. Rptr. 481 (1970); Hollis v. Commonwealth, 652 S.W.2d 61 (Ky. 1983) (specifically upheld the common law rule regardless of viability).

[60]LaFave & Scott, *supra* note 59 at 531.

[61]Fla. Stat § 782.09 (1983); Ill. Ann. Stat. ch. 38 § 9-1.1 (Smith-Hurd 1986); Ind. Code § 35-42-1-6 (1986); Iowa Code § 707.7 (1985); Mich. Comp. Laws § 750.323 (1968); S.D. Codified Laws Ann. § 22-17-6 (1979).

[62]Cal. Penal Code § 187 (West Supp. 1986) (emphasis in original).

[63]*See* Cal. Penal Code § 270 (West Supp. 1986).

[64]*See supra* note 59.

[65]Commonwealth v. Cass, 392 Mass. 799, 467 N.E.2d 1324 (1984).

[66]*See supra* note 39 and accompanying text.

[67]410 U.S. 113 (1973).

an abortion, it recognized that this right is limited.[68] The pregnant woman cannot be isolated from her fetus.[69] The state interests in the health of the mother and the potential for human life increase during pregnancy.[70] The first becomes compelling at the end of the first trimester, the second at viability.[71]

Other cases which involve the weighing of the interests of the fetus and the mother are refusal of treatment cases. The first of these was *Raleigh Fitkin—Paul Morgan Memorial Hosp. v. Anderson*.[72] A pregnant woman, in conformity with her beliefs as a Jehovah's Witness, refused to accept necessary blood transfusions.[73] The one page decision in the case displays little legal analysis. The court reasoned that since a *child* could be given transfusions over the parent's objections and a *child* could sue its parents for injuries inflicted prior to its birth, then the fetus was entitled to the law's protection.[74] It ignored the legal significance of the common law distinction between a child and a fetus. Further, the court simply disregarded the rights of the mother by stating that, since the two are inseparable, the court could order that transfusions be given to the mother.[75]

Jefferson v. Griffin Spalding County Hospital Authority[76] took the holding in *Raleigh Fitkin* even further. The court ordered a woman, contrary to her religious beliefs, to submit not only to a blood transfusion, but also to a Caesarean section.[77] In order to enforce its order, the court granted custody of the fetus to the Georgia Department of Human Resources.[78] In doing so the court overrode the mother's freedom of religion, her right to bodily integrity, and her right as a competent parent to autonomy in family matters.[79] The balancing test which the court used was not fully explained and leaves little to aid future decision-makers:

> The Court finds that the state has an interest in the life of this unborn, living human being. The court finds that the in-

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[68]*Id.* at 155.
[69]*Id.* at 159.
[70]*Id.* at 163-64.
[71]*Id.* at 163-65.
[72]42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964).
[73]*Id.* at 423, 201 A.2d at 537-38.
[74]*Id.* at 423, 201 A.2d at 538.
[75]*Id.*
[76]247 Ga. 86, 274 S.E.2d 457 (1981).
[77]*Id.* at 89, 274 S.E.2d at 458, 460.
[78]*Id.* at 88, 274 S.E.2d at 459.
[79]*See* Finamore, *Jefferson v. Griffin Spalding County Hospital Authority: Court-Ordered Surgery to Protect the Life of an Unborn Child*, 9 AM. J. LAW AND MED. 83 (1983); *see also* Note, *Court-Ordered Surgery for the Protection of a Viable Fetus*, 5 W. NEW ENG. L.REV. 125 (1982).

trusion involved into the life of Jessie Mae Jefferson and her husband, John W. Jefferson, is outweighed by the duty of the state to protect a living, unborn human being from meeting his or her death before being given the opportunity to live.[80]

IV. Factors for Consideration

"To be a therapist to a dying patient makes us aware of the uniqueness of each individual in this vast sea of humanity." Elisabeth Kubler-Ross, *On Death and Dying*, 276 (1969).

A. Viability

Fetal viability is an important issue in any discussion of fetal rights. The Court in *Roe* stated that fetal viability is the decisive point at which a woman's right to choose to have an abortion may be overridden by the state interest in the potential life of the fetus.[81] The Court has since defined viability as the point, according to the judgment of the attending physician, where there is a "reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support."[82] This definition creates a fluid interpretation of this crucial point. It is dependent on advancements in neonatal technology as well as unbiased opinions by physicians.[83]

Although the Court in *Roe* addresses only the woman's right of privacy as it is manifested by her right to choose to have an abortion, the issue of viability has carried over to other contexts. The Supreme Court of Georgia relied on *Roe*'s viability criteria as a basis for its decision in *Jefferson*. "A viable unborn child has the right under the U.S. Constitution to the protection of the state through such statutes prohibiting the arbitrary termination of the life of an unborn fetus."[84] On the other hand, the Supreme Court of Massachusetts did not find

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[80]*Jefferson*, 274 Ga. at 89, 274 S.E.2d at 460 (quoting order issued by lower court).

[81]410 U.S. at 164-65.

[82]Colautti v. Franklin, 439 U.S. 379, 388 (1979).

[83]*See* Comment, *Fetal Viability and Individual Autonomy Resolving Medical and Legal Standards for Abortion*, 27 U.C.L.A. L. Rev. 1340 (1980). This comment examines the difficulties involved in a changing definition of viability as well as the problems of a definition of viability that includes extraordinary artificial means. For example, since medical technology is increasing the ability to sustain fetal life at earlier stages, the article questions who will take on the financial burdens of long-term, neo-natal medical care if the mother does not want the child.

[84]*Jefferson*, 247 Ga. at 88, 274 S.E.2d at 458 (quoting order issued by lower court). It is ironic that the Georgia court cites as authority the very decision which establishes that a fetus is not a "person" under the Constitution and therefore not entitled to its protection. *See* Roe v. Wade, 410 U.S. 113, 158 (1973).

a state interest which was sufficient to force a pregnant woman to submit to a "purse string" operation which would allow her to carry her non-viable fetus to term.[85] The Court stated that "[n]o case has been cited to us, nor have we found one, in which a court ordered a pregnant woman to submit to a surgical procedure in order to assist carrying a child not then viable to term."[86]

Viability is a convenient point at which to balance a woman's fundamental right to choose to procreate against a moral interest in a developing fetus. There are stronger emotions tied to a fetus that more closely resembles a fully developed child. Also, a fetus that can sustain life outside the womb is felt to be more independent of the mother. A decision by a court in the situation of a terminal pregnant woman wishing to die will undoubtedly take viability into account. However, *Roe* does not mandate the use of viability as the deciding factor. The decision states, "If the state is interested in protecting fetal life after viability, *it may go so far as* to proscribe abortion during that period. . . ."[87] A court may decide that violating the woman's right to refuse life-sustaining treatment is a lesser or greater violation than forbidding an abortion. It may be found that the fetus should be protected from its mother's decision to die irrespective of its point of development. On the other hand, it may be found that the woman's rights are superior to the fetus' regardless of its viability. It would be unwise for a court to look only to the stage of fetal development in weighing these two important interests.

B. *Maternal Condition*

An important consideration for the court must be the physical condition of the mother. Although there is a broad range of terminal states, the possibilities may be broken into three catagories which are the chronic vegetative state, terminal but cognizant, and brain dead. Each of these should be approached differently by a decision-maker.

1. Chronic Vegetative—The chronic vegetative state has been defined as a "chronic condition that sometimes emerges after severe brain injury and consists of a return of wakefulness accompanied by an apparent total lack of cognitive function."[88] In this condition the sapient functions of the brain are inoperative. What remains are the vegetative functions, which are those that control body temperature, breathing, blood pressure, heart rate, chewing, swallowing, sleeping and waking.[89]

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[85]Taft v. Taft, 388 Mass. 331, 334, 446 N.E.2d 395, 397 (1983).

[86]*Id.* n.4.

[87]410 U.S. at 164-65 (emphasis added).

[88]*Maternal Vegetative State*, *supra* note 2 at 470.

[89]*In re* Quinlin, 70 N.J. 10, 24, 355 A.2d 647, 654 (1976) (testimony of Dr. Fred Plum).

This was Karen Ann Quinlin's condition at the time her father requested to withdraw the use of a respirator.[90]

A patient in this persistent vegetative state can survive for long periods of time. One woman has survived in this condition for over twenty years.[91] However, recovery with return of cognitive functions is rare.[92] If a pregnant woman is in this state, her developing fetus is not necessarily affected adversely.[93] If proper nutrition is maintained and infection is avoided, a fetus may develop normally despite mechanical maintenance of maternal bodily functions at an early gestational age.[94] Although the fetus may be successfully delivered at twenty-eight weeks, some physicians believe that the best environment for fetal development is the mother's womb.[95]

In many states, a person is considered legally dead if his brain is no longer functioning.[96] The patient who is in a chronic vegetative state does not fulfill the requirements of brain death. The portions of the brain which control vegetative functions are still operative. The patient is still "alive," and he still retains his right of privacy and right of bodily integrity. Since the patient is unable to communicate, these rights have been invoked by guardians in most cases. This allows discontinuance of life support so as to avoid prolonged existence in this state.[97] Nevertheless, it can be argued that this manner of "life" with no awareness of the environment, degrading maintenance by mechanical means, and no hope of recovery is not life at all. Today, in most circumstances,

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[90]*Id.*

[91]2 GREAY & GORDY, ATTORNEYS' TEXTBOOK OF MEDICINE § 29A.71 (1986).

[92]*Id.*

[93]Heikkinen, Rinne, Alahuhta, Lumme, Koivisto, Kirkinen, Sotaniemi, Nuutinen, Jaruinen, *Life Support for 10 Weeks with Successful Fetal Outcome After Fatal Maternal Brain Damage* 290 BRIT. MED. J. 1237, 1238 (April 1985) [hereinafter cited as *Life Support*].

[94]Aderet, Cohen, Abramowicz, Becker, Sazbon, *Traumatic Coma During Pregnancy with Persistent Vegetative State*, 91 BRIT. J. OB. & GYN., 939, 940 (Sept. 1984). In this situation, the fetus developed normally in a comatose mother from 17 weeks gestation and was successfully delivered at 34 weeks despite anemia, hypozia, and treatment with numerous medications. *See also Maternal Vegetative State*, *supra* note 2, at 470. A male infant was successfully delivered by cesarean although the mother was in a chronic vegetative state from 14 weeks gestation. *Life Support*, *supra* note 93.

[95]*Maternal Vegetative State*, *supra* note 2, at 471-72.

> [I]f the mother's condition is stable, as in the chronic vegetative state, the intrauterine environment could well be safer than an incubator for maturation and development. . . . Although the decision about the optimal time for delivery may be dictated by the maternal condition, elective delivery might best be performed at a gestational age of 32 to 34 weeks.

Id., 471-72.

[96]*See infra* note 115 and accompanying text.

[97]*See supra* note 35.

if the patient has clearly expressed verbally or in writing[98] a desire to avoid extraordinary treatment if in this condition, or if the patient's guardian makes a substituted judgment for the patient,[99] he will be allowed to die with no extraordinary measures taken to prevent it.

This may not be the case if the patient is pregnant. The court will have to weigh the invasion of the mother's right to privacy against the state interest in the survival of the fetus. As previously noted, a previable fetus may be successfully carried by a comatose woman through a complete gestation period.[100] Even a viable fetus has a better chance for survival if kept in the womb to develop.[101] This increased, or at times sole, chance of survival may outweigh the burden imposed on the mother. First, the arguments presented by the Supreme Court in *Roe* for not requiring a woman to carry a fetus to term are not present in this instance.[102] The woman has lost cognitive functions. Because she is unable to think, she cannot be disturbed by maternity, or unwed motherhood. It may also be assumed that since the woman did not elect to abort the fetus prior to the onset of her coma, she intended to give birth to the child. Unless she gave explicit instructions to remove life-support regardless of whether she was pregnant, allowing the fetus to fully develop may fulfill the mother's desires.[103]

Second, the arguments for allowing the mother to die while in a persistent vegetative state may be less persuasive than those posed if she were in a cognitive state. Although it is not known if there is any physical pain, the supposition of pain is usually not the reason offered for rejecting treatment. The comatose patient is allowed to die rather than being subjected to constant treatment giving no hope of meaningful life. It also eases the emotional and economic burdens of the family who must watch a loved one linger in a mechanically maintained half-existence. It does not seem so great a burden to require that the mother be maintained for a matter of weeks, or at most nine months, to ensure the life of the fetus. The successful nurturing of the fetus may even

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[98]*See infra* notes 127, 128 and accompanying text. *See also* Bartling v. Superior Court, 163 Cal. App. 3d 186, 198, 209 Cal. Rptr. 220, 226 (1984); John F. Kennedy Memorial Hosp., Inc. v. Bludsworth, 452 So. 2d 921, 926 (1984); *In re* Storar, 52 N.Y.2d 363, 378-80, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274 (1981), *cert. denied sub nom.* Storar v. Storar, 454 U.S. 858 (1981).

[99]*See, e.g.*, *In re* Quinlin 70 N.J. 10, 54, 55, 355 A.2d 647, 671, 672 (1976); Superintendent of Belchertown State School v. Siakewicz, 373 Mass. 728, 745-752, 370 N.E.2d 417, 427-31 (1976).

[100]*See supra* notes 93, 94 and accompanying text.

[101]*See infra* note 113 and accompanying text.

[102]410 U.S. 133, 153 (1973) (factors include stressful life, mental and physical harm of child care, and stigma of unwed motherhood).

[103]*See supra* notes 95-97 and accompanying text.

give some meaning to her existence. Once delivery is completed, the mother may be allowed to die naturally.

2. Terminally Ill and Cognizant—The decision may be different if the patient is terminally ill and fully cognizant. Prior to viability, the woman's right to choose to carry the fetus to term is paramount.[104] Because she is capable of making her decision known, the mother may request a legal abortion, evading the conflict. This is simply an application of the Supreme Court's decision in *Roe*.[105] After viability, the decision again becomes one of balancing interests. The treatment of a number of diseases can continue without adversely affecting the fetus.[106] Therefore, it may be in the best interest of the fetus to keep the mother alive long enough to improve its chances for survival.[107]

Nevertheless, the state's intrusion into the life of the mother may be greater than the state interest in the life of the fetus, because the woman is aware of the pain she is experiencing. She must live with this and the knowledge that attempts to keep her alive for much longer will be futile. If she has made a rational decision to withdraw permission for life-sustaining treatment, the court should respect that decision. The court may, however, on the basis of *Raleigh Fitkin*, order that the fetus be delivered by cesarean section or that labor be induced so as to give it some chance to live.[108]

The court may take a dim view of allowing the mother to withdraw necessary treatment if the burden on her is not so great. If she is not in pain and only hastening an inevitable death, her need is not as critical. In this case a decision should be made to continue treatment long enough to safely deliver the fetus.

3. Brain Dead—In the case of a pregnant woman who is brain dead, new dilemmas may become manifest. If a patient is brain dead,[109]

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[104]410 U.S. at 164.

[105]*Id.*

[106]*See, e.g.*, Banks, *Pregnancy and Lymphoma*, 109 ARCHIVES PATHOLOGY LABORATORY MED. 802 (1985); Deitch, Rightmire, Clothier, & Blass, *Management of Burns in Pregnant Women*, 161 SURGERY, GYN. & OB. 1 (1985); Iochim, *supra* note 3.

[107]*See supra* note 82. "Improved life support with modern techniques has increased the possibility of prolonging pregnancy in a mother with acute fatal illness. Sometimes one or two weeks' life support is enough for the fetus to survive." *Life Support*, *supra* note 93 at 1237.

[108]*See supra* notes 59-67 and accompanying text.

[109]An often used set of criteria for brain death was established in the *Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*. The report listed three points to be considered in diagnosing death. They are: (1) Unreceptivity and Unresponsivity; (2) No Movement or Breathing, and (3) No Reflexes. The diagnosis should then be confirmed by a flat electroencephalogram. *A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 205 J.A.M.A. 85, 86 (1968).

somatic life[110] may be reasonably maintained for only up to two weeks.[111] That is, the cells of the body will begin to deteriorate to the point where attempts to maintain essential bodily functions are useless. The mother's body will begin to harm the fetus. Therefore, the body of a woman who is brain dead may only be used to sustain her fetus for approximately two weeks.[112] This two week span may be sufficient to favorably alter the chances of survival for the fetus. A study done at hospitals in Buffalo, New York, showed that a fetus at 25 weeks has a 38% chance of survival. At 26 weeks it has a 61% chance of survival. At 27 weeks the chances of successful fetal outcome grow to 76%.[113] The authors of the study stated, however, "Attempts to prolong maternal life in the face of brain death are expensive, frustrating and ultimately futile."[114]

That a woman is brain dead may have greater legal significance than medical. A majority of states have accepted by statute a brain oriented method of determining death.[115] In these states, therefore, the patient whose normal brain functions have ceased is legally dead. The

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[110]Meaning that which pertains to the body. SCHMIDT, ATTORNEYS' DICTIONARY OF MEDICINE AND WORD FINDER (1986).

[111]*Maternal Vegetative State*, *supra* note 2, at 471.

[112]*Id.*

[113]Dillon, Lee, Tronolone, Buckwald, & Foote, *Life Support and Maternal Brain Death During Pregnancy*, 248 J.A.M.A. 1089, 1091 (1982) [hereinafter cited as Dillon].

[114]*Id.* Dillon advocates in the case of a "pregnancy complicated by maternal brain death . . . a fetus of 28 weeks or beyond should be delivered as soon as practicable after confirmation of brain death." The authors of the Mayo Clinic Study maintain that a decision to deliver the fetus be based on maternal condition with best outcomes at 32 to 34 weeks. *Maternal Vegetative State*, *supra* note 2, at 472.

[115]ALA. CODE § 22-31-1 (1984); ALASKA STAT. § 9.65.120 (Supp. 1986); ARK. STAT. ANN. § 82-537 (Supp. 1983); CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1986); COLO. REV. STAT. § 12-36-136 (1985); CONN. GEN. STAT. ANN. § 19a-278 (West Supp. 1986); D.C. CODE ANN. § 6-2401 (Supp. 1986); FLA. STAT. § 382.085 (1986); GA. CODE ANN. § 31-10-16 (Supp. 1986); HAWAII REV. STAT. § 327C-1 (1985); IDAHO CODE § 54-1819 (1979 & Supp. 1986); ILL. REV. STAT. ch. 110 1/2, § 302 (1983); IND. CODE ANN. § 1-1-4-3 (West Supp. 1986); IOWA CODE ANN. § 702.8 (West 1979); KAN. STAT. ANN. § 77-205 (1984); LA. REV. STAT. ANN. § 9.111 (West Supp. 1987); ME. REV. STAT. ANN. tit. 22 § 2811 (Supp. 1986); MD. [HEALTH-GENERAL] CODE ANN. § 5-202 (Supp. 1986); MICH. STAT. ANN. § 333.1021 (Callaghan 1980); MISS. CODE ANN. § 41-36-3 (1972); MO. ANN. STAT. § 194-005 (1983); MONT. CODE ANN. § 50-22-101 (1985); NEV. REV. STAT. § 451.007 (1985); N.H. REV. STAT. ANN. § 141-D:2 (Supp. 1986); N.M. STAT. ANN. § 12-2-4 (1978); N.C. GEN. STAT. § 90-323 (1985); OHIO REV. CODE ANN. § 2108.30 (Supp. 1985); OKLA. STAT. ANN. tit. 63, §§ 3121-23 (West Supp. 1987); OR. REV. STAT. § 146.001 (1984); 35 PA. CONS. STAT. § 10203 (Supp. 1986); S.C. CODE ANN. § 44-43 460 (1985); TENN. CODE ANN. § 68-3-501 (1983); TEX. REV. CIV. STAT. ANN. art. 4447T (Vernon Supp. 1987); VT. STAT. ANN. tit. 18, § 5218 (Supp. 1986); VA. CODE § 54-325.7 (1982 & Supp. 1986); W. VA. CODE § 16-19-1(c) (1985); WIS. STAT. ANN. § 146.71 (West 1986); WYO. STAT. § 35-19-101 (Supp. 1986). Also, Massachusetts, Arizona, Washington, Nebraska, New Jersey, and New York have judicially determined brain death standards.

physician is no longer under a moral or legal duty to continue treatment even over the objections of the family.[116]

If a pregnant woman is brain dead, an argument may be posed that her death extinguished her right of privacy. Therefore, there is no need to weigh interests. The life of the fetus is the sole concern. The mother may be kept "alive," that is functioning, even against her prior requests or requests of her next of kin. This argument appears to solve the two pronged dilemma. The life of the fetus is saved and no fundamental rights are violated. However, the legal basis of the decision is faulty.

The legal death of the mother poses a much greater threat to the life of the fetus than does her right of privacy while alive. Once it is recognized that the woman is dead, the issue changes. Then the question is, may the physician use the newly dead, although mechanically maintained, cadaver of the mother as an incubator for her fetus?[117] Even in life or death situations, courts have never demanded that the organs or body of a deceased person be used to benefit another.[118]

The ability to use the body is no longer founded upon the right of privacy or interest in potential fetal life but rather on the state laws concerning organ donation.[119] Every state and the District of Columbia has passed some form of the Uniform Anatomical Gift Act.[120] According to the Uniform Anatomical Gift Act, the use of the body is predicated on the prior written gift of the body by the deceased.[121] If the deceased had not executed an anatomical gift, the family and certain others may do so.[122] If the physician knows that the woman explicitly wished not to make a gift of her body, he may not use the body after her death.[123]

Where there is agreement among the survivors as to the use of the body for the benefit of the fetus, there will be no problem. The physician may postpone pronouncement of death for the one or two weeks necessary. Complications may arise where there is disagreement over whether bodily functions should be maintained.[124] If the next of kin wants treatment to continue until the fetus can be safely delivered, absent

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[116]Schwartz, *supra* note 1, at 431.

[117]Veatch, *Maternal Brain Death: An Ethicist's Thoughts*, 248 J.A.M.A. 1102, 1103 (1982).

[118]*Id.*

[119]*Id.*

[120]Cotton & Sandler, *The Regulation of Organ Procurement and Transplantation in the United States*, 7 J. Leg. Med. 55, 60 (1986).

[121]Unif. Anatomical Gift Act § 2(a), 8A U.L.A. 34 (1968).

[122]*Id.* § 2(b). In order of priority, those who can consent to organ donations are, "The spouse, adult son or daughter, either parent, adult brother or sister a guardian of the person of the decedent at the time of death, and any other person under authorization or obligation to dispose of the body." *Id.*

[123]*Id.* § 2(c).

[124]Veatch, *supra* note 104.

express rejection by the mother prior to death, he can so authorize it. The husband of the woman has first priority in allowing or denying the use of the body.[125] Where the father of the fetus is not the mother's husband, there may be contention. The father would not be able to override the spouse's, or next of kin's wishes without violating express provisions of the statute.[126] Therefore, the final decision in this case will be an interpretation of the statute rather than a balancing test.

V. Natural Death Acts

Not only the courts, but also the legislatures have become involved in assisting those who wish to die with dignity. A number of states have passed statutes which provide a mechanism by which a person may make known his desire not to be kept alive by artificial means if his physical state should become hopeless.[127] The mechanism, often called a living will, provides a means by which guardians can make a decision for incompetent patients with guidance and security. It allows the patient peace of mind that his wishes will be carried out even though he should become physically unable to assert his desires.[128]

Some Natural Death Acts explicitly state that the authority granted by the patient to withhold life-sustaining procedures is suspended while

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[125]Unif. Anatomical Gift Act § 2(b), 8A U.L.A. 34 (1968).

[126]*Id.*

[127]Ala. Code §§ 22-8A-1 to 10 (1984); Ariz. Rev. Stat. Ann. §§ 36-3201 to 3210 (1986); Ark. Stat. Ann. §§ 82-3801 to 3804 (Supp. 1983); Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1986); 1986 Conn. Acts 85-606 (Reg. Sess.); Colo. Rev. Stat. § 15-18-101 to 113 (Supp. 1986); Del. Code Ann. tit. 16, §§ 2501-2509 (1983); D.C. Code Ann. §§ 6-2421 to 2430 (Supp. 1986); Fla. Stat. Ann. §§ 765.01-15 (West 1986); Ga. Code Ann. §§ 88-4101 to 4112 (1986); Idaho Code §§ 39-4501 to 4508 (1985 & Supp. 1986); Ill. Ann. Stat. ch. 110 1/2, §§ 701-710 (Smith-Hurd Supp. 1986); Ind. Code Ann. §§ 16-8-11-1 to 22 (West Supp. 1986); Iowa Code Ann. §§ 144A.1 to .11 (West Supp. 1986); Kan. Stat. Ann. §§ 65-28, 101 to 109 (1984); La. Rev. Stat. Ann. §§ 40:1299.58.1 - 1299.58.10 (West Supp. 1987); Me. Rev. Stat. Ann. tit. 22 §§ 2921-2931 (Supp. 1986); Md. Health-General Code Ann. §§ 5-601 to 5-614 (Supp. 1986); Miss. Code Ann §§ 41-41-101 to 41-41-121 (Supp. 1986); Mo. Ann. Stat. §§ 459.010 - 459.055 (Vernon Supp. 1986); Mont. Code Ann. §§ 449.540 - 449.690 (1985); N.H. Rev. Stat. Ann. §§ 137-H:1 to 137-H:16 (Supp. 1986); N.M. Stat. Ann. §§ 24-7-1 to 24-7-10 (1986); N.C. Gen. Stat. §§ 90-320 to 90-323 (1985); Okla. Stat. Ann. tit. 63, §§ 3101-3111 (West Supp. 1986); Or. Rev. Stat. §§ 97.050 - 97.090 (1983); Tenn. Code Ann. §§ 32-11-101 to 32-11-110 (Supp. 1985); Tex. Rev. Civ. Stat. Ann. art. 4590h §§ 1-11 (Vernon Supp. 1986); Utah Code Ann. §§ 75-2-1101 to 75-2-118 (Supp. 1985); Vt. Stat. Ann. tit. 18, §§ 5251-5262 (Supp. 1985); Va. Code §§ 54-325.8:1 to 54-325.8:12 (Supp. 1986); Wash. Rev. Code Ann. §§ 70.122.010 - 70.122.905 (Supp. 1987); W. Va. Code §§ 16-30-1 to 16-30-10 (1985); Wis. Stat. Ann. §§ 154.01-154.15 (West Supp. 1986); Wyo. Stat. §§ 35-22-101 to -109 (Supp. 1987).

[128]*See generally* Bryan, *supra* note 1; Hallagan, *Natural Death Acts and Right to Die Legislation*, 1986 Med. Trial Tech. Q. 301, 309; *The "Living Will": The Right to Die with Dignity?*, 26 Case W. Res. L. Rev. 485 (1977).

the patient is pregnant.[129] In these states, therefore, the question of whether a pregnant woman has the right to have procedures withheld has been decided by the legislature. It is interesting to note that with two exceptions,[130] this legislative solution, unlike the judicial decision in *Roe*, makes no qualifications as to viability or stage of pregnancy. The declarations are unenforceable at any time during the pregnancy. Only the statutes in Colorado and Iowa take viability into account. The Colorado Code requires that "a medical evaluation shall be made as to whether the fetus is viable and could with a reasonable degree of medical certainty develop to live birth with continued application of life-sustaining procedures. If such is the case, the declaration shall be given no force or effect."[131]

However, in *Dinino v. State ex rel Gorton*,[132] a woman brought suit seeking a declaration that her directive is valid and enforceable. The directive, as she had written it, varied from the standard set forth in the Natural Death Act in that it required that if she were to become terminally ill at a time when she was pregnant, an abortion was to be performed and subsequently, life-support was to be discontinued.[133] Although the case was not decided on its merit for lack of justiciable controversy,[134] the State in its brief and at oral argument "conceded that an individual can draft a directive that contains a properly worded abortion provision, or in the alternative, simply delete the pregnancy provision in the model directive."[135]

This assertion by the State would appear to undermine the legislative directive if the provision is seen as protection for the fetus. If the pregnancy provision is protection for the woman who wants to be assured that her life will continue until her fetus is safely delivered, the directive and the State's views are in line. If the woman wants to have the option of deleting the provision, or adding a valid abortion consent, then her wishes could be carried out. The woman who wished the child to be carried to term would rest easily just as would the woman who wanted to be assured of her right to die regardless of her pregnant state.

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[129]*See* statutes listed *supra* note 127 for Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Maryland, Mississippi, Missouri, Nevada, New Hampshire, Oklahoma, Texas, Utah, Washington, and Wisconsin.

[130]COLO. REV. STAT. § 1518-101-104 (Supp. 1986); IOWA CODE ANN. § 144A.6 (West Supp. 1986).

[131]COLO. REV. STAT. § 1518-101-104 (Supp. 1986). The Iowa statute states basically the same idea.

[132]102 Wash. 2d 327, 684 P.2d 1297 (1984).

[133]*Id.* at 1299.

[134]The plaintiff was neither pregnant nor diagnosed as terminally ill. *Id.*

[135]*Id.* at 1300.

VI. Conclusion

Today's technologies have altered our patterns of birth and death. Life is being extended, for better or worse, at both ends of the spectrum. When a woman is dying yet carrying a child the request to be allowed to die creates serious problems. A balancing test must be performed in order to determine whether or not a pregnant woman or her guardian has the right to order the withdrawal of life-sustaining procedures. The outcome of this test has grave consequences for the mother, her fetus, and her family.

There are several factors which should be considered by a decision-maker in determining the extent of the woman's right to determine what procedures may be performed to sustain her life. A factor which repeatedly has been weighed against the right to die is the integrity of medical ethics. Since the attending physician views a woman and her fetus as two patients, it may violate his ethics to allow them both to die. A factor of greater legal importance is viability. The Supreme Court's *Roe v. Wade* decision established that the state interest in fetal life may override a woman's right to choose to end her pregnancy at this point.[136] Although this ruling does not mandate the use of viability as the cut-off point for all of a mother's rights, it will certainly be an important consideration.

Also important in the decision is the physical condition of the mother. The decision whether to mandate the use of life-sustaining measures on a comatose woman may be resolved differently if a woman is aware of her condition and is requesting death. If a woman is brain-dead, the medical procedures only sustain a cadaver. Therefore, use of the body depends upon compliance with the state's anatomical gift act.

Some states have adopted living-will statutes. In some of these jurisdictions the statutes preclude use of these directives while the woman is pregnant. In these states, the woman's right to die may depend upon whether the statutes forbid the use of a living-will or only suggest that they not be used during pregnancy.

No hard and fast rule may be made about a woman's right to die or a fetus' right to be born. There are too many variables to create one single standard. One hopes the relevant factors will be weighed in each case to determine the best overall solution.

Kristin A. Mulholland

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[136]410 U.S. 113 (1976).