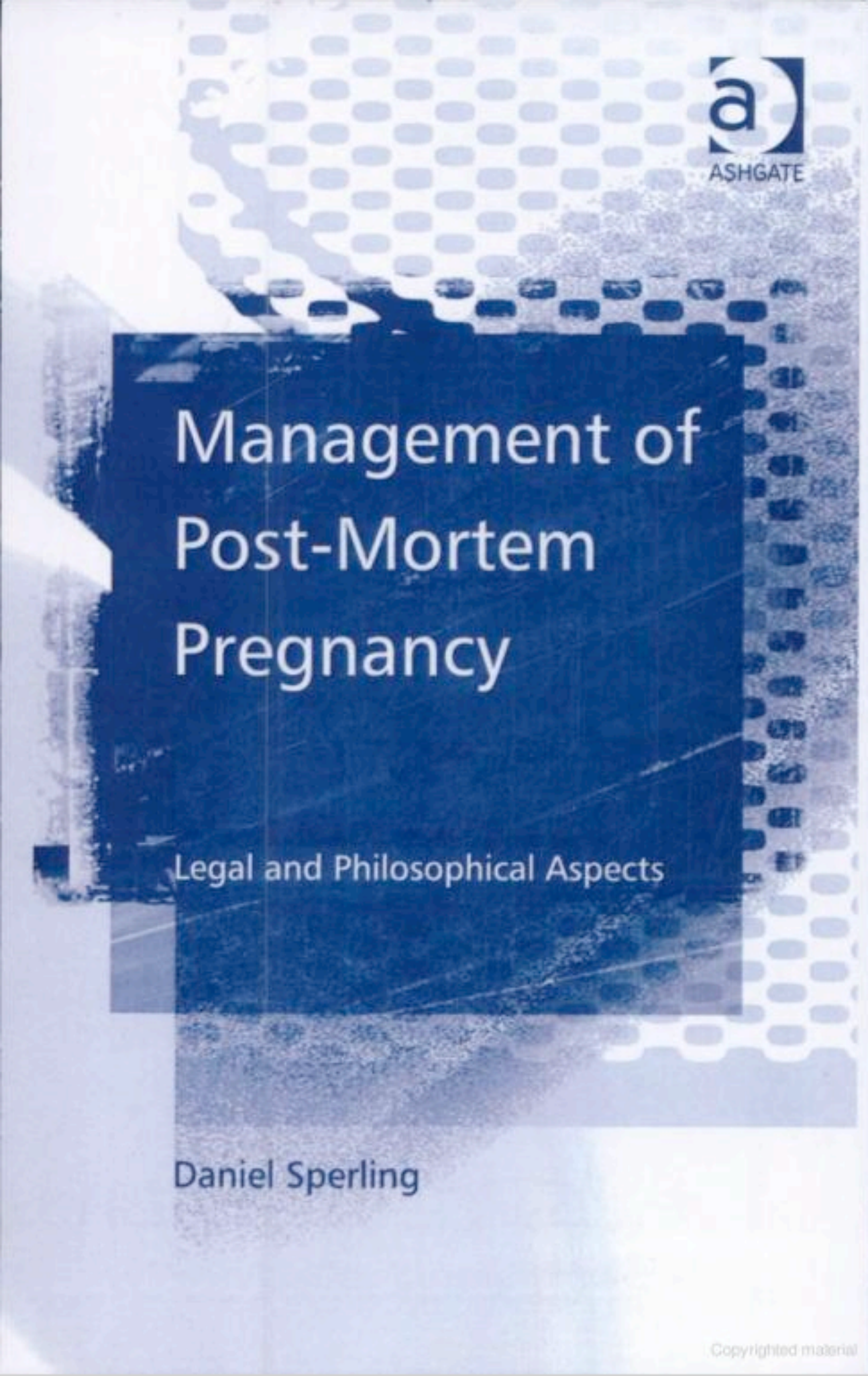

wish to execute advance directives.[21] In section 5.25 to the report, the Law Commission said:

> We do not accept that a woman's right to determine the sorts of bodily interference which she will tolerate somehow evaporates as soon as she becomes pregnant. There can, on the other hand, be no objection to acknowledging that many women do in fact alter their views as to the interventions they find acceptable as a direct result of the fact that they are carrying a child.[22]

The Law Commission view is in accordance with the ethical guidelines on this matter. In a supplement to its previous report, the College of Obstetrics and Gynecologists stated that if the incompetent pregnant woman, who was fully informed, refused treatment during pregnancy in advance, her wishes should be respected *even at the expense of the fetus*. However, if the woman referred in her advance directive to some forms of treatment but had no opportunity to discuss treatment during pregnancy, and if pregnancy is not mentioned in the directive, 'the directive could be declared invalid because the circumstances at the critical time of decision were not clearly envisaged when the directive was made'.[23]

So far, I have discussed the existing laws in Canada, US, and the UK. As we do not have evidence that Canada considered the American approach and rejected it by *deliberately* avoiding the enactment of pregnancy clauses in advance directive legislation, an overview of the arguments which support and oppose pregnancy clauses is necessary to form a proper policy on this issue.

## ARGUMENTS FOR LIVING WILL PREGNANCY LIMITATION

### Balance of interests

Pregnancy clauses in living will legislation reflect an outcome of a balance between a woman's *right* to refuse treatment and control her future care, and the state's *interest* in saving the life of a fetus or in the fetus's interest for life (if it exists). Like any other balance, this balance has different outcomes depending on the proportionate weight given to the interests involved. As shown above, no unified approach or coherent solution has been offered by making such a balance. In some states, the fetus is given full protection and the mother's interests are struck for the full term of a pregnancy. In others, additional proof of the fetus's healthy development or viability is needed in order to restrain the mother.

Balancing the woman's rights with the state's (or the fetus's) interests can raise objections under four potential sources: 1) the subject of the interests involved, 2) the outcomes of the balance compared to similar conflicting situations, 3) the special place given to the fetus's interest to life, and (4) the process of balancing in itself between the 'parties' involved.





*Subject of interests*

One cannot ignore the jurisprudential questions of balancing between *rights* of a *living person* and the *interests* of an *abstract* called the state or, more problematic, the fetus itself. As will be elaborated on in chapter 5, while many are willing to concede that an individual life begins at fertilization, only a few argue that there is a psychological human being at fertilization. In addition, it is commonly believed that in order for one to have interests or rights, one has to be morally and legally classified as a 'person'. Applying the requirements set in the literature for moral personality (self-consciousness, rationality, capacity for moral judgments and communication etc.) also leads to the conclusion that the fetus is not a 'person'. My analysis in chapter 5 further shows that courts in the US and Canada have been reluctant to declare the fetus a person in the various opportunities they had.

Indeed, applying the criteria for 'human being' and 'person' can also lead to the unsettling determination that an incompetent, and certainly a brain-dead, pregnant woman is neither a human being nor a person. Still there is a difference between these categories. Unlike the fetus, an incompetent or even a deceased pregnant woman has held the status of personhood and humanness earlier in life. She is perceived and described as such. Her 'story of life' does not end with her biological condition of incompetency. Equating her with a fetus, thereby making her a 'non-person', would be stripping away a status that was previously recognized rather than declining to bestow a new one.

Even if we claim that an incompetent or a brain-dead pregnant woman is still a person, does it follow that it is the *same* person who issued the advance directive? While our intuition leads us to acknowledge personal identity in the first situation, we may be more careful as to the second. Within the personal identity query rests the assumption that if the criteria for personal identity include the 'preservation of the individual's … entire complement of mental traits and capacities' (Green and Wikler, 1980, p. 125), and if brain-death is the irreversible loss of brain functions, then a prior directive has no moral authority to govern treatment decisions for the new person or the nonperson that the incompetent patient has become (Dresser, 1990, p. 432). A more moderate opinion suggests that although some cognitively impaired patients might be regarded as new persons, loss of personal identity should be taken to *diminish but not invalidate* the moral authority of a prior directive for individuals who, according to this view, have become nonpersons (Buchanan and Brock, 1989, p. 185).

The argument from personal identity is committed to a radical distinction between the death of a person (represented by the death of its brain as the locus of his or her psychological capacities) and the death of the body. Although the person might no longer exist, her body does. When 'maintained' on life-support, the brain-dead woman's body even 'lives'. But our intuition supports a different view. As will be further elaborated in chapter 5, our recognition of every other person depends upon recognition of an array of physical characteristics, which are *distinctive* features during life that are not extinguished immediately upon death (especially brain death). There is a spatial-temporal continuity of the physical body that leads one to *believe* that it is the *same* body that exists. Hence,

what is done to a dead body has relevance for *our feeling about that person when alive*. The cadaver and the person are inseparable.

But are psychological capacities, memories, and mental traits so important that without them one can be claimed not to exist? Of course, one cannot ignore the 'slippery slope' peril of such an argument, which can easily apply to various living people with mental impairments, such as adults with severe dementia or anencephalic infants. One can also hypothesize a situation in which such mental capacities are transferred from a body (plus mental capacities) 'A' to a body 'B', whose brain has been cleared of its previous memories through a sophisticated physiological process (Agich and Jones, 1986, p. 273). Would we still argue that 'A' and 'B' are the same persons only because they share similar (subjective) mental capacities?

Additionally, the self who issued the directive has interests in how he or she is treated which survive the loss of personal identity. In fact, by issuing an advance directive one gives an implied consent to the validation of its wishes by the survival of his or her interests after death. The surviving of our interest in the future regardless of our condition in that future has an important value. As will be further elaborated in chapter 5, it gives meaning to our actions at present.

Moreover, what makes X the same person today that she was last week is some important connection between experiences at these two points in time that justifies saying that X had *both* experiences. The argument for personal identity assumes that the connection between these experiences is located within the psychological states of the *self* who has these experiences. But there can be another possibility. The connection between these experiences can be *maintained externally to the experienced self*, and can be regarded from the perspectives of others. This is especially true in brain death where the 'dead' appears to be alive, warm, pink, breathing, and in possession of a beating heart. In chapter 5, it will be argued that the brain-dead person represents an array of built-in memories from which they can never be completely separated by those who remember them while 'alive'. One who is brain-dead is the subject of a history in which choices, actions, and relationships play a central part. We cannot speak exclusively about one without reference to the other.

*Different outcomes for similar situations*

Even assuming that the mother and the fetus (or the state on its behalf) are of the same moral status, a second problem arises with the balance offered in pregnancy clauses. The analysis made in chapters 1 and 2 of this book suggests that the same balance between the same 'persons' concerning the same interests/rights is resolved *differently* in cases of abortion and in cases of bodily intervention, which are directly related to the pregnant woman's physical condition, i.e. with regard to cesarean sections and blood transfusion. Is there a justification for these different results?

*Abortions* It is clear from *Roe v. Wade* (1973) that at the foundation of any balance of interests between (or within) the pregnant mother and her fetus is the assumption that the answer to the abortion dilemma lies in the moral status





of the fetus. This moral status is derived from a biological development, which has been roughly determined by *Roe* as the point of viability. *Roe* is still the leading case in abortion law at the US and also seems to enjoy public support to this date.[24]

Two basic ideas have been identified in chapter 1 considering the Canadian abortion law. The first is the idea of freedom of choice (rather than privacy, as in the American context) as an almost absolute principle. It is the woman's right to fully control her body, so that even the biological father of the fetus cannot interfere with such a right. The second idea is the resistance of courts to interpret existing law in a way that would confer upon the fetus a legal substantial status prior to birth. The outcome is respect for the woman's choice and her right to make decisions concerning her body even during pregnancy.

Also shown in chapter 1 of this book is that Canadian abortion law demonstrates a weaker tendency to protect the potential life of a fetus than the American approach. Nor is the trimester framework a mandatory guideline in the ethical dilemma. Following *R. v. Morgentaler* (1988), it is reasonable to assume that the more developed the fetus, the less inclination there would be to terminate the pregnancy. More flexibility in this regard is expected in Canada.

Pregnancy clauses go beyond (or below) the viability criteria. Most of the pregnancy clauses do not distinguish between a woman who is in the earlier stages of pregnancy, and who could, therefore, have chosen to have an abortion if competent, and between those in the later stages, for whom abortion might be prohibited under state law. By not considering the developmental stage of pregnancy, the right of pregnant women to control their bodies and health-related choices is strictly infringed by these clauses. Thus, the incompetent pregnant mother's interests are given less weight than those in the abortion situation, without any legal justification (Mahoney, 1989, p. 225). In addition, pregnancy clauses accord much weight to interest in the life of the fetus and its moral status, far beyond that which is already determined in abortion cases.

*General interventions during pregnancy* The state's interest in the potential life of the fetus has shaped the scope of the procreative autonomy of pregnant women in areas other than abortion. In chapter 2 it was discussed how a growing number of courts have found that protection of the fetus justifies the imposition of medical treatment upon a non-consenting mother. Courts have ordered pregnant patients to undergo medical treatment, blood transfusions, or cesarean sections in order to benefit the fetus.

Analysing cases of bodily interventions with regard to pregnant women has brought me to the conclusion that despite the severity of the interference in the woman's right to self-determination and bodily integrity, in most cases courts try to balance the woman's interests with the state interest in protecting the unborn, viable, fetus. Nevertheless, courts demonstrate a tendency to protect the woman's right to refuse treatment with less interference than in abortion-law, along with an inclination to ask for a more serious harm to the fetus, if at all, in order to allow such an interference with the pregnant woman's liberties.

The analysis in the previous chapter also showed that whether through an advance directive or other methods used to infer the woman's opinion about

the case, obtaining the woman's consent is a precondition for any potential intervention with her body. Also suggested in these cases is that the death of a fetus is not necessarily considered to be an unbearable result by the law, especially if the bodily intervention with regard to the pregnant woman, which could have saved the fetus's life, is done without her approval.

The limits imposed by pregnancy clauses are much more severe than in the cases analysed above. In contrast to the *Re A.C.* case (1990), discussed in the previous chapter, the balance reflected in these clauses does *not* demonstrate that interference with the woman's prior wishes is justified only when the interest to life is compelling. The fact that pregnancy clauses exist deviates from the courts' willingness to equate a competent patient's right to self-determination with that of an incompetent one. Moreover, the emphasis of pregnancy clauses on the interests of the fetus (derived from its moral status) should be questioned in light of these and other established decisions, according to which a fetus has interests only once it is born. Most pregnancy clauses do not ask, like in the *Baby Boy Doe* case (1994), for a proof of harm to the fetus, and, in contrast to the *M.B.* case (1997), the idea behind them is that a woman's right to refuse to consent to medical treatment is not absolute.

*The interest to life*

At the heart of the balance of interests provided by pregnancy clauses lies the interest/right of the fetus to life. Aside from the above general analysis of whether a fetus can be a subject of interest as a philosophical concept and when in 'conflict' with its mother, a special legal examination of the interest to life is required. In chapter 5, such an examination will be made. It is sufficient to argue here, that from a legal standpoint there exists no protractible interest to life for the fetus neither under the Canadian Charter of Rights and Freedoms, nor under the interpretation of the European Convention of Human Rights.[25] Incorporating such an interest to the balancing process appears to have no legal substantial sufficient support.

*The process of balancing*

A balance on its own seems to be a weak justification for the outcomes of such a balance. As will be shown in chapter 5, the notion of independent fetal rights or interests to be balanced with (or against) the pregnant woman's rights or interests is predicated on an idea of a disembodied fetus, separate and apart from the woman's body that sustains it. Iris Young puts it nicely: 'The dominant culture projects pregnancy as a time of quiet waiting. We refer to the woman as 'expecting', as though this new life were flying in from another planet and she sat in her rocking chair by the window, occasionally moving the curtain aside to see whether the ship is coming' (Young, 1990, p. 167). This dualistic view, which posits a maternal-fetal conflict, not only assumes antagonistic rights between a pregnant woman and her fetus but also lends itself to advocating a range of state policies and legal interventions that are inherently adversarial in their approach to regulating the lives of pregnant women (Dyke, 1990, p. 886).





**Implying the woman's wish to bring her fetus to term**

One of the arguments that supports the constitutionality of pregnancy clauses in living will legislation is that, in contrast to *Roe v. Wade*, which dealt with a case of a healthy woman who did not want to give birth and to care for the children that the abortion laws sought to force on them, a mother in a terminal condition who has signed a living will would likely have wanted the child to be born (or she would already have terminated the pregnancy) and she would not have to care for it (Gelfand, 1987, p. 780).

The evidence for such an argument is hard to come by. If it is only an implied impression, or even a legal presumption, then it is not enough to block the fundamental interests of the mother. Of course, the fact that a woman decides to continue a pregnancy to term is not conclusive. As will be explained in the discussion of implied consent in chapter 5, a pregnant woman may continue her pregnancy not as a result of deliberate choice but because of lack of access to therapeutic abortion, or because of cultural, social, personal, or family constraints. A physician cannot simply assume the woman would want her pregnancy continued after she becomes incompetent based on the fact that she is pregnant.

But more importantly, the argument for implied consent does not apply when the mother has explicitly written in her advance directive, as in the *DiNino* case, that she would want to withdraw life-sustaining treatment even in case of pregnancy. Would one still claim that she wanted to bring the child to full term? Or is she not allowed to issue such a directive in the first place? If the latter is correct, this argument still does not explain why the woman cannot choose to control her treatment in such a way.

**A matter of privacy**

Some have addressed the constitutionality of the pregnancy clauses as a matter of privacy (Dyke, 1990, p. 873). According to this view, if the privacy right is broad enough to grant women complete autonomy regarding reproductive decisions, pregnancy clauses are unconstitutional for attempting to restrict this autonomy. On the other hand, if the right to privacy is limited to the extent that a pregnant woman must forfeit her right to choose and to make decisions to the state, pregnancy clauses seem to be constitutional.

According to this argument we should decide first on the extent of the right to privacy, and only after doing so can we justify (or not) the existence of pregnancy clauses. Basically, this argument attracts an objection similar to the argument against balancing of interests, discussed above. In addition to the fact that this argument does not really provide an answer but rather shifts our attention to privacy questions, and even assuming that it is a matter of privacy, why does the 'same privacy' that a pregnant woman enjoys lead to a different conclusion when the woman's wishes to abort her fetus or when a bodily intervention is being considered with respect to her? Is there a reasonable justification for narrowing the extent of the right to privacy when the woman puts her wishes in writing?

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In the Canadian context it is more appropriate to talk about the right to refuse life-sustaining medical treatment. This right has been well-developed in Canadian Law (*Malette v. Shulman*, 1990;[26] *Nancy B. v. Hotel-Dieu de Quebec et al.*, 1992[27]). No doubt, the right to refuse life-sustaining treatment lies at the 'very heart' of an individual's right to be free from any interventions when it comes to making important personal decisions. If the law truly wishes to protect this sanctified and elementary right of a human being, it should let the competent woman make the decision by herself and be responsible for it, instead of patronizing her when it seems that there is no meaningful interest against her decision to die. Moreover, the situation in which the right to refuse life-sustaining treatment allegedly endangers the life of the fetus, is test-case for the legal protection of the woman's right to self-determination. Just as it cannot be claimed that one has freedom of speech if they are restrained from saying irritating and annoying things, a woman cannot be claimed to hold a right to self-determination (or privacy) if her most important decisions in life could eventually be dominated by a group of judges or legislators. I see no reason to restrict her right due to pregnancy, especially when she chose to execute it while competent and healthy.

### Authorizing an unlawful act

An additional argument that is brought in favor of pregnancy clauses is that doctors, who comply with a pregnant woman's request to withdraw life-sustaining treatment, knowing that it would kill the unborn child, would be committing a criminal offence.[28] Pregnancy clauses are needed because an advance directive cannot authorize the performance of an unlawful act.

The possibility of criminal liability seems to be extremely rare. There are terminological reasons as well as valuable policy considerations for rejecting the anticipation of criminal liability.[29] But more substantially, doctors, who follow their patient's wishes and have successfully gone through the process of an advance directive seem to be immune from criminal or civil liability and can be solely bound by professional practice standards. This is exactly one of the purposes of advance directives. If an act of withdrawing life-sustaining treatment from a patient were lawful, we would not have asked for it to be done through the mechanism of an advance directive. Advance directives are necessary to perform actions that would otherwise have been unlawful.

Furthermore, the House of Lords in the case of *Anthony Bland* went further to state that avoiding a request to withdraw life-sustaining treatment is perhaps an unlawful act by itself (*Airedale N.H.S. Trust v. Bland*, 1993). The court stated:

> If there comes a stage where the responsible doctor comes to reasonable conclusion … that further continuance of an intrusive life support system is not in the best interests of the patient, he can no longer lawfully continue that life support system: to do so would constitute the crime of battery and the tort of trespass to the person.[30]





Apart from the flaws that exist in the arguments supporting pregnancy clauses in living will legislation, there are sound independent reasons to oppose such clauses. I will turn to discuss these now.

## ARGUMENTS AGAINST LIVING WILL PREGNANCY LEGISLATION

### Self-control and medical care

Disregard for the pregnant woman's advance directives derogates the woman-patient's rights of self-determination and bodily integrity with respect to a deeply personal and self-defining decision. As discussed in chapter 2, the right of individuals to self-determination in health care is firmly rooted in the common law. It is founded on the fundamental right to be left alone, tied to the right to privacy,[31] and 'turns on the subjective wishes of the patient rather than on public opinion, state or familial preferences, or any objective test' (*In re Guardianship of Browning*, 1989, p. 273). Pregnancy provisions infringe on a woman's right to refuse medical treatment on the basis of her pregnant status. Pregnancy clauses deprive the woman of an interest in protecting what and who is most important to her, exactly when those values are infinite. They directly contravene the woman's express wish for privacy and personal autonomy (MacAvoy-Smitzer, 1987).

### An argument for equality

While discussing pregnancy clauses, Anne Lederman brings into consideration a case of a newborn child whose father is in a terminal or vegetative condition, supported by artificial means (Lederman, 1994, pp. 369–70; Mahoney, 1989, pp. 230–1). In Lederman's example:

> Prior to his condition, the child's father executed a living will in which he asked to withdraw all life-sustaining treatment if he is in a state similar to the current one. The newborn son suffers from a disease treatable only by transplanting several organs and the father is the *only* acceptable donor. However, the baby cannot accept the organs immediately, and there is no way to store the organs outside the father's body. It is clear that without the organ donation the boy will die.[32]

Lederman asks whether, in this difficult situation, the state's interest in preserving life justifies the imposition of life-sustaining treatment upon the father so that his organs may be harvested for his newborn child at a later date. She gives a negative answer to this question. Lederman's answer correctly reflects the legal view on this matter. In contrast to pregnancy clauses, neither living will legislation nor court decisions require a father in such circumstances to continue treatment so that his body may be used for the child. Indeed, in contrast to civil law, common law 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 (*In re A.C.*, 1990, pp. 1243–4), even in cases where denying aid would result in *the death* of the endangered person. In *McFall v. Shimp* (1978), a Pittsburgh judge refused to order bone marrow transplant to a young man dying from cancer from his cousin, who was the only compatible potential donor located, but disagreed to donate. The court ruled that:

> The common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue … . For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.[33]

A pregnant woman does not and should not owe a 'duty to rescue' her fetus. The argument here is that state's interest in the life of the fetus should be equal to its interest in any other individual in need of immediate rescue, and not more than that. It is clear from the example that living will legislation imposes a greater obligation on the pregnant woman than it does on the father of a born child whose existence depends upon the organ donation from his father.

Not only do pregnancy clauses discriminate on a sexual basis (between incompetent women and incompetent men), but they also discriminate on the basis of incompetency (between a competent pregnant woman and an incompetent pregnant woman). Whereas a competent pregnant woman may choose to have an abortion with little restriction on her rights (especially before viability of the fetus), an incompetent pregnant woman cannot terminate her pregnancy, even before viability. This is so only because of her incompetency, and regardless of her or her relatives' view on this issue.

Finally, pregnancy clauses discriminate women on the basis of their *pregnancy* (between an incompetent pregnant woman and an incompetent non-pregnant woman). While an incompetent woman's directive to have life-support withdrawn would be effectuated, such a directive, when issued by a pregnant incompetent woman, would not be valid. Therefore, pregnancy clauses deny women the equal right of choice that is enjoyed by both men and other women, whether competent or incompetent.[34]

### Trivializing the mother's choice

The mother's decision not to be maintained on artificial life-support requires her to confront herself with the most frightening and enigmatic concept of her own mortality. According to this argument, the seriousness of such a consideration makes it unlikely that she makes the choice easily. Pregnancy clauses trivialize the significance of the mother's self-defining and conscientious choice by automatically overriding it (Lederman, 1994, pp. 370–1). The mother may have been fully aware of her pregnancy but failed to specifically include it in her advance directive, or she may have been unaware of her pregnancy before she became incompetent. In either of these cases, the importance of the woman's





decision, which is reflected in issuing the advance directive itself, provides a solid moral reason to support an implementation of her living will even when pregnant.

### Ignoring the woman's family

It is reasonable to assume that the pregnant woman, as a competent adult, executed the living will solely out of concern for her family, regardless of fear of her own suffering or experience when her living will became operative. Under this argument, it is possible that she believed that maintaining her on life-sustaining care would devastate her family's financial and emotional resources, preventing them from caring for themselves and for each other. Therefore, disregarding the pregnant patient's directives ignores the cost of whatever harms the woman feared would come to pass to her family. Pregnancy clauses in living will legislation ignore not only the woman's wishes with respect to herself but also with respect to her family.

### Involuntary servitude

The Thirteenth Amendment to the US Constitution declares:

> Neither slavery nor involuntary servitude, except as punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction.[35]

In Canada, the Charter of Rights and Freedoms does not provide a specific prohibition against slavery, though this can be based on the 'right to life, liberty and security of the person' under section 7 of the Charter (Canadian Charter of Rights and Freedoms, 1982, section 7).

Timothy Burch argues that pregnancy clauses reduce incompetent pregnant women to a state of slavery and involuntary servitude (Burch, 1995). In his view:

> Just as the African American woman's body was controlled by her master in all respects including reproduction, so is the body of an incompetent pregnant woman controlled by its new master – the state … a state order to remain attached to medical machines and produce a child must also be considered a form of involuntary servitude prohibited by the Thirteenth Amendment.[36]

Ignoring the woman's advance directives and treating her body without due respect for her wishes amounts to a form of slavery. This form of 'involuntary servitude' is definitely reflected in the case of a brain-dead pregnant woman, who is being maintained purely for the sake of her fetus. Even if Burch's argument is far reaching, it still gives us a flavor of the resistance we should feel when considering imposing such medical procedure against a patient's expressed wishes.

## CONCLUSION

The most important role of advance directives, in my view, is that they help to focus medical decisions along the patient's wishes. Dr. William Molloy conducted a survey, asking 909 people questions related to care and advance directives. Over 90 per cent of them said it was extremely important for them to be able to decide their treatment. Over 90 per cent of them were concerned that they would receive treatment without their consent, or that treatment would be too aggressive. When asked whether they would want to have their health care choices documented, almost 90 per cent said they would (Molloy, 1993, p. 218).

What do these big numbers from Molly's survey teach us? They surely serve as an indication of the importance of living wills regardless of the physical state of the incompetent person. Most of all, living wills provide a means of exercising some degree of control over medical care. But they also facilitate the process of decision-making in times of crisis and emergencies. By doing this, not only do they honour the patient's wishes but they respect the patient's family as well. In addition, they provide sense of security for physicians, enabling them to fulfill the patient's wishes without being threatened of lawsuit or prosecution.

A woman's decision to issue an advance directive and to have it effectuated implicates her fundamental right to make decisions regarding procreation, family relationships and bodily integrity. These are the most intimate and personal choices a person makes in a lifetime, and they are central to personal dignity and autonomy and to the 'liberty' interest that is protected under the Canadian Constitution.

Pregnancy clauses that exist under the American law should not be a model for Canadian law. Not only do they infringe on a woman's right to refuse medical treatment just because she is pregnant, and hence discriminate them from other non-pregnant women on the basis of their pregnancy, but they also discriminate them on a gender basis and on the basis of their incompetency. Pregnancy clauses also trivialize the significance of the mother's self-defining and conscientious choice by automatically overriding it. They ignore the pregnant woman's family, pretending to protect potential life without even drawing the line at the viability of the fetus. Finally, they control the woman's body, devalue it, and bring it to a state of involuntary servitude. The woman's wishes are automatically ignored just because she is pregnant.

The original intent of living will statutes was to permit the 'natural death' of persons who would otherwise linger for years on life-support in a vegetative but 'alive' state (Gelfand, 1987, p. 742). Pregnancy clauses totally disregard the wishes of the woman and her loved ones. Such legislation compels providers to force intensive and intrusive treatment upon a woman, inflicting exactly the sort of indignity upon the patient and anguish upon her family and friends, that 'Do Not Resuscitate' orders and living wills are meant to protect us against.

However, it is not enough to conclude that Canada should not follow the American model of pregnancy clauses. A more active step should be taken, similar to that in the UK, so that the American model should be publicly discussed and rejected. No doubt should be left in such an important area. What then should be the proper way to deal with incompetency during pregnancy with respect to Canadian women who issue an advance directive?





Timothy Burch suggests that physicians should consult with or defer the decision-making to the family or friends of the pregnant woman, instead of allowing the state to intervene in legislation (Burch, 1995, p. 565). However, this suggestion ignores the woman's wishes, reflected in her advance directive. Moreover, it is not clear from his proposal what is the mechanism for such decision-making in case of a conflict between the woman's directive and the family or friend's wishes. Whose view outweighs?

Gregory Gelfand offers a model of living will legislation that would include a pregnancy clause (Gelfand, 1987, pp. 802–21). According to his suggestion, if a patient is not in pain, a fetus that has not already been aborted should no longer be eligible for abortion. In cases where the patient is in pain, however, the balance shifts in favour of the patient, *even if the fetus is beyond the second trimester*. Because of the conflicting interests involved, Gelfand suggests calling upon the court at this stage to make any further decision (Gelfand, 1987, pp. 816–17).

Gelfand's model seems to be problematic. The keypoint of his suggestion is the woman's ability to feel pain. I find it odd that a terminally ill patient who feels pain but is, for example, two weeks from full-term can decide to withdraw life-sustaining treatment, whereas an incompetent mother, who, for instance, has just entered her second trimester, cannot ask for it. Why not respect the woman's prior decisions if one can infer from them the woman's view regarding life-sustaining treatment in case of incompetency during pregnancy? This brings me to my preferred suggestion.

Pregnant women and the proxies they appoint to make decisions about their care should have *full information* and an opportunity to make decisions about continuing pregnancy under circumstances where the pregnant woman might face health problems. This could be done by supplying forms for living wills (Weisbrad, 1995) as well as educational and explanatory material developed for patients in early stages of pregnancy and doctors. These materials would include the various kinds of treatment for which pregnant women may choose to give special instructions. When necessary, statutes should also require that women clearly state in their advance directive what is to happen if they become incompetent while pregnant. If a competent woman follows this suggestion, then her wishes must be effectuated at pregnancy with no exceptions, as in other situations when incompetency arises.

Until this happens, I would suggest upholding the living will of a woman even at pregnancy, especially in the first and second trimester when the state cannot claim to have any interest in potential life (as discussed in chapter 1). If the woman who issued the advance directive becomes incompetent in her third trimester, I would suggest consulting her family and friends to try to ascertain *her* views and ideology. In any event, I would not recommend having a mandatory provision that would invalidate the woman's directive solely on the basis of the gestational age of her fetus.

If there is no advance directive or durable power of attorney for health care decisions (specifically for maternal incompetency, or in general when the fetus is in its third trimester), directions must be sought from previously expressed statements of the pregnant woman. Due to the undignified nature I see in the medical

treatment proposed, the assessment by the surrogate as to what the deceased's wishes were should be obtained through clear and convincing evidence.

Besides the weakness of arguments that support pregnancy limitation in living wills and the strength of those opposing it, there is a significant reason that Canada should not choose the American model. As shown in the two previous chapters, Canadian abortion law and the general law that governs legal interventions with regard to pregnant women seem to place more emphasis on the pregnant woman's wishes and her rights to self-determination, and tend to give less weight to considerations of the fetus's potential life than the American approach. Canada's avoidance from enacting pregnancy clauses in the many forms of living will legislation that exist in the country, strengthens my interpretation of the way in which a pregnant woman is regarded under the Canadian law. My recommendation is consistent with this interpretation. It is helpful to keep this in mind for the discussion in the next chapter, where I analyse the case of a brain-dead pregnant woman from a different angle, *i.e.* from the perspective of the dead.

## NOTES

1 Capacity usually means the ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health care decision.

2 The argument assumes that the now-incompetent patient is the same person who previously authored that directive. However, one can argue that for some patients we cannot make this claim because incompetence brings a loss of psychological continuity and connectedness with the prior competent self, thereby destroying the conditions necessary for personal identity. At the heart of this argument is the assumption that psychological continuity is an essential feature of the 'unity relation', that allows us to say that the stages of a person's life are stages of the *same* person's life. Thus, the argument goes, a prior directive has no moral authority to govern treatment decisions for the *new person* or the *nonperson* that the incompetent patient has become (Dresser, 1990). A more moderate opinion suggests that although some cognitively impaired patients might be regarded as new persons, loss of personal identity should be taken to *diminish but not invalidate* the moral authority of a prior directive for individuals who, according to this view, have become nonpersons (Buchanan and Brock, 1989, p. 185). This personal identity challenge to the effect of advance directives plays a more important role when a person is dead than when she is in a coma or suffers from a partial disfunction of the brain. With the death of a person, we can allegedly no longer argue that it is a new person. We might argue that it is a nonperson, as such having lesser significant moral status. Although the person might no longer exist, her body does. When 'maintained' on life-support, the brain-dead woman's body even 'lives'. Thus, the argument from personal identity is also committed to a radical distinction between the death of a person and the death of the body. I will elaborate on these issues in my fifth chapter.

3 Meisel rightly mentions that advance directives will not always avoid the need for judicial proceedings. For example, when an advance directive does not designate a proxy but merely gives instructions, a surrogate will still need to be designated by the court. Another situation that would necessitate a judicial intervention would be when a third party (a family member or a friend of the patient) is dissatisfied with the patient's designation of a proxy through the advance directive.





4 Meisel, however, correctly asserts that it is not clear whether it costs less to treat patients near the ends of their lives who have advance directives than to treat those who do not.

5 Nevertheless, a criticism can be raised regarding the extent to which living wills promote an incompetent patient's right of self determination, since they reflect only the individual's past preferences and values as a once-competent adult and fail to incorporate the now-incompetent individual's interest. See *supra* note 2.

6 For an exhaustive description of this legislation see www.utoronto.ca/jcb/main.html, accessed on 1 May 2004.

7 This term applies to hospitals, nursing facilities, home health care providers, hospice programs, and health maintenance organizations.

8 These states are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Minnesota, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming (Jerdee, 2000).

9 Alabama, California, Connecticut, Hawaii, Idaho, Indiana, Kansas, Montana, New Hampshire, Ohio, Oklahoma, South Carolina, Texas, Utah, Washington, Wisconsin, Wyoming. Interesting to note here that in Oregon, § 127.540 to the Oregon Review Statute, 1990 mentions abortions as one of the things to which the durable power of attorney is not authorized to consent.

10 Alaska, Delaware, Montana, Nebraska, Nevada, and Rhode Island. This is also the language of the *Uniform Rights of Terminally Ill Act* of 1989, which reads: 'Life sustaining treatment must not be withheld or withdrawn pursuant to a declaration from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.'

11 Arizona, Arkansas, Illinois, Minnesota.

12 Kentucky, North Dakota.

13 For the difficulties in interpreting the language of the ambiguous terms 'probable' and 'possible' in this regard see Jerdee, 2000, pp. 996–7.

14 The Georgia Natural Death Act served as an inspiration to the court in the *Piazzi* case (*University Health Services, Inc. v. Piazzi*, 1986), thereby ordering to maintain Donna Piazzi (who had not left any directive at issue) on life-support. See *infra* my discussion on this case in section 2.

15 Minn. Stat. § 145B.13 subd. 3 (1998).

16 The language of the Minnesota statute is also far from being clear. The possibility that the fetus will develop to the point of live birth arguably encompasses the period before and after fetal viability. Of course, one could also argue that there is always a possibility of live birth of a fetus, when a woman is pregnant, and that this possibility ends only with the termination of pregnancy.

17 Minn. Stat. § 145C.10 (g). For discussion on the new law in Minnesota see Blumer, 1998.

18 *DiNino v. State*, 1984, p. 333.

19 Additionally, section 23–06.4–07(3) to the statute provided that: 'Notwithstanding a declaration executed under this chapter, medical treatment must be provided to a pregnant patient with a terminal condition unless ... such medical treatment will not maintain the patient in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful or unreasonably painful to the patient or will prolong severe pain that cannot be alleviated by medication.'

20 Nevertheless, the English government announced in 1999 that it intends to put in place a new system of Continuing Power of Attorney that would enable adults to delegate decision-making powers on healthcare to proxies (Peart *et al.*, 2000, p. 277).
21 Loss of capacity from a cerebral injury can occur under two typical situations: patients in a permanent vegetative state (PVS) and patients who are brain stem dead. Peart *et al.* (2000) report that in England, a diagnosis of PVS cannot be confirmed until the patient has been insentient for at least 12 months. So, PVS patients are unlikely to be pregnant unless they were raped in the nine months before the diagnosis of PVS. In contrast, Peart *et al.* mention that in Virginia (US), the diagnosis of PVS can be made after only one month of insentience.
22 *Report of the Law Commission on Mental Incapacity* 1995, London: H.M.S.O, § 5.25.
23 Section 3.4.2 to the supplement. See *Ethical Guidelines on Court-Authorised Obstetric Intervention: a Consideration of the Law and Ethics* from 1996, available at http://www.rcog.org.uk/guidelines.asp?PageID=109&GuidelineID=33, accessed on 26th April 2004.
24 A recent poll in the US shows that 52 per cent of Americans agreed and 37 per cent disagreed, with the result of *Roe v. Wade* (1973), while 50 per cent identified themselves as pro-choice and 42 per cent as pro-life (Jost, 2002, p. 644).
25 See *infra* my discussion in chapter 5.
26 In this case, the Ontario Court of Appeal upheld a finding of battery against a physician who had administered blood transfusions to an incompetent patient who was in a life-threatening condition. Although the physician was aware that the patient had signed a Jehovah's Witness medical alert card, refusing blood under *any* circumstances, he ignored the directive in order to save her life.
27 In 1992, the *Nancy B.* case explicitly recognized the right of a mentally competent patient to refuse artificial life-support and thereby hasten death. Nancy B. was totally and permanently paralyzed and unable to breathe on her own due to a neurological disease she suffered from. The court ruled she could be disconnected from the respiratory, acknowledging that such an act would lead to her death. The court ruled that if Nancy died after the respiratory was stopped it would not be an act of suicide, rather nature taking its course.
28 This argument especially applies when the fetus is viable. See, for example, in the UK, section 1 of the *Infant Life (Preservation) Act* 1929: 'Any person who with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of a felony, to wit a child destruction.'
29 There are three main arguments against criminal liability. First, the requisite of intent is lacking. The doctor does not intend to procure an abortion or destroy the life of a child capable of being born alive. The intention is to withdraw treatment from the woman *in accordance with her request*. Second, it seems that criminal liability in this context requires some positive act. If a treatment is withdrawn because its continuation is considered futile, death is caused not by the discontinuation of treatment but by the preexisting condition from which the patient was suffering. Third, patients are entitled not only to withdraw treatment but also to request withdrawal of treatment provided they are competent when making the decision. To deny a pregnant woman this right, the argument goes is to override her autonomy and subject her interests to those of her fetus (Peart *et al.*, 2000, p. 282).
30 *Airedale N.H.S. Trust v. Bland*, 1993, p. 883.
31 The right to privacy extends also to allow *a patient's surrogate* the right to refuse medical treatment for the patient (*In re Quinlan*, 1976). It has been suggested that the privacy interest in bodily integrity is even more fundamental than the privacy interest in terminating pregnancy (MacAvoy-Smitzer, 1987, p. 1290).





32 Lederman, 1994, pp. 369–70.
33 *McFall v. Shimp*, 1978, p. 91.
34 For a feminist critique, including an argument for equality, see the excellent piece by Taylor, 1997. See also Rothenberg, 1996, pp. 76–7.
35 U.S. Const. amend. XIII, §. 1.
36 Burch, 1995, p. 555.