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COMMENTS

A WOMB OF MY OWN: A MORAL EVALUATION OF OHIO'S TREATMENT OF PREGNANT PATIENTS WITH LIVING WILLS

I. INTRODUCTION

In 1991, Ohio enacted legislation¹ enabling competent adults to execute a "declaration,"² a document commonly referred to as a living will or a type of advance directive.³ A declaration states an individual's wishes for the use, continuation, withholding or withdrawal of life-sustaining treatment in the case of that person's subsequent inability to authorize or to decline such treatment. Declarations obtain their utility and legitimacy from the assumption that the preferred manner of decision-making for all patients, including those lacking rational capacity, is that which reflects as closely as possible the patient's own wishes.⁴

By providing a legislatively-defined mechanism by which

1. Modified Uniform Rights of the Terminally Ill Act, OHIO REV. CODE ANN. §§ 1337.11-.17 (Anderson 1993), §§ 2133.01-.15 (Anderson Supp. 1992) [hereinafter the Act].

2. *See id.* § 2133.01(F).

3. A living will, for which a form exists in Ohio, is a commonly used term for the declaration itself. The term "advance directive" may also include the appointment of a durable power of attorney for health care. *See generally* ALAN MEISEL, *THE RIGHT TO DIE* §§ 10.1-2 (1989). Ohio law regulates the appointment of a durable power of attorney for health care under OHIO REV. CODE ANN. §§ 1337.11-.17 (Anderson 1993).

4. *See* MEISEL, *supra* note 3, at § 10.1-2. *See also In re A.C.*, 573 A.2d 1235, 1249 (D.C. Cir. 1990) (accepting substituted judgment, under which the court determines as best it can what choice the individual, if competent, would make, as the best procedure to follow to determine an incompetent pregnant patient's wishes regarding health care as "it most clearly respects the right of the patient to bodily integrity").

individuals, "declarants,"⁵ can effectuate their health care decisions after they are unable to make or communicate an informed choice,⁶ the Act generally advances the ethical principles of individual autonomy, self-determination, and bodily integrity.⁷ Numerous provisions in the Act further protect the declarant's autonomy by attempting to ensure that the decision regarding the termination of life-sustaining treatment was informed, deliberate, and carefully considered, and that the declaration accurately depicts the declarant's wishes.⁸

Recognizing that a declaration constitutes the best evidence of a patient's wishes, the Act supports the implementation of all valid declarations, with one exception. Amidst the substantive and procedural safeguards against misunderstanding or contravening a declarant's wishes, the Act contains the following:

Life-sustaining treatment shall not be withheld or withdrawn from a declarant pursuant to a declaration if she is pregnant and if the withholding or withdrawal of the treatment would terminate the pregnancy, unless the declarant's attending physician and one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive.⁹

Even if a pregnant woman specifically declined life-sustaining treatment in her living will, the clause mandates such treatment until the fetus can be brought to a live birth.

This Comment addresses the ethical implications of Ohio's

5. See OHIO REV. CODE ANN. § 2133.01(E) (Anderson Supp. 1992).

6. See William M. Todd, *Directing Health-Care Choices*, OHIO LAW., Sept.-Oct. 1991, at 10 (offering one drafter's summary of Ohio's living will law).

7. Commentators have criticized the extent to which living wills actually advance an incompetent patient's right of self-determination, as they reflect only the individual's past preferences and values as a once-competent adult and fail to incorporate the now-incompetent individual's interests. See Rebecca Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425, 431 (1990) (arguing for a modified objective standard to honor the incompetent patient's present interests). She does not dispute, however, that living wills enable individuals to control their futures.

8. Substantively, under Ohio law a living will becomes operative only in the very narrow circumstances when a terminal or persistently vegetative patient who would otherwise die of natural causes is being maintained on artificial means of life support. Procedurally, the statute contains extremely specific directions to indicate treatment choices so that the declaration is valid under the law. See OHIO REV. CODE ANN. §§ 2133.01-.03 (Anderson Supp. 1992).

9. *Id.* § 2133.06(B) [hereinafter the pregnancy clause].

pregnancy clause. As background, Part II summarizes the legal principles implicated in the dilemma presented by pregnant declarants. Part III articulates an analytic test proposed by a bio-medical ethicist¹⁰ to determine if Ohio's treatment of pregnant declarants is morally justified and thereby embodies sensible state policy. Part IV applies the proposed test. As the analysis exposes inconsistent and unjustified moral judgments implicit in the policy toward the pregnant woman, this Comment concludes that the automatic refusal to implement her living will is unacceptable state policy. Part V suggests balancing the state's interest in the fetus' potential life more evenly against the numerous and complex moral responsibilities implicated when a pregnant patient's living will directs the termination of life-sustaining treatment.

II. LEGAL BACKGROUND

The circumstances in which Ohio's pregnancy clause operates create a confounding legal problem. The declarant's pregnancy introduces the interests of an *other* into a legislative scheme designed to protect the declarant's autonomy in decision making. Independently of the statute, the declarant's end-of-life decisions reflect her deepest, most profound beliefs and emotions about her own existence. Yet, the interests of that *other*, or the state's assertion of those interests, cannot be considered separately from the declarant's because the two are, at the time, inextricably merged. In addition to their physical interrelatedness, the mother's role in creating the fetus precludes independent consideration of their legal interests. This section briefly presents the legal principles which converge in the case of a pregnant declarant.

A. *The Right to Refuse Treatment*

The right of individuals to self-determination in health care finds its basis in common law. This country has long protected individuals' rights of autonomy and freedom from state intervention in decision-making.¹¹ Historically, invasions of one's physical being were particularly egregious.

10. See *infra* notes 58-87 and accompanying text.

11. See *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (arguing that defendant's objections to evidence obtained by wire-tapping ought to be sustained). Justice Brandeis observed that the "right to be left alone—the most comprehensive of rights and the right most valued by civilized men," encompassed individuals' thoughts, beliefs, emotions and sensations. *Id.*

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."¹²

Even in the context of medical therapy, touching an individual without her consent constitutes an unwarranted invasion of her right to bodily integrity, a battery.¹³ The doctrine of informed consent developed to ensure that an individual's consent was "true": that the individual exercised her choice free from imposition and with knowledge of available options and risks.¹⁴ As a logical corollary of the doctrine of informed consent, competent patients possess the right not to consent, that is, the right to refuse treatment.¹⁵

Several state courts have held the common law right of bodily self-determination provided a sufficient ground to refuse life-sustaining treatment.¹⁶ However, the United States Supreme Court's landmark decision of *Cruzan v. Director, Missouri Department of Health*¹⁷ raised the right of self-determination to a federal constitutional "liberty interest" guaranteed by the Fourteenth Amendment.¹⁸ Inferring federal constitutional protection of that right from

12. *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (refusing to require plaintiff in tort action to undergo surgical examination to verify injuries (quoting THOMAS M. COOLEY, A TREATISE ON THE LAW OF TORTS 29 (1880))).

13. *See Canterbury v. Spence*, 464 F.2d 772, 783 (D.C. Cir. 1972) (developing the doctrine of informed consent, a legal and ethical principle encompassing an individual's understanding of the risks and benefits accompanying a particular medical treatment, and the individual's voluntary acceptance of the intervention).

14. *Id.* at 780-83.

15. *See Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 270 (1990).

16. *See James M. Jordan III, Note, Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 GA. L. REV. 1103, 1105 (1988) (citing cases). Other courts have found the right encompassed under state constitutions. *Id.*

17. 497 U.S. 261 (1990).

18. *Id.* at 278. Several state courts, including Ohio, have found the right to decline life-sustaining treatment within the fundamental constitutional right of privacy. *See, e.g., Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1138 (1986); *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976); *Leach v. Akron Gen. Medical Ctr.*, 426 N.E.2d 809, 814 (Ohio C.P., Summit County 1980). *See also Jordan, supra* note 16, at 1105 (citing cases). However, the Supreme Court expressly eschewed a privacy analysis in *Cruzan*, establishing the right to refuse treatment as a liberty interest. *See*

prior decisions,¹⁹ the Court affirmed the right of a competent person to refuse life-sustaining treatment, including nutrition and hydration.²⁰

The Court's characterization of the right to refuse life-sustaining treatment as a constitutionally protected liberty interest, rather than as a fundamental right, disappointed some right-to-die proponents.²¹ Weighing the liberty interest against "relevant state interests,"²² the Court held that Missouri could properly require clear and convincing evidence of the incompetent patient's wishes before treatment was discontinued.²³ Thus the Court refused to overturn the state supreme court's decision that testimony at trial regarding Nancy Cruzan's wishes did not meet the clear and convincing evidentiary standard.²⁴

Though the majority declined to define the right to refuse life-sustaining treatment as fundamental,²⁵ *Cruzan* essentially promoted a patient's right of self-determination. The Court asserted the state had "more particular interests"²⁶ in imposing the evidentiary burden than its interest in the preservation of human life.

The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.²⁷

In the Court's view, the state's requirement protected the

Cruzan, 497 U.S. at 279 n.7.

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

20. *Id.* at 278-79.

21. See Leon R. Kass, *Is There a Right to Die?*, HASTINGS CTR. REP., Jan.-Feb. 1993, at 34, 40 (describing the response of right-to-die proponents).

22. *Cruzan*, 497 U.S. at 279 (citing *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

23. *Id.* at 280.

24. *Id.* at 285.

25. The dissenting opinion characterized the right of competent individuals to refuse treatment as fundamental, which obtains the highest constitutional protection, and advocated extending that right to incompetents as they are no less entitled to due process and the equal protection of their rights. *Id.* at 304-09. In a concurring opinion, Justice O'Connor affirmed the protection afforded competent patients' rights to refuse unwanted medical treatment, and suggested that the state may have a duty to enforce a surrogate's decision to protect an incompetent patient's liberty interest as well. *Id.* at 288. O'Connor's opinion has been read as raising the right to refuse treatment to a fundamental level. See Richard E. Shugrue, *The Patient Self-Determination Act*, 26 CREIGHTON L. REV. 751, 759 (1993).

26. 497 U.S. at 281.

27. *Id.*

individual's right to self-determination by ensuring an accurate understanding of the patient's wishes. The deeply personal and final nature of a decision to forego life-sustaining treatment may legitimately warrant a higher evidentiary standard to ward against misinterpretations of a patient's ambiguous expression. Thus, *Cruzan* guarantees an individual's right to effectuate her health care preferences once those preferences have been expressed in accordance with state standards.

B. *The Scope of a Woman's Procreative Autonomy*

The Supreme Court has long protected childbearing decisions from state intrusions. As part of the constitutional right of personal privacy, decisions in matters of childbearing lie at the "very heart"²⁸ of an individual's right to independence in certain kinds of important decisions.²⁹ Providing a legal construct for the scope of a pregnant woman's autonomy in her procreative capacity, *Roe v. Wade*³⁰ established as fundamental a woman's right to choose to terminate her pregnancy before fetal viability. Only a compelling state interest advanced by narrowly tailored means may override the woman's right to choose.³¹

In *Roe*, the Court found two state interests that grow weightier and eventually become compelling as a woman approaches full term: "preserving and protecting the health of the pregnant woman,"³² and "protecting the potentiality of human life."³³ The

28. *Carey v. Population Serv. Int'l*, 431 U.S. 678, 684 (1977) (holding that the decision whether or not to bear or beget a child was among those protected by the constitutional right to privacy).

29. The Court accords parental decisions regarding their children special protection from government interference as well. *See, e.g., Wisconsin v. Yoder*, 406 U.S. 205 (1972) (upholding parents' interest in guiding the religious future and education of their children); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (invalidating a state statute requiring students to attend public rather than private schools as it unreasonably interfered with parents' liberty in upbringing and educating children under their control); *Meyer v. Nebraska*, 262 U.S. 390 (1923) (including within "liberty" under the Fourteenth Amendment the right of an individual to marry, establish a home and bring up children).

30. *Roe v. Wade*, 410 U.S. 113, 164-65 (1973).

31. *Id.* at 155.

32. *Id.* at 162. Considering the potential detriment to the health of pregnant women if abortion were prohibited, the Court enumerated the following factors: the distress of maternity or of having additional offspring, psychological harm, distress for all concerned associated with an unwanted child, the problem of bringing a child into a family unable, psychologically and otherwise, to care for it, and the difficulties and stigma of unwed motherhood.

33. *Id.* at 162.

Court's subsequent decision in *Planned Parenthood v. Casey*³⁴ affirmed viability as the point in the pregnancy when the state's interests in the fetus' potential life are strong enough to support restrictions on abortion.³⁵ At no time in the pregnancy, however, may the state's abortion regulations endanger the woman's life or health;³⁶ statutes that require a trade-off between the woman's health and fetal survival are unconstitutional.³⁷

In *Casey*, as in *Cruzan*, the Court emphasized the special deference a state must accord decisions involving an individual's definition of her identity.

[A mother's] suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.³⁸

Combined with the force of stare decisis, the personal and spiritual nature of childbearing decisions convinced the Court to preserve the woman's right to be free from government interference before fetal viability.

The state's interest in the fetus' potential life has shaped the scope of pregnant women's procreative autonomy outside the abortion arena. Courts have ordered pregnant patients to undergo medical treatment, commonly blood transfusions or cesarean sections, in order to benefit the fetus. While some courts followed *Roe's* demarcation of viability as the earliest point at which a state may interfere with a pregnant woman's decisions affecting her fetus,³⁹ others have forced medical treatment upon pregnant patients prior

34. 112 S. Ct. 2791 (1992).

35. *Id.* at 2804.

36. *Id.*

37. See *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986) (invalidating certain provisions in Pennsylvania's Abortion Control Act of 1982); *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979) (invalidating provisions in Pennsylvania's 1974 Abortion Control Act). See also Deborah K. Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Cesareans*, 74 CAL. L. REV. 1951, 1975-81, 1989-94 (1986) (establishing that neither Samaritan nor abortion law supports the subordination of the mother's well-being to save an endangered fetus).

38. *Casey*, 112 S. Ct. at 2807.

39. See, e.g., *Taft v. Taft*, 446 N.E.2d 395 (Mass. 1983) (declining to order medical treatment for patient pregnant with nonviable fetus).

to fetal viability.⁴⁰ In addition to considering fetal welfare in these contexts, courts have recognized the state's interest in protecting dependent third parties from loss of a parent when considering whether state intervention is justified.⁴¹

The judicial decisions imposing treatment upon pregnant women contradict the common law rule which denies the existence of a duty to rescue. "Courts do not compel one person to permit a significant intrusion upon his or her bodily integrity for the benefit of another person's health."⁴² Affirming this principle even where denying aid would result in the death of the endangered person, a Pennsylvania court refused to order one individual, Shimp, to donate bone marrow which was necessary to save the life of his cousin, McFall.⁴³ While the court characterized Shimp's refusal to aid his cousin as "morally indefensible," it held that compelling an individual to submit to a bodily intrusion would "defeat the sanctity of the individual [in violation of] the very essence of our free society."⁴⁴

The District of Columbia Court of Appeals upheld this principle in the context of a mother's duty to her fetus.⁴⁵ In *In re A.C.*,⁴⁶ the court considered the propriety of an order to perform a cesarean section on an unconsenting, questionably competent pregnant patient to save her viable fetus. The court declined to distinguish the case from *McFall* on the grounds that a woman who "has chosen to lend her body to bring [a] child into the world' has an enhanced duty to assure the welfare of the fetus."⁴⁷ Rather, the fetal case did not support a duty to rescue because "a fetus cannot have rights in this respect superior to those of a person who has already been born."⁴⁸ The maternal-fetal relationship did not abrogate the mother's right to be free of unwanted bodily

40. See, e.g., *In re Jamaica Hosp.*, 491 N.Y.S.2d 898 (Sup. Ct. 1985) (ordering life-saving treatment for a pregnant woman with a nonviable fetus).

41. See Rhoden, *supra* note 37, at 1973 (summarizing decisions incorporating the state's interest in protecting dependent children).

42. *In re A.C.*, 573 A.2d 1235, 1243-44 (D.C. Cir. 1990).

43. *Shimp v. McFall*, 10 Pa. D. & C.3d 90 (Allegheny County Ct. 1978).

44. *Id.* at 91.

45. While the law of rescue contains an exception imposing a duty upon parents to aid their children, rescues that risk life or limb remain optional. See Rhoden, *supra* note 37, at 1976-77.

46. *In re A.C.*, 573 A.2d at 1235.

47. *Id.* at 1244 (quoting John A. Robertson, *Procreative Liberty and the Control of Conception, Pregnancy and Childbirth*, 69 VA. L. REV. 405, 456 (1983)).

48. *Id.*

intrusions even where a forced intervention would protect the fetus' life or health.⁴⁹

While most of the conflict between the state and a woman's reproductive autonomy centers on the right *not to procreate*, a recent societal phenomenon involves state intervention in a woman's decision *to procreate*. In a widely publicized controversy, the Supreme Court of New Jersey condemned surrogate mother contracts.⁵⁰ Labeling such surrogacy arrangements as "potentially degrading to women,"⁵¹ the court asserted that the essential evil in surrogacy arrangements lay in taking advantage of the woman's need for money, despite the woman's consent to providing the procreative service.⁵² The court also recognized the legitimacy of state regulations designed to prevent coercion of expectant mothers with offers of financial inducements to part with their children.⁵³ Ohio courts concur in this view.⁵⁴ These decisions support the existence of a societal policy against coercion in women's decisions to procreate.⁵⁵

III. A MORAL "TEST" FOR PUBLIC POLICIES

While pregnancy clauses such as Ohio's have been subjected to analysis under the law that *is*,⁵⁶ this Comment evaluates Ohio's treatment of pregnant declarants in terms of the law that *ought to be*.⁵⁷ Thomas H. Murray, Director of the Center for Biomedical

49. *Id.* at 1252.

50. *In re Baby M.*, 537 A.2d 1227 (N.J. 1988) (invalidating a surrogacy contract). In the particular surrogacy arrangement at issue, a woman agreed to be artificially inseminated with the semen of another woman's husband for a fee of \$10,000, to carry the resulting fetus to term, and to surrender the baby after birth to the natural father and his infertile wife.

51. *Id.* at 1234.

52. *Id.* at 1249. The court asserted several other policy arguments against surrogacy arrangements, such as the rights of natural parents compared to adoptive parents, and the desire to allow both natural parents to raise the child.

53. *See id.* at 1248 (recognizing the law prohibiting the use of money in adoptions).

54. *See, e.g., In re Adoption of Infant Baby Girl Banda*, 559 N.E.2d 1373, 1375 (Ohio Ct. App. 1988) (asserting that the purpose of Ohio's adoption statute is to protect the mother and her baby from improper financial incentives in the mother's decisions).

55. *See also* Guido Calabrese, *Do We Own Our Own Bodies?*, 1 HEALTH MATRIX 5, 9 (1991) (acknowledging society's disapproval of a woman selling her womb in the case of surrogate motherhood).

56. *See, e.g.,* Elizabeth Carlin Benton, Note, *The Constitutionality of Pregnancy Clauses in Living Will Statutes*, 42 VAND. L. REV. 1821 (1990); Jordan, *supra* note 16, at 1103; Janice MacAvoy-Snitzer, Note, *Pregnancy Clauses in Living Will Statutes*, 87 COLUM. L. REV. 1280 (1987).

57. *See* H.L.A. Hart, *Positivism and the Separation of Law and Morals*, 71 HARV.

Ethics at Case Western Reserve University School of Medicine, has articulated an analytic approach to determine if moral judgments underlying public policies are sensible and thereby provide adequate support for those public policies.⁵⁸ By relying on ethical principles which apply to all individuals by virtue of their personhood, or their simple existence as human beings, his approach encourages reasoned discussion of the emotionally and politically charged policy articulated by the pregnancy clause.

Murray responds to the periodic emergence of medical ethical issues which implicate a mother's autonomy and the welfare of a fetus *in utero*. In the past, Murray has focused on public policies by which the state intervenes in a pregnant woman's conduct that threatens nonfatal harm to her fetus.⁵⁹ While his analyses do not specifically address the treatment of pregnant declarants, the pregnancy clause dilemma shares the essential feature of all ethical questions regarding medical interventions designed to aid a fetus. These cases require "asking how far the state—and physicians as agents of the state—ought to go in coercively intervening in the life of a woman in order to benefit her fetus."⁶⁰

As a first step, Murray inquires whether a fetus obtains the moral standing inherent to personhood.⁶¹ Addressing only those interventions designed to prevent nonfatal harm to the fetus, Murray avoids perhaps the most emotional and divisive controversy of this century, the abortion debate. According to Murray, the primary ethical concern in nonfatal interventions is the well-being of a fetus

L. REV. 593 (1958) (arguing against the separation of law and morals).

58. See Thomas H. Murray, *Moral Obligations to the Not-Yet-Born: The Fetus as Patient*, 14 CLINICS IN PERINATOLOGY 329 (1987) [hereinafter Murray, *Moral Obligations*]; Thomas H. Murray, *Prenatal Drug Exposure: Ethical Issues*, THE FUTURE OF CHILDREN Spring 1991, at 105 [hereinafter Murray, *Prenatal Drug Exposure*].

59. Murray has discussed the incarceration of pregnant drug addicts, see Murray, *Prenatal Drug Exposure*, *supra* note 58, at 105, and "Fetal Protection Policies" adopted by American companies which prohibit pregnant women or potentially pregnant women from working in toxic environments. See Murray, *Moral Obligations*, *supra* note 58, at 329.

60. Murray, *Moral Obligations*, *supra* note 58, at 329.

61. Murray's inquiry implicitly assumes that individuals, by virtue of their existences as human beings, possess fundamental, inalienable rights of freedom and equality, which support a moral duty to protect these rights. His analyses explicitly explore the scope of that duty, as it exists from the mother and from society in general.

Under federal law, an individual is not owed the full protection of the state until the individual is a "person" within the language and meaning of the Fourteenth Amendment, an event which occurs at birth. See *Roe v. Wade*, 410 U.S. 113, 157 (1973). However, *Roe* establishes that the state incurs a significant duty to protect fetuses as potential persons at the point of viability. *Id.* at 163.

that will be brought to a live birth, a "not-yet-born child."⁶² As beneficence toward a not-yet-born child is shared universally, the moral stature of the fetus with respect to a mother's choice to abort it is irrelevant in the context of nonfatal harm.⁶³

The fetus' destiny, to become a person in being, also establishes the moral irrelevancy of the viability issue for nonfatal harms.⁶⁴ "An act resulting in harm to a not-yet-born person, (who will eventually be a full-fledged person according to everyone's moral theory) is as great a harm as if it were done later."⁶⁵ The timing of the particular harm which a medical intervention is designed to prevent does not affect the moral evaluation of the act which causes the harm.⁶⁶

Once dissociating his analysis from the abortion controversy, Murray cautions against oversimplifying the relationship between the mother and her child-to-be.

Rather than viewing a woman who is pregnant as having one more relationship with moral import to add to the others she already has, we tend to treat a pregnant woman as if the fact that she is pregnant is the only morally important thing about her. Her pregnancy becomes a trump card, overwhelming all other moral considerations.⁶⁷

Murray contends the moral life is not so simple. First, an individual exists in a "complex web"⁶⁸ of morally significant relationships with many people. A mother's obligation to born or not-yet-born children may be particularly broad and deep, but it may not overwhelm all other morally relevant considerations in all circumstances.⁶⁹

Nor is a pregnant mother the only party who influences the fetus' well-being.⁷⁰ Murray points out that the health care system in this country, which results in many women not receiving adequate prenatal care, may cause more damage to more not-yet-born

62. Murray, *Moral Obligations*, *supra* note 58, at 331. Murray describes such a fetus as a "not-yet-born child to distinguish it from both the already-born child and from the fetus who will not be born alive." *Id.*

63. Murray, *Prenatal Drug Exposure*, *supra* note 58, at 106.

64. Murray, *Moral Obligations*, *supra* note 58, at 332-33.

65. *Id.* at 331.

66. Murray, *Prenatal Drug Exposure*, *supra* note 58, at 106.

67. *Id.* at 107.

68. *Id.*

69. *Id.* at 107-08; Murray, *Moral Obligations*, *supra* note 58, at 334.

70. Murray, *Prenatal Drug Exposure*, *supra* note 58, at 107.

children than any illegal drug.⁷¹ Furthermore, moral judgments behind policies towards fetuses must consider the obligations of fathers. As many actions a father-to-be takes may affect the fetus' well-being, Murray asserts that fathers-to-be may be equally or more at fault than the pregnant woman for not ensuring the fetus' welfare.⁷²

Second, moral obligations in real-life contexts cannot adequately be evaluated as all-or-none.⁷³ Every decision a parent makes regarding a born child involves a multiplicity of risks and considerations; certain risks are reasonable based on the probability of harm, its severity, the importance of the purpose for which the risk is run and the avoidability of the risk.⁷⁴ The complexity persists among the decisions of a pregnant woman. Murray admits the "geography" of pregnancy, the fact of the fetus' physical location within the woman, broadens the scope of actions potentially affecting the fetus beyond that posed by actions of parents of born children.⁷⁵ He argues, however, that is a difference in number, not in kind. "Fundamentally, a pregnant woman's moral obligations to her not-yet-born child are comparable to a parent's obligations to a born child."⁷⁶

Murray applies this principle of moral equivalency to evaluate the ethical nature of a mother's conduct that affects her fetus, and thereby the ethical boundary of the state's permissible intervention in a pregnant woman's behavior to benefit the fetus. Murray notes the almost universal recognition that a pregnant woman has a moral duty to take reasonable measures to prevent fetal injury.⁷⁷ To assess the scope of that duty, Murray analogizes a pregnant woman

71. *Id.*

72. *Id.* Murray explains that many actions of a father-to-be impact the long-term well-being of the fetus. Drinking or taking drugs that engender violent behavior or encourage the pregnant woman to do so, or refusing to pay for or discouraging adequate prenatal care, incurs moral culpability. See also Hilde L. Nelson, *Paternal-Fetal Conflict*, HASTINGS CTR. REP., Mar.-Apr. 1992, at 3 (summarizing studies establishing the deleterious effects on offspring due to sperm damaged by exposure to toxins).

73. Murray, *Moral Obligations*, *supra* note 58, at 334-35.

74. *Id.* at 336. As a simple example of the multiplicity of moral factors involved in any parental decision, Murray offers the practice of subjecting a child to a long car ride to enable visits with grandparents. More complex balancing appears in a parent's morally justified decision to expose a child to the considerable risks of cytotoxic drugs when the purpose is the treatment of cancer.

75. Murray, *Prenatal Drug Exposure*, *supra* note 58, at 108.

76. *Id.* at 108-09.

77. *Id.* at 109.

and her fetus to a father⁷⁸ and his born child, based on the common and comparable moral obligations flowing from parent-to-be to fetus and father to child. Because a fetus cannot have rights superior to a person in being, he argues that the obligations imposed on the father constitute an upper bound on the moral obligations that may be imposed upon the pregnant woman. Under this "child-as-maximum"⁷⁹ principle, the obligations of the pregnant woman to ensure the fetus' welfare may equal but not exceed the father's obligations to a born child.⁸⁰

Even when the moral comparison suggests that a pregnant woman's conduct is morally questionable or wrong, state intervention in her decisions is not always morally justified by the state's interest in protecting children. "We do not ban all conduct we regard as morally suspect, nor do we compel people to carry out every moral duty."⁸¹ Society grants parents wide latitude in decisions to expose children to risk.⁸² Where state intervention involves coercion, bodily invasion, or incarceration, society especially constrains the state's power to force its views of correct conduct on individuals.⁸³ "The moral and other costs of enforcement may outweigh the good that might be done."⁸⁴

Protecting children when they are fetuses is especially problematic, according to Murray. When necessary, the state may remove born children from physical surroundings which endanger them.⁸⁵ Not-yet-born children, in contrast, are not so separable. Due to the geography of pregnancy, Murray warns that "the moral cost of protecting not-yet-born children can be grave, interfering, perhaps grossly, with the autonomy of pregnant women."⁸⁶ The assessment of the moral costs of a policy consists of moral judgments that can be tested with the analogy to fathers and children. Constructing a situation involving a father and his child with similar moral dimensions to the dilemma confronted by pregnant women enables evalu-

78. Murray compares pregnant women to fathers, as opposed to parents in general, to help remove cultural blinders which might distort society's view of a pregnant woman's responsibility to her fetus. Murray, *Moral Obligations*, *supra* note 58, at 336.

79. *Id.* at 338.

80. *Id.*; Murray, *Prenatal Drug Exposure*, *supra* note 58, at 109.

81. Murray, *Moral Obligations*, *supra* note 58, at 337.

82. Murray, *Prenatal Drug Exposure*, *supra* note 58, at 110.

83. Murray, *Moral Obligations*, *supra* note 58, at 337.

84. *Id.*

85. Murray, *Prenatal Drug Exposure*, *supra* note 58, at 110.

86. *Id.*

ation to see if a parallel policy response is morally justified.⁸⁷

Murray's inquiry into the extent to which the state, and physicians as agents of the state, ought to intervene coercively in the life of a woman in order to benefit her fetus emphasizes the complexity and multiplicity of interests in moral decision making. Attempting to balance among moral considerations, Murray pursues public policies towards pregnant women which satisfactorily resolve the conflict these interventions pose between the ethical principles of beneficence or nonmaleficence toward the fetus, and patient autonomy for the mother. Employing the analogy to fathers of born children, Murray's test exposes inconsistencies in the moral judgments society imposes upon pregnant women that weaken the public policies based upon those judgments.

IV. ANALYSIS

Murray's moral test challenges the drastic intervention⁸⁸ required by pregnancy clause. The forced continuation of life-sustaining treatment for a pregnant declarant in contravention of her advance directive poses an extremely complex, difficult ethical dilemma. The hopelessness of the pregnant declarant's medical condition, combined with the potential for life that still exists inside her, create an emotional vortex in which the interests of the declarant, the declarant's family,⁸⁹ the fetus, the physicians, and the state intertwine. While factual distinctions between this and contexts Murray has addressed require some adjustments to his test, his method of moral analysis exposes inconsistencies inherent in the policy underlying the pregnancy clause, discrepancies enlarged by prevailing legal rules. By asserting the primacy of the state's interest in the fetus' potential life over all other significant moral considerations, the mandate to treat the pregnant declarant crosses the

87. Murray acknowledges that public policies must be evaluated by several criteria, including their effectiveness, efficiency and proportionality, which includes the consideration of the moral costs. *Id.* at 110-11.

88. One might argue that continuing treatment for the pregnant declarant is not an intervention that compares to, for example, the more blatantly intrusive incarceration of a pregnant drug addict, or a forced cesarean section to benefit a fetus. The similarity is clearer when the pregnancy clause forces initiation of life-sustaining treatment, rather than prohibits its withdrawal. However, the state's exercise of power intrudes upon the pregnant woman's autonomy and bodily integrity in all of the above contexts.

89. This Comment uses the term "family" to include traditional family members as well as other friends or care givers important to the declarant and responsible for her care.

ethical boundary of permissible state intervention.

In the contexts Murray has addressed involving interventions designed to prevent nonfatal harm to fetuses, he dissociated his analysis from the abortion controversy by recognizing the consensus regarding the welfare of not-yet-born children.⁹⁰ The fetus' viability is irrelevant where the fetus may suffer a nonfatal harm, for the fetus-as-born child would exhibit the injury as a living person regardless of the time it suffered the injury.⁹¹ In contrast, the moral evaluation of Ohio's pregnancy clause must address the fact that terminating life-sustaining treatment for the declarant will result in the simultaneous death of the developing fetus.

The fact of fetal death catapults the analysis of the pregnancy clause into the abortion debate. As both abortion and the discontinuation of life-sustaining treatment of a pregnant declarant result in fetal death, both contexts expose the tension between a woman's freedom to choose and the state's interest in the existence of the fetus. Theoretically, the controversy may be bypassed. The mother's decision to forego life-sustaining treatment does not contain the morally condemnable intent to kill her fetus, even if she were competent and aware of her pregnancy. When her treatment ceases, she will die of natural causes, as will her fetus.⁹² While the termination of the fetus' potential life magnifies the human tragedy in such a situation, the mother is no more morally culpable for the fetus' death than she is for the condition that has devastated her own existence.

The theoretical distinction between intentionally aborting a fetus and recognizing that a fetus will expire with the natural death of the mother may not satisfactorily resolve the debate over whether to implement a pregnant declarant's living will. The availability of medical technology that can artificially sustain the life of the mother, and thereby the fetus, creates the need for a more practical ethic to address the question of the fetus' personhood at the time the treatment dilemma arises.⁹³ Perceiving the fetus as a person will influence moral judgments of whether treatment ought to be imposed upon a pregnant patient against her wishes.

If one believes the fetus obtains no moral standing until it is a

90. See *supra* notes 61-66 and accompanying text.

91. See *supra* notes 64-66 and accompanying text.

92. See MacAvoy-Snitzer, *supra* note 56, at 118.

93. Theoretically, the availability of the technology does not necessitate its use. See Rhoden, *supra* note 37, at 1964 (criticizing the "technological imperative").

person in being, an act which terminates the fetus' development is morally inconsequential. However, if one grants the fetus any moral standing while *in utero*, even if a lesser moral stature than adults or children, or stature that grows as the fetus develops, an act which terminates the fetus' development obtains some degree of moral culpability. Furthermore, one's emotional reactions to the fetus' development may contribute to the existence and strength of moral judgments regarding the appropriateness of terminating the mother's treatment. Unlike in the contexts of nonfatal harm addressed by Murray, timing seems critical to the moral analysis of state intervention in a pregnant woman's decision to forego life-sustaining treatment.

The pregnancy clause comprehends the significance of timing. As written, the provision presumptively mandates the imposition or continuation of life-sustaining treatment for a pregnant declarant if failing to do so would terminate the pregnancy. However, the provision does not require treatment to continue if two physicians determine that the fetus "would not be born alive."⁹⁴ Only under such circumstances does the state allow considerations beyond its own interest in the fetus to affect the treatment decision.

Presumably influenced by abortion law, commentators have interpreted Ohio law to "render a directive invalid for a pregnant declarant only if the fetus is viable."⁹⁵ The definition of "viable" provided by Ohio case law compares to the language of the pregnancy clause; a viable fetus has "reached such a state of development that it can live outside the uterus."⁹⁶ If viability were the standard intended by the drafters of the pregnancy clause, the statute would mandate state intervention against terminating the declarant's treatment after approximately the twenty-fourth week of pregnancy, when the fetus has approximately a fifty percent chance

94. OHIO REV. CODE ANN. § 2133.06(B) (Anderson Supp. 1992).

95. See MEISEL, *supra* note 3, § 11.14 n.60. As *Roe* and its progeny protect the woman's right to choose to have an abortion before fetal viability, commentators generally consider this provision to save Ohio's statute from constitutional challenge. However, applying abortion law may be inappropriate. *Roe* allows states to prohibit intentional fetal destruction after viability, unless continuing the pregnancy threatens the mother's life or health. "It says nothing about whether the state may require invasive medical procedures to promote fetal health." Rhoden, *supra* note 37, at 1953.

96. *Peterson v. Nationwide Mut. Ins. Co.*, 197 N.E.2d 194, 196 (Ohio 1964) (holding that an "unborn viable child capable of life outside its mother's womb" is a person within family compensation clause of automobile liability policy providing death benefits for persons killed as result of motor vehicle accident).

of survival on its own.⁹⁷

Though the law endorses viability as the point in time when a fetus obtains the rights of personhood, and thus the state's protection, no moral consensus has been reached.⁹⁸ However, even assuming viability *ought* to constitute when the state's interest in the fetus' potential life outweighs the mother's autonomy and bodily integrity, the pregnancy clause denies the declarant that extent of protection. Instead of employing the legal term "viability," the clause refuses to implement the pregnant woman's declaration unless physicians determine the fetus would *not be born alive*. The ambiguous drafting exacerbates the moral problems with the state's singular promotion of its own interest in protecting the fetus.

While one physician's interpretation of "born alive" might compare to that under the viability standard, another might consider a fetus to be born alive if the fetus could be maintained on a respirator, feeding tubes and incubator with only a ten percent chance of eventually surviving independently. At a different hospital, that fetus might have only a five percent chance of survival, yet physicians there might agree the fetus would be born alive. The Ohio pregnancy clause subjects the pregnant woman's rights to such arbitrary factors as the sophistication of her treating hospital and physicians or the physicians' own biases regarding the fetus' moral status.

The Ohio statute on vital statistics⁹⁹ suggests a more specific definition of "born alive," but incorporating the definition into the pregnancy clause would retract almost entirely a pregnant woman's right to autonomy in her end-of-life decision. Ohio law requires physicians to report as a "live birth" any "product of human conception that after expulsion or extraction [from its mother] breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles."¹⁰⁰ In light of this definition, the pregnancy clause may

97. Telephone Interview with Nancy Judge, M.D., an obstetrician/gynecologist specializing in maternal-fetal medicine at University Hospitals of Cleveland, Ohio (Sept. 30, 1994).

98. The closest consensus may simply be that reasonable minds may disagree over when the fetus obtains personhood, a problematic conclusion if a sense of moral objectivity is the goal.

99. OHIO REV. CODE ANN. § 3705.01(A) (Anderson 1992).

100. *Id.* Dr. Judge, *supra* note 97, indicated that the law as she understood it requires physicians to report as a live birth a delivered fetus that exhibited agonal gasping, the last breath taken before death. She also reported delivering ectopic pregnancies with heartbeats, thereby qualifying as live births.

mandate the disregard of pregnant declarants' living wills as soon as the collection of fetal cells displays a heartbeat, which occurs at approximately four to five weeks after conception.¹⁰¹ Thus the provision may effectively extinguish a pregnant declarant's right of self-determination and bodily integrity from the outset of her pregnancy, in deference to the state's interest in the fetus' potential life.

The potential significance of timing in the context of forced treatment of pregnant declarants does not impair the instructive and compelling force of Murray's analytical approach. Even if one concedes the moral wrongness of a pregnant declarant's decision to forego treatment at any point in her pregnancy, the question remains whether state intervention in her decision is justified.¹⁰² Irrespective of the point in time at which the fetus obtains personhood, Murray's "child-as-maximum" principle holds that the obligations of the pregnant woman to ensure the fetus' welfare may equal but not exceed a father's obligations to a born child. As exposed by an analogy which presents the father of a born child in an ethical dilemma similar to that of pregnant declarants, the pregnancy clause violates this principle without sufficient justification.

Consider a father of a newborn child. He is currently hospitalized, in a terminal or vegetative condition, and supported by artificial means.¹⁰³ Prior to his decline in health, he executed a living will in accordance with the specifications of Ohio's living will

101. The heart begins to beat and propel blood through the embryo on approximately the 22nd day of the pregnancy. WILLIAM LARSEN, HUMAN EMBRYOLOGY 153 (1993). However, current medical technology cannot detect a fetal heart rate until five weeks after conception. DAVID N. DANFORTH, OBSTETRICS AND GYNECOLOGY 129 (1994).

Interpreting the "born alive" terminology so as to force treatment upon the mother if the fetus would be delivered as a live birth under OHIO REV. CODE ANN. § 3705.01 (Anderson 1992) would clearly violate *Roe's* prohibition against a state's undue interference with a woman's right to choose abortion before fetal viability. Thus, courts would be unlikely to interpret the pregnancy clause accordingly. Yet physicians seem likely to be aware of the live birth definition as they are responsible for reporting such vital statistics to the state. *See id.* § 3705.09 (requiring filing and registration of birth certificate for each live birth in the state, with the physician in attendance providing the medical information required by the certificate). Even if the drafters of the pregnancy clause intended to allow pregnant declarants greater autonomy than such a definition would allow, its language may convince physicians and their counsel to err on the side of legal safety when treating pregnant declarants.

102. *See supra* notes 81-84 and accompanying text.

103. The author thanks Dr. Murray for his suggestion of the outline of the following hypothetical situation. Interview with Thomas H. Murray, Ph.D., Director of the Center for Biomedical Ethics at Case Western Reserve University School of Medicine, Cleveland Ohio (Sept. 9, 1994).

law. He now meets the statutory definition of a "qualified patient"¹⁰⁴ so that his physicians and family are prepared to comply with his advance directive to withdraw all life-sustaining treatment.

Before treatment is withdrawn, physicians discover his newborn son suffers from a disease treatable only by transplanting several organs from an acceptable donor. The physicians determine the father is the only acceptable donor. However, the baby is unable to accept the organs immediately; physicians cannot attempt a transplant for three to six months, and there is no way to store the organs outside the father's body. Once the father's organs are used, physicians could continue to maintain his body as before on life support, or they could terminate treatment and allow him to die. Without his father's donations, physicians concur, the baby will surely die.¹⁰⁵

Although the father cannot alter his living will, would one judge him as morally wrong if he had included in his living will a provision specifically denying his newborn the use of his organs? While some might find the idea of organ donation disquieting or objectionable for any number of reasons, the moral obligation to assist one's child is extremely compelling under such circumstances. Yet, does the state's interest in preserving life justify the imposition of life-sustaining treatment upon the father so that his organs may be harvested for his newborn child at a later date?

Even if one's response is "yes," the analogy illuminates the fact that Ohio's living will law *does not* require a father in such circumstances to continue treatment so that his body may be used to save the child.¹⁰⁶ Yet the statute *does* force treatment upon a pregnant woman whose fetus is similarly dependent upon the use of her body. The inconsistency may reflect, as Murray suggests, a narrow view of the relationship between a pregnant woman and her fetus,¹⁰⁷ or perhaps some other bias not implicated with fathers of

104. See OHIO REV. CODE ANN. § 2133.01(Z) (Anderson Supp. 1992).

105. The hypothetical establishes that the unique geography of mother and fetus does not create a unique physical interrelatedness, although it may make the circumstances more viscerally disarming. As the fetus has only one available means of sustaining its life, its physical dependence is not qualitatively different than that of the newborn upon the father in the hypothetical, or of McFall upon Shimp. See *supra* notes 43-44 and accompanying text. Even if other organ donors exist, they cannot be forced to donate; the born child relies solely upon the father as a means for continued existence.

106. Again, the living will statute mandates treatment exclusively for pregnant declarants while supporting the implementation of the declarations of all other qualified patients. See OHIO REV. CODE ANN. §§ 2133.01-15 (Anderson Supp. 1992).

107. See *supra* notes 67-76 and accompanying text.

born children. Arguably, the inconsistency may result from mere oversight, as the drafters could not possibly consider every circumstance which might favor continuing treatment against a declarant's wishes.¹⁰⁸ Regardless of the reason for the differential treatment, the statute imposes a greater obligation on the pregnant declarant than it does on the father of a born child whose existence depends upon the appropriation of the father's body.

The discrepancy illuminated by the analogy exposes that the state *ought not* to force treatment automatically upon pregnant declarants in contravention of their advance directives. The circumstances in which a pregnant patient's living will becomes operative create numerous and complex moral responsibilities among the mother and her fetus, the father, family, and physicians. The state may legitimately intend to protect the fetus, but the pregnant declarant's pregnancy, as Murray notes, is not the only morally important thing about her.¹⁰⁹ The pregnancy clause wrongly precludes determining whether any moral considerations override the state's interest in the fetus' potential life and support the implementation of the mother's living will.

To the extent the enactment of a living will law reflects society's commitment to patient autonomy,¹¹⁰ respecting the mother's declaration constitutes an inherent moral good. The mother's decision not to be maintained on artificial life support required her to confront her own mortality, perhaps the most frightening and perplexing concept an individual must face.¹¹¹ As recognized by the Supreme Court, the "choice between life and death is a deeply personal decision of obvious and overwhelming finality."¹¹² Perhaps even more than in a woman's decision to bear or

108. One might argue the impossibility of including prohibitions against terminating treatment in all circumstances which might justify disregarding any adult's advance directives. My response would be complete agreement; this impossibility directly exposes the flaw of the pregnancy clause. The statute isolates the plight of the pregnant declarant, assuming all other groups of otherwise qualified patients will be treated justly under the provisions for objection in the event circumstances challenge the guarantee to implement the patient's living will. *See infra* note 116 and accompanying text.

109. *See supra* note 67 and accompanying text.

110. *See supra* notes 4-8 and accompanying text.

111. *See* ERNEST BECKER, *THE DENIAL OF DEATH* ix (1973) (exploring the psychological effect of the concept of mortality); JAMES P. CARSE, *DEATH AND EXISTENCE: A CONCEPTUAL HISTORY OF HUMAN MORTALITY* 7 (1980) (studying ten major conceptions of death); Daniel Cappon, *The Psychology of Dying*, in *THE INTERPRETATION OF DEATH* 61 (Hendrik M. Ruitenbeek ed., 1984) (studying the fear of death in dying hospital patients).

112. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 281 (1990). *See supra*

abort a child, "her own conception of her spiritual imperatives and her place in society"¹¹³ likely shaped her decision to forego life-sustaining treatment. The gravity of these considerations makes it unlikely that she made the choice lightly; the procedural requirements of the living will law could only enhance the deliberateness of her decision.¹¹⁴

The pregnancy clause trivializes the significance of the mother's self-defining and conscientious choice by automatically overriding it. The moral cost of doing so depends, at least in part, on whether the mother knew she was pregnant when she executed her living will. Without this knowledge, her refusal of treatment was not entirely informed, thus diminishing the moral compulsion to implement her advance directive as a means of protecting her autonomy. Yet the pregnancy clause does not recognize any level of consent by the mother to treatment in light of her pregnancy.¹¹⁵ The mother may have been fully aware of her pregnancy but have failed to reconsider her living will, or she may have been unaware of her pregnancy before she became incompetent. In either of these cases, good moral reasons may support a refusal to implement her living will. The mandate, however, to ignore the pregnant declarant's directive is an unnecessary diminution of her personhood, as the statute already contains mechanisms through which her family and physicians may object to the discontinuation of treatment.¹¹⁶

Even assuming the pregnant declarant refused medical treatment with full knowledge of her pregnancy, the state's interest in protecting the fetus' potential life does not alone justify intervening in the patient's decision. Deontologically,¹¹⁷ the mandatory interven-

note 27 and accompanying text.

113. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992). See *supra* note 38 and accompanying text.

114. See *supra* note 8 and accompanying text.

115. The statute fails to consider any other circumstances of the declarant's pregnancy. Did she freely consent to sex? To becoming pregnant after intercourse? Even those staunchly opposed to abortion often concede that abortion may be justified in cases of rape or incest; the pregnancy clause precludes consideration of any circumstances other than the fact of pregnancy.

116. Individuals, including family members, may object to the implementation of a qualified patient's declaration on the grounds that the course of action proposed is not authorized by the declaration, that the declarant did not give informed consent to the decisions within the declaration, or that the declaration does not substantially comply with the statutory requirements. See OHIO REV. CODE ANN. § 2133.05 (Anderson Supp. 1992). Physicians who object to the implementation of a qualified patient's living will may arrange for the patient's transfer. *Id.* § 2133.10.

117. Deontological ethics deny that the moral value of actions is exclusively a function

tion inflicts a grave moral wrong. Just as neither the law¹¹⁸ nor society¹¹⁹ requires the father to sacrifice the use of his body, the pregnant declarant should not be singularly considered the means to further the state's interest in the potential life of the fetus. The affront to her personhood is starkly illuminated by the fact that the pregnant declarants' bodies are treated with less respect than corpses; society refuses to force the donation of organs or tissue from cadavers to benefit or save the lives of thousands in need of them.¹²⁰ Neither her medical condition nor her pregnancy erodes her sanctity as an individual.

The state's opposition to coercive influences in women's procreative decision making in other contexts exacerbates the moral wrongness of its coercive intervention affecting pregnant declarants. Inconsistently, family law condemns coercion in a woman's use of her reproductive capacity,¹²¹ while the pregnancy clause coercively treats a pregnant declarant as having nothing more. The state must believe its interest in protecting the fetus justifies the physical and ideological duress of imposing unwanted treatment upon a pregnant declarant, whereas the interest of the adoptive parents in a surrogacy arrangement does not justify coercing the woman with money. But state intervention under the pregnancy clause seems immeasurably more coercive, for the pregnant declarant has no way of voicing her consent even if she were willing to give it. Whatever the extent of the surrogate mother's choice, however imperiled, involuntary, or coerced is her decision to accept money for the use and the product of her womb, it is greater than that of the pregnant declarant who is forced to undergo unwanted medical treatment to incubate her fetus.

Most would agree that the depth and strength of the maternal-

of the consequences of those actions; the means used to reach a desired end may be so condemnable that the action is morally unjustifiable. See generally BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 6-28 (1991) (defining two ethical theories, utilitarian and Kantian, predominant in current culture).

118. See *supra* notes 42-44 and accompanying text.

119. The *McFall* court recognized that other societies might require an individual to sacrifice his body in such a manner. However, the court confirmed that compelling an individual "to submit to an intrusion of his body would change every concept and principle upon which *our* society is founded." *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91 (Allegheny County Ct. 1978) (emphasis added).

120. See Lawrence J. Nelson & Nancy Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 J.A.M.A. 1060, 1065 (1988) (arguing that neither the medical profession nor society should support judicially compelled treatment of pregnant women).

121. See *supra* notes 50-54 and accompanying text.

fetal relationship proportionately magnifies the declarant's moral duty to aid her fetus beyond the duty owed by Shimp to McFall, as a cousin,¹²² and beyond the duty of one stranger to another.¹²³ Conceding this judgment, however, does not necessitate the conclusion that the scope of her duty justifies the state intervention required by the pregnancy clause. The sanctity of each individual life supports the position that one being may not be harmed for the sake of another. Reflecting this principle, the law does not allow the state to require a trade-off of a mother's health for her fetus' survival.¹²⁴ Arguably the physical invasion mandated by the pregnancy clause does not expose the mother to risk, due to her terminal or vegetative condition. However, to the extent the living will law generally recognizes the harm in depriving incompetent individuals of their rights of self-determination and bodily integrity, the pregnancy clause forces an otherwise impermissible trade-off.

Regardless of the scope of the mother's moral obligation, her ethical duty is incidental to the state's purported interest. The policy's defense, both legal and moral, depends upon the weight of the state's interest in the fetus' potential life being sufficient to trump the declarant's right to autonomy.¹²⁵ The maternal-fetal relationship may impose a greater moral duty upon the mother to protect her endangered fetus, but the magnitude of the state's objective obligation to protect life must remain constant among those owed its protection.¹²⁶ That is, the state's purported interest in protecting life may not vary by the relationship between the person owed protection and the person denying aid. As the state's interest in the particular fetus' life may only equal its interest in any other individual in need of immediate rescue, its justification for intervention is no greater when a fetus needs the pregnant declarant's uterus than when a born child needs the hypothetical father's organs, or when McFall needed his cousin's bone marrow. The state

122. See *supra* notes 42-44.

123. See Helene M. Cole, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 J.A.M.A. 2663, 2664 (1990) (recognizing a greater moral responsibility of a pregnant woman to her fetus than that of one individual to another, but arguing against judicial intervention when a woman has made an informed refusal of treatment); Nelson & Milliken, *supra* note 120, at 1061 (acknowledging a mother's ethical obligation not to harm her fetus).

124. See *supra* notes 36-37 and accompanying text.

125. See *supra* notes 30-31 and 81-84 and accompanying text.

126. Gradations in the state's interest in individuals' or groups of citizens' lives would seem to violate the Equal Protection Clause. See U.S. CONST. amend. XIV, § 1.

cannot claim its interest in protecting life justifies its treatment of pregnant declarants.

Rather than strengthening the state's justification for intervention, the close familial relation of the pregnant declarant to her fetus arguably weakens the state's position both legally and morally. First, while the state is by no means prohibited from regulating parental decisions, traditional legal doctrine regards the family unit as sacred and only reluctantly grants states the right to interfere in family decisions.¹²⁷ The decisions articulated in a living will often incorporate the declarant's concern for the needs and suffering of her family.¹²⁸ While society may justifiably impose upon a pregnant woman a greater moral duty to submit to treatment to save her fetus than upon an individual without familial obligation, the family's legal right to be left alone may render the state less justified in forcing her submission.

Second, the declarant, when competent, was the person most directly responsible for the fetus' welfare, and, as reflected by the deference accorded parental decisions, the most deserving of the right to determine the child-to-be's best interests. Thus, even if—*especially* if—the mother knew of her pregnancy when she directed the withholding of life-sustaining treatment, the state ought to recognize the moral cost of automatically disregarding her directive. As admitted by the Supreme Court, the creation of another life may not be an immutable moral good; the *Roe* opinion recognized the suffering of an unwanted child and “the problem of bringing a child into a family already unable, psychologically or otherwise, to take care of it.”¹²⁹ Ohio's pregnancy clause advances the state's abstract interest in the fetus' potential life with no consideration whatsoever of the life that fetus as a born child might have.¹³⁰ Dispensing with the knowledge or opinions infused

127. See *supra* note 29.

128. See *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 636 (Mass. 1986) (patients may execute living wills to ensure that they are not kept alive in a condition they see as burdensome to their loved ones). See also MEISEL, *supra* note 3, § 10.2 (stating that the second general purpose of advance directives, following the patient's desire to exercise control in health care decision making, is to guide and ease confusion when others must make life and death decisions for the incompetent patient).

129. *Roe v. Wade*, 410 U.S. 113, 162 (1973). See *supra* note 32 and accompanying text.

130. In its policy analysis of a surrogate mother arrangement, the New Jersey Supreme Court considered the “feared” effects of surrogate parenting arrangements, predominantly “the impact on the child who learns her life was bought, that she is the offspring of someone who gave birth to her only to obtain money.” *In re Baby M.*, 537 A.2d 1227,

into the mother's living will may entail a significant moral cost.

The pregnancy clause's singular advancement of the state's abstract interest in the fetus' life also ignores the costs continuing treatment may impose on the declarant's family beyond the fetus. While the reasons for her decision may remain unknown, a pregnant declarant's living will may reflect her view, implicitly or expressly, that terminating treatment best served her family's interests.¹³¹ It is not unlikely that the declarant, as a competent adult, executed the living will solely out of concern for her family, rather than her own fear of suffering or perceived indignity in being maintained artificially, for she may have anticipated her lack of awareness of any experience whatsoever when her living will became operative. Perhaps she believed that futile life-sustaining care would devastate her family's financial¹³² and emotional resources, preventing them from caring for themselves and for each other. The mandate to disregard the pregnant declarant's directives ignores the cost of whatever harms the declarant feared would befall her family, which may include the fetus as a born child, by continuing her treatment. As the pregnancy clause precludes consideration of the complex moral obligations among all the parties involved, its mandate to continue treating pregnant declarants against their wishes is unacceptable state policy.

1250 (N.J. 1988). Even in the best of outcomes in which the life of a pregnant declarant's born child is not filled with hardships, the child's discovery of the circumstances of her birth seems equally harsh.

131. This reflection or motivation of the competent adult who executed the living will seems to remain consistent, even if, as Dresser argues, *see supra* note 7, at 432-34, that the competent patient's interest in controlling her future care through a living will transforms when the patient becomes incompetent. No way exists of ascertaining whether the value of an incompetent patient's current sensations outweighs the harm of contravening her wish, as a competent person, not to burden her family with life-sustaining treatment once she became incompetent. However, her living will may evince the declarant's primary concern for the impact continuing treatment would have on her family, and ought not to be disregarded.

132. The issue of cost beyond the family raises other problems with the pregnancy clause's narrow focus. While the benefit of saving the fetus may offset the cost of treatment, the state abdicated its responsibility if it failed to consider the costs to society of mandating expensive life-sustaining care for pregnant declarants. Furthermore, it seems hypocritical to condone the allocation of money in this context when the state does not guarantee every woman adequate prenatal care, nor every born child, to whom the state owes arguably greater protection than fetuses, adequate health care. *See Murray, Prenatal Drug Exposure, supra* note 58, at 107 (alleging that the nation's "patchwork system of health care, which results in many women not getting adequate prenatal care, may cause more damage to more children than any illegal drug").

V. CONCLUSION

The moral flaw in Ohio's policy toward pregnant declarants arises not from its recognition of the state's interest in protecting the potential life of the fetus. Rather, the flaw lies in its singular promotion of the state's abstract interest in potential life to the exclusion of all other moral considerations. Foremost is the moral cost of mandating treatment for the pregnant declarant as the means toward that end. The disregard for her advance directives derogates her rights of self-determination and bodily integrity in a deeply personal and self-defining decision. Treating the duty owed by mother to fetus as the only morally important one, the policy ignores responsibilities the declarant may have beyond the fetus. Her obligations to herself, her family and friends, as may have influenced her advance directives regarding her demise, should not be automatically sacrificed. The state cannot justify the unprecedented physical intrusion in any other context; only the declarant's family and caregivers ought to determine whether it should be here. Their judgments regarding the propriety of terminating treatment, in light of their knowledge of the declarant's awareness of her pregnancy prior to her incompetence,¹³³ her views regarding the moral standing of her fetus, and all parties' views regarding the best interests of the child if the pregnancy continued to full term, are among worthy considerations.

Living wills offer individuals the opportunity to define the meaning of their respective existences on this earth, and the circumstances which extinguish that meaning. Ohio's living will law deprives pregnant declarants of their rights to self-determination and bodily integrity, and of their interests in protecting what and who is most important to them, at exactly the point in time when those values are infinite. "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe,

133. While articulating comprehensive and specific guidelines for terminating a pregnant declarant's medical treatment is beyond the scope of this Comment, the living will law inarguably ought to require a competent female adult with a valid living will to reevaluate her directives once she becomes aware of her pregnancy, and ought to require all women with childbearing capacity who execute a living will to include specific treatment directives in the case of pregnancy.

and of the mystery of human life."¹³⁴ The state of Ohio should not deprive pregnant women of that liberty.

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134. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992).

