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Breaking Through the Silence: 
Minnesota's Pregnancy Presumption and the Right To Refuse Medical Treatment

Amy Lynn Jerdee*

Cases of pregnant women on life support, sadly, are no longer unheard of. On April 24, 1999, Maria Lopez was declared brain-dead in a California hospital due to a rare condition called arteriovenous malformation.1 Lopez was also pregnant with twins, leaving her family with the difficult decision of whether to maintain her life support. Even though her family was advised to withdraw life-support measures, they did not, and subsequently the two children were successfully delivered prematurely through cesarean section.2 Maria Lopez, in fact, has shown some improvement in her “brain-dead” status, and is now able to communicate with gestures.3 This scenario may become more common as technological advances make possible medical feats that previously would have been unthinkable. However, such scenarios may also leave family members, pregnant women, and health care personnel caught in an ethical dilemma.4 The Minnesota advance directive5 law offers a unique approach to end-of-life decision-making for pregnant

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1. See Matthew Fordahl, Colton Woman out of Coma, Bears Twins, PRESS-ENTERPRISE, July 8, 1999, at B3.
2. See id.
3. See id.
4. See ARTHUR CAPLAN, DUE CONSIDERATION: CONTROVERSY IN THE AGE OF MEDICAL MIRACLES 21-22 (1998) (advocating court involvement in assisting decision-making by family members of a woman, vegetative for years, who is now pregnant after having been raped in her hospital bed).
5. An advance directive is a legally binding document consisting of a living will, a durable power of attorney or both. See infra notes 17-18 and accompanying text.
women and women of childbearing age. The pregnancy presumption, embodied in the state's advance directive statute, has far-reaching implications for a woman and her fetus.

In 1998, the Minnesota Legislature fundamentally revised the then-existing Minnesota advance directive law by creating one document that encompasses either a living will or durable power of attorney, or both. Within the amended advance directive law is a pregnancy presumption provision containing the requirements that must be satisfied in order to withdraw life-sustaining treatment from a pregnant woman.

Some legal scholars contend that pregnancy provisions, which mandate the continuation of life-sustaining treatment during pregnancy, infringe on a person's right to refuse medical treatment. They assert that these provisions give more weight to the state's interest in potential life than to the patient's right to refuse medical treatment. Their arguments, however, raise many questions. For example, when a woman is pregnant, is it constitutional to forbid withdrawal of life-sustaining treatment? Or, what if the woman has a living will demanding withdrawal, even if pregnant, and the fetus is not yet viable? State advance directive statutes rarely discuss the viability of the fetus and leave many issues unsettled about how to properly resolve these situations.


7. See MINN. STAT. § 145C (1998); see infra note 58.

8. See MINN. STAT. § 145C.01 subd. 5a (defining health care directive as "a written instrument that complies with section 145C.03 [requirements] and includes one or more health care instructions, a health care power of attorney, or both; or a durable power of attorney for health care executed under this chapter before August 1, 1998").

9. See Durable Power of Attorney for Health Care, Presumptions, MINN. STAT. § 145C.10(g).

10. See, e.g., Katherine A. Taylor, Compelling Pregnancy at Death's Door, 7 COLUM. J. GENDER & L. 85, 93 (concluding that pregnancy provisions should not be constitutionally justified); Janice MacAvoy-Snitzer, Note, Pregnancy Clauses in Living Will Statutes, 87 COLUM. L. REV. 1280, 1280 (1987) (arguing that pregnancy provisions are unconstitutional when a woman has stated her wishes in an advanced directive); Shannon K. Such, Note, Lifesaving Medical Treatment for the Nonviable Fetus: Limitations on State Authority under Roe v. Wade, 54 FORDHAM L. REV. 961, 965 (1986) (arguing that a person's privacy interest should allow the refusal of lifesaving medical treatment before a fetus is viable); see also infra Part I.B.1 (discussing the right to refuse medical treatment and its limits).

11. Viable means that a fetus is "able to maintain an independent existence; able to live after birth." ENCYCLOPEDIA AND DICTIONARY OF MEDICINE,
Minnesota made noteworthy strides in balancing the right of women to refuse treatment with the state interest in the potential life of the child by amending its pregnancy provision, which no longer makes the health care directive automatically void with pregnancy. According to the statute, "the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant." The amended portion then allows the withdrawal of life-sustaining treatment if the wish is expressed, specific to pregnancy, within the living will or if there is clear and convincing evidence that this is what the patient would have wanted. This approach acknowledges the state interest in potential fetal life while still preserving the pregnant patient's right to withdraw treatment. By amending the advance directive statute, the Minnesota legislature hoped to "encourage health professionals to discuss the issue with women who are or could become pregnant.

This Note argues that the pregnancy presumption within the revised Minnesota advance health care directive statute is constitutional and should serve as a model for other states. Part I provides an overview of the use of pregnancy provisions and a discussion of the surrounding constitutional issues. Part II discusses how the Minnesota statute should be applied and how it succeeds in balancing the right to refuse medical treatment with the state interest in potential life. Part III suggests how the statute could be improved, in addition to encouraging other states to consider a similar approach. Suggestions for improvement include promoting the further education of health

Nursing, and Allied Health 1199 (3d ed. 1983). "[T]he compelling point [of the state's interest] is at viability. . . . [T]he fetus then presumably has the capability of meaningful life outside the mother's womb." Roe v. Wade, 410 U.S. 113, 163 (1973); see also Colautti v. Franklin, 439 U.S. 379, 394 (1979) (holding that a viability determination requirement was impermissibly vague).

12. See Timothy J. Burch, Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes, 54 Md. L. Rev. 528, 540-50 (1995) (discussing the applicability of pregnancy clauses before and after fetal viability and determining that the state interest in potential life will override the mother's interest in refusing medical treatment).

13. See Minn. Stat. § 145C.10(g).
14. Id.
15. See id.
16. Blumer, supra note 6, at 50 (discussing the more flexible advance directive law).
care professionals and the public on the appropriate application and lasting ramifications of the provision. The Note concludes that the Minnesota advance directive pregnancy provision is constitutional, but its language should be clarified to promote a better understanding of its application.

I. ADVANCE DIRECTIVE PREGNANCY PROVISIONS AND THEIR CONSTITUTIONALITY

A. ADVANCE HEALTH CARE DIRECTIVES

An advance directive statute allows individuals to make decisions about the kind of care they want if they are unable to make decisions on their own and to appoint someone to make those decisions for them. An advance directive is a legally binding document that can consist of a living will, a durable power of attorney, or both. A living will is "[a] document which governs the withholding or withdrawal of life-sustaining treatment from an individual in the event of an incurable or irreversible condition that will cause death." A durable power of attorney allows a person appointed by another to make decisions as the agent of the other in the event that the person becomes disabled. Currently, all fifty states and the District of Columbia have an advance directive statute of some kind, although they vary considerably among the states. This varia-

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20. See id. at 812.

tion has resulted in some inconsistencies and limitations in interpreting the different statutes.22

When people become seriously ill, health care professionals and family members look to whether or not the patient has a valid advance directive.23 Based on research data, it is likely that a person has not completed an advance directive,24 and even if they have, their wishes are often not clearly defined.25 Additionally, health care professionals, families, and friends often hold divergent views concerning the patient's end-of-life care management.26 In cases where a patient has completed an advance directive, the health care provider is legally obligated to abide by the patient's wishes to the extent that the wishes

therapeutic capabilities in medicine and the problems that this may bring; MARGARET PABST BATRIN, THE LEAST WORST DEATH 3-7 (1994) (recognizing that "the new medical prospects ordinary individuals would face in dying" blossomed following the Quinlan decision and has continued with medical technological advancement).

22. See RAYMOND S. EDGE & JOHN RANDALL GROVES, ETHICS OF HEALTH CARE 150-51 (2d ed. 1998) (discussing the limitations posed by living wills compared with the use of durable powers of attorney).

23. The woman that completes an advance directive and is still of childbearing age must bring the directive to the attention of family members and physicians. See ALAN MEISEL, THE RIGHT TO DIE 400-01 (1989).

24. The SUPPORT study looked at the use of advance directives two years before and two years after the enactment of the Patient Self-Determination Act to find that "patients and their families did not know more about advance directives or use them substantially more often" reporting use in "less than one in four" cases as compared to one in five before the Act. Joan Teno et al., Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention, 45 J. AM. GERIATRICS SOC'Y 500, 505 (1997); see Laura C. Hanson & Eric Rodgman, The Use of Living Wills at the End of Life, 156 ARCHIVES INTERNAL MED. 1018, 1018 (1996) (finding that in a national study of 16,678 deaths, 9.8% of those deceased had a living will).

25. See COMMITTEE ON THE SOCIAL AND ETHICAL IMPACTS OF DEVELOPMENTS IN BIOMEDICINE, supra note 21, at 318 (stating that a concern with living wills is that they lack specificity); Joanne Lynn & Joan Teno, A Care Provider Perspective on Advance Directives and Surrogate Decision-Making for Incompetent Adults in the United States, in ADVANCE DIRECTIVES AND SURROGATE DECISION MAKING IN HEALTH CARE 3, 16 (1998) (Hans-Martin Sass et al. eds., 1998) (arguing that advance directives are ineffective because they lack clear instructions).

26. See BERNARD GERT ET AL., BIOETHICS: A RETURN TO FUNDAMENTALS 308-09 (1997) (asserting that it may be helpful to recognize the overwhelming majority opinion to withdraw life-sustaining treatment in gravely ill patients without an advance directive). See generally Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 285 (1990) (establishing the right to refuse medical treatment).
stated in the advance directive can be understood.\textsuperscript{27} Even if the patient's wishes are not clearly defined, the document can be utilized as a guideline in decision-making.

Advance directive statutes vary from state to state. Some states have only a living will,\textsuperscript{28} or a durable power of attorney,\textsuperscript{29} while other states have both a living will and durable power of attorney in separate statutes.\textsuperscript{30} Nevertheless, the majority of

\textsuperscript{27} See GERT ET AL., supra note 26, at 307 (discussing the policy implications of not following a patient's valid advance directive).

\textsuperscript{28} See D.C. CODE ANN. §§ 6-2421 to 2430 (1995); LA. REV. STAT. ANN. §§ 40:1239.58.1 to .10 (West 1992); MO. ANN. STAT. §§ 459.010 to .055 (West 1992); MONT. CODE ANN. §§ 50-9-101 to 206 (1999).

\textsuperscript{29} See MASS. GEN. LAWS ANN. ch. 201D, §§ 1-17 (West 1994); MICH. COMP. LAWS ANN. §§ 700.495 to .499 (West 1995); NEB. REV. STAT. §§ 30-3401 to 5432 (1995); N.Y. PUB. HEALTH LAW §§ 2980-2994 (McKinney 1993).


states integrate a living will and a durable power of attorney into one legal document. This latter approach promotes clarity while facilitating completion of both documents if desired.

1. Pregnancy Provisions in the United States

While every state has enacted an advance directive statute, only thirty-four states contemplate the validity of the advance directive when a woman is pregnant. Each of these pregnancy provisions has specific guidelines regarding the applica-


bility of the advance directive during pregnancy. Requirements of the pregnancy provisions vary widely between states but can be divided into two basic categories: the majority provision and all others. The majority provision automatically mandates the disregard of an advance directive throughout the entire pregnancy and has been adopted by seventeen states. For example, Alabama's advance directive statute states that "[t]he advance directive for health care of a declarant who is known to be pregnant shall have no effect during the course of the declarant's pregnancy." There are no qualifying statements within these statutes that would permit enforcement of a valid advance directive during pregnancy.

The remaining seventeen state statutes that do not follow the majority provision employ varying requirements that will prompt the application of the state's pregnancy provision. For example, six states will not give effect to an advance directive if it is probable that the fetus will develop to live birth, and four states will not give effect if it is possible that the fetus will

34. For example, some states require a medical certainty that the fetus will survive to the point of live birth before voiding the advance directive, see, e.g., KY. REV. STAT. ANN. § 311.629 (Michie 1995), while other states require only that the woman be pregnant before voiding the advance directive, see, e.g., CONN. GEN. STAT. ANN. § 19a-574 (West 1996).


37. See ALASKA STAT. § 18.12.040(c) (Michie 1998); DEL. CODE, ANN. tit. 16, § 2503(j) (Supp. 1998); MONT. CODE ANN. § 50-9-202(3) (1999); NEB. REV. STAT. § 30-3417(1)(b) (1995) (limiting the authority of the durable power of attorney "when the principal is known to be pregnant"); NEV. REV. STAT. ANN. § 449.624(4) (Michie 1996); R.I. GEN. LAWS § 23-4.11-6(c) (1996).

38. "Possible" is defined as: "[c]apable of existing, happening, being, becoming or coming to pass; feasible." BLACK'S LAW DICTIONARY 808 (6th ed. 1991).
develop to live birth.\textsuperscript{39} Kentucky and North Dakota require a medical certainty that the fetus will develop to live birth,\textsuperscript{40} while Pennsylvania and South Dakota require both reasonable medical certainty of live birth as well as assurance that physical harm or pain to the woman can be alleviated.\textsuperscript{41} Florida limits the ability of the proxy decision-maker to withdraw life-sustaining treatment throughout pregnancy.\textsuperscript{42} Two other states mention the viability of the fetus—Colorado requires fetal viability before voiding an advance care directive,\textsuperscript{43} and Georgia requires that the fetus not be viable to allow the discontinuation of treatment.\textsuperscript{44}

Not only do the pregnancy provisions differ between states, but also the language of the statutes is often ambiguous and vague.\textsuperscript{45} For example, the Minnesota statute requires “a real possibility that . . . the fetus could survive to the point of live birth,” yet, the statute fails to define what is meant by the possibility of live birth.\textsuperscript{46} To date, few state courts have been required to interpret a pregnancy provision.\textsuperscript{47} In the rare in-

\begin{enumerate}
\item See \textit{ARIZ. REV. STAT. ANN.} § 36-3262(3) (West 1993 & Supp. 1999) ("Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment."); \textit{ARK. CODE ANN.} § 20-17-206(c) (Michie 1991); \textit{755 ILL. COMP. STAT. ANN.} 35/3(c) (West 1992); \textit{MINN. STAT.} § 145C.10(g). The Minnesota statute requires that there is “a real possibility . . . the fetus could survive to the point of live birth.” \textit{Id.}
\item See \textit{KY. REV. STAT. ANN.} § 311.629(4) (Michie 1995); \textit{N.D. CENT. CODE} § 23-06.4-07(3) (Supp. 1999).
\item See \textit{20 PA. CONS. STAT. ANN.} § 5414(a) (West Supp. 1999); \textit{S.D. CODIFIED LAWS} § 34-12D-10 (Michie 1994).
\item See \textit{FLA. STAT. ANN.} §§ 765.113, 765.305 (West 1997).
\item See \textit{COLO. REV. STAT. ANN.} § 15-18-104(2) (1999) (requiring fetal viability and a medical certainty that the fetus will survive to live birth).
\item See \textit{GA. CODE ANN.} § 31-32-8(a)(1) (1996) (requiring fetal viability and a statement within the living will to allow withdrawal of life-sustaining treatment).
\item See \textit{JAMES F. DRANE, CLINICAL BIOETHICS, THEORY AND PRACTICE IN MEDICAL-ETHICAL DECISIONMAKING} 148 (1994) (stating that obtaining precise details in an advance directive is not always helpful when the ideal goal is to get “a reliable expression of patient preferences”); James Bopp, Jr. & Daniel Avila, \textit{The Due Process “Right to Life” in Cruzan and Its Impact on “Right-to-Die” Law}, 53 U. PITT. L. REV. 193, 221 (1991) (discussing the lack of clarity in state advance directive statutes).
\item \textit{MINN. STAT.} § 145C.10(g) (1998).
\item See \textit{Gabrynovich v. Heitkamp}, 904 F. Supp. 1061, 1063-64 (D.N.D. 1995) (holding that a woman does not have standing to bring suit on the constitutionality of provisions regarding abortion and pregnancy under North Dakota's Uniform Rights of the Terminally Ill Act); DiNino v. State, 884 P.2d
stances where courts have been called upon to apply an advance directive pregnancy provision, the ambiguous language has made the statute difficult to interpret and apply as the legislature intended. This has lead to inconsistent decision-making.

Pregnancy provisions also create uncertainty for the medical practitioner. Because of continued advances in medical treatment and technology, health care professionals are able to maintain a person's life using extensive life support measures, and therefore, are often forced to make urgent end-of-life decisions. These decisions create challenging moral and ethical dilemmas, especially when the patient is pregnant. For example, uncertainty about the patient's wishes for care at the end of life may lead to the continuation of life-sustaining treatment in order to save the fetus. This situation may undermine the traditional doctor-patient relationship because the physician may, in effect, feel obligated to withdraw her commitment to the patient and become the fetus's practitioner. Thus, pregnancy provisions may create a conflict of interest for physi-

1297, 1300 (Wash. 1984) (holding that a person could amend their living will to delete a pregnancy provision); Molly C. Dyke, Note, A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes, 70 B.U. L. REV. 867, 870-72 (1990) (citing University Health Services v. Piazzi, No. CV86-RCCV-464 (Ga. Super. Ct. Aug. 4, 1986) (unreported opinion) (holding that a brain-dead pregnant woman without a living will had no protectable privacy interest because she was dead and that her wishes were irrelevant because her pregnancy would have made a living will ineffective)).


49. See, e.g., DiNino, 684 P.2d at 1300 (failing to reach a decision on the applicability of a pregnancy provision when the advance directive expressly stated that pregnancy should not alter the force of the directive).

50. See generally BANDMAN & BANDMAN, supra note 17, at 273-305 (discussing the role of nurses in caring for the dying); COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MED. ASSOC., CODE OF MEDICAL ETHICS 45-61 (1998) (discussing the withholding or withdrawal of life-sustaining treatment).

51. See In re A.C., 573 A.2d 1235, 1243 (D.C. Cir. 1990) (discussing that there was no clear indication by the mother of her wishes to undergo a cesarean section even though some thought that she had indicated that she did not want the procedure done).

52. See BERNARD LO, RESOLVING ETHICAL DILEMMAS, A GUIDE FOR CLINICIANS 37 (1995) (discussing physicians’ commitment to “do no harm” to their patients).
cians who must become advocates for the fetus, possibly at the mother's expense.  

2. The Minnesota Pregnancy Presumption

Prior to the 1998 amendment, Minnesota's pregnancy provision provided that "in the case of a living will of a patient that the attending physician knows is pregnant, the living will must not be given effect as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment." To date, other states continue to apply this standard and maintain the invalidity of an advance directive once a person is found to be pregnant. As amended, the Minnesota pregnancy provision currently states:

[w]hen a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is a real possibility that if health care to sustain her life and the life of the fetus is provided the fetus could survive to the point of live birth, the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant. This presumption is negated by health care directive provisions [written within the directive] . . . or, in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary.

Both the original and amended pregnancy provisions create a presumption, "an inference in favor of a particular fact," 

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53. See In re K.I., 735 A.2d 448, 455-56 (D.C. Cir. 1999) (concluding that the best interest of a patient may be to forego painful resuscitative measures, even if the patient's parents disagree with this course of action).

54. MINN. STAT. § 145B.13 subd. 3 (1998).

55. See supra note 39.

56. MINN. STAT. § 145C.10(g).

57. See id. § 145B.13 subd. 3.

58. See id. § 145C.10(g). A valid Minnesota advance health care directive executed prior to August 1, 1998, still remains in effect despite the 1998 amendment changing the statutory scheme to an integrated living will and durable power of attorney because the current law did not repeal the previous advance directive statute. See MINN. STAT. ANN. § 145C.03, Historical and Statutory Notes (West 2000).

A document executed prior to August 1, 1998, that purports to be a living will . . . a durable power of attorney . . . or a declaration regarding intrusive mental health treatment . . . is valid if the document: (1) complied with the law in effect on the date executed; or (2) complies with . . . Minnesota Statutes, section 145C.03 [the 1998 requirements of a valid health care directive].

Id.

that a woman would want treatment continued in the case that she was pregnant. However, the amended provision makes this presumption rebuttable. It states that if a valid health directive document or clear and convincing evidence indicate otherwise, treatment may be withheld or withdrawn. Thus, the amended Minnesota statute differs significantly from the majority of pregnancy provisions that do not recognize a right to refuse medical treatment throughout pregnancy.

B. CONSTITUTIONAL ISSUES

In determining the constitutionality of any pregnancy provision, it is important to understand that a pregnant woman enjoys a constitutional privacy right to determine what will be done to her body. The privacy right includes a woman’s right to decide to terminate her pregnancy. A woman also has a liberty interest in refusing medical treatment. However, once a pregnant woman is no longer competent to make decisions, should her right to refuse medical treatment be suspended because of her pregnancy? And what if there is no advance directive, when is it appropriate for the state’s interest to override the right to refuse medical treatment to protect the potential life of the unborn?

60. See MINN. STAT. § 145C.05(2)(a)(10). This provision states “[a] health care directive may include provisions consistent with this chapter, including, but not limited to: ... health care instructions by a woman of child bearing age regarding how she would like her pregnancy, if any, to affect health care decisions made on her behalf.”

61. The clear and convincing standard of proof is discussed in detail in Cruzan, where the U.S. Supreme Court found that Nancy Cruzan’s statement to her housemate “that she would not want to live should she face life as a ‘vegetable’” was insufficient to meet the standard of proof necessary to withdraw life-sustaining treatment. Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 285 (1990). In making its determination, the Supreme Court cited to a New York case that required “proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented.” Id. at n.11 (quoting In re Westchester County Med. Ctr., 72 N.Y.2d 517, 531, 534 (1988)).

62. See supra note 35 and accompanying text (listing states that have adopted the majority provision).

63. See Cruzan, 497 U.S. at 269. (“Every human being ... has a right to determine what shall be done with his own body.” (citation omitted)).

64. See infra Part I.B.2.

1. The Right To Refuse Medical Treatment

In the 1970s, advances in medical treatment and technology, along with the landmark In re Quinlan case, prompted a movement to permit the refusal of life-sustaining treatment.\(^66\) Quinlan was pivotal in defining the right of a parent to decide to withdraw life-sustaining medical treatment for his or her child.\(^67\) Karen Ann Quinlan, twenty-two years old, was declared to be in a "chronic and persistent 'vegetative' state, having no awareness of anything or anyone around her."\(^68\) Quinlan's father wanted to discontinue "all extraordinary medical procedures" for his daughter.\(^69\) The case raised the difficult issue of whether the interest in withdrawing life support outweighed the competing state interest in the preservation of life.\(^70\) The New Jersey Supreme Court concluded that the right to privacy extends to allow a patient's surrogate the right to refuse medical treatment for the patient.\(^71\) The Quinlan decision was based on the constitutional right to privacy recognized by the federal courts.\(^72\) As a result, Karen Quinlan's father could make a decision in the best interests of his daughter, and he had the right to choose to withdraw her life-sustaining medical treatment.\(^73\)

\(^{66}\) 355 A.2d 647, 647 (N.J. 1976); see also supra note 21 and accompanying text (discussing the trend to enact advanced directives and the new technological capabilities).

\(^{67}\) See 355 A.2d at 652 (discussing the importance of the decision and the profound impact it would have on society).

\(^{68}\) Id. at 655.

\(^{69}\) Id. at 651.

\(^{70}\) See id. at 663 (stating "[t]he claimed interests of the State in this case are essentially the preservation and sanctity of human life").

\(^{71}\) See id. at 664. The court in Quinlan stated that "[w]e think that the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." Id. The court also discussed the penumbra of the right of privacy that allows the recognition of this right as constitutionally protected. See id. at 663. Scholars argue that the right to privacy approach was adopted from the right to abortion case law. See, e.g., Alexander Morgan Capron, Historical Overview: Law and Public Perceptions, in BY NO EXTRAORDINARY MEANS 11, 12 (Joanne Lynn ed., 1986).

\(^{72}\) See Quinlan, 355 A.2d at 663 (establishing the right of personal privacy under the federal Constitution).

\(^{73}\) See id. at 664 (concluding that the patient's right to privacy may be asserted by her father under these circumstances to allow withdrawal of life-sustaining treatment); see also John F. Kennedy Mem'l Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); In re Torres, 357 N.W.2d 332, 338-40 (Minn. 1984) (discussing the ability to allow the removal of life-sustaining treatment if it is found to be in the patient's best interest by a decision of the guardian or conservator); In re Conroy, 486 A.2d 1209, 1231-32 (N.J. 1985) (authorizing
Fourteen years after the Quinlan case, the United States Supreme Court addressed the constitutionality of a patient's right to die. In Cruzan v. Director, Missouri Department of Health, the Supreme Court stated that "a competent person has a constitutionally protected liberty interest [under the Due Process Clause] in refusing unwanted medical treatment." Cruzan involved a request by the parents of a patient in a permanent vegetative state to remove life-sustaining treatment. Chief Justice Rehnquist, writing for the majority, upheld the state's ability to require family members to prove by "clear and convincing evidence" that the incompetent person would have wanted withdrawal of the life-sustaining treatment. Although the Court referred to a balancing of the state interest in the preservation of life with the patient's liberty interest, the test lacked the clarity necessary to give state courts guidance in recognizing a liberty interest to refuse medical treatment. Consequently, the Supreme Court decision allowed the withdrawal of life-sustaining treatment in the furtherance of the patient's best interests as established by the guardian.

75. Id. at 278.
76. Persistent vegetative state is defined as "generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." Id. at 266; see also State v. Olson, 435 N.W.2d 530, 532 (Minn. 1989) (discussing the difference between a persistent vegetative state and brain death).
77. Cruzan's parents requested that the hospital employees remove the artificial nutrition and hydration that was keeping their daughter alive. See Cruzan, 497 U.S. at 267.
78. Id. at 282; see also Martin v. Martin, 538 N.W.2d 399, 409 (Mich. 1995) (discussing the requirements of the clear and convincing standard and finding that a guardian's testimony and affidavit did not meet the standard to allow withdrawal of life-sustaining treatment).
79. See Cruzan, 497 U.S. at 281 ("We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements."). See generally NORMAN L. CANTOR, ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY 6 (1993) (discussing the goal of the Supreme Court in Cruzan to safeguard a person's right to self-determination through the clear and convincing evidence standard which actually ended up frustrating the probable choice of Nancy Cruzan); LO, supra note 52, at 198 (concluding that "states may establish procedural safeguards governing medical decisions for incompetent patients that are more stringent than requirements for competent patients").
80. See Cruzan, 497 U.S. at 279 (stating that once a liberty interest is identified, a constitutional violation can be determined by balancing that interest with relevant state interests).
81. See id. ("For purposes of this case, we assume that the United States Constitution would grant a person a constitutionally protected right to refuse
allowed the state to protect its interest in the preservation of life and to not allow the withdrawal of treatment, unless there was clear and convincing evidence that the person would want the treatment withdrawn.

Under *Cruzan*, the right to refuse medical treatment was attributed to the constitutional guarantee of a liberty interest under the Due Process Clause, and not to a privacy right. Because the right to refuse medical treatment was not declared a fundamental right, a compelling state interest could be strong enough to override the patient's right to refuse medical treatment. For example, interests that could override the right to refuse medical treatment include the preservation of life, the prevention of suicide, the protection of third parties, and the maintenance of the ethical integrity of medical professionals.

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82. See id. at 279 n.7 (discussing the constitutional basis for the right to refuse medical treatment in the Fourteenth Amendment liberty interest).

83. See SUE WOODMAN, LAST RIGHTS, THE STRUGGLE OVER THE RIGHT TO DIE 57-60 (1998) (discussing the *Cruzan* case and the fact that the Supreme Court declined to decide that the right to withdraw life-sustaining treatment is a fundamental right); see also CANTOR, supra note 79, at 3-8 (discussing the debate over whether *Cruzan* created a fundamental right through a liberty interest).

84. See *Cruzan*, 497 U.S. at 281 (“It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.”).

85. See, e.g., *Roe v. Wade*, 410 U.S. 113, 162 (1973) (stating that “the State does have an important and legitimate interest in... protecting the potentiality of human life”); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977) (stating that “[i]t is clear that the most significant of the asserted State interests is that of the preservation of human life”).

86. See, e.g., MINN. STAT. § 609.215 (1998) (stating that “[w]hoever intentionally advises, encourages, or assists another in taking the other’s own life may be sentenced to imprisonment”); see also *Foody v. Manchester Mem'l Hosp.*, 482 A.2d 713, 718 (Conn. 1984) (discussing the state interest in the prevention of suicide); BATTIN, supra note 21, at 192-93 (discussing the public policy issues associated with the prevention of suicide and the pressure exerted by right-to-die groups promoting the legalization of suicide in certain situations).

87. See, e.g., *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984) (discussing the state interest in the protection of third parties).

88. In *Superintendent of Belchertown State School v. Saikewicz*, the court stated:

This survey of recent decisions involving the difficult question of the right of an individual to refuse medical intervention or treatment indicates... [t]he State has a claimed interest in: (1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity
Thus, the scope of the right to refuse medical treatment has marked boundaries. The Supreme Court has determined that terminally ill patients do not have the right to decide the time and place of their death because "refusals of life-prolonging therapy must be distinguished both from active euthanasia and from assisted suicide." Accordingly, the judiciary's role is to balance the patient's right to refuse medical treatment with countervailing state interests. The courts have established that "countervailing state interests do not preclude recognition of the individual right to have life-sustaining treatment discontinued." Therefore, a competent woman does have a constitutionally protected right to decide in advance if she wants to continue her pregnancy in the case that she must undergo life-sustaining treatment. However, the state pregnancy provision would then dictate whether her wishes are considered.

Notwithstanding the liberty interest, some courts have limited a patient's right to refuse medical treatment once they are declared brain-dead. For example, in University Health
Services v. Piazzi, the Georgia Superior Court held that a pregnant woman did not have a right to refuse medical treatment because she no longer maintained the right once she was declared brain-dead.95 Although the woman did not actually have a living will to trigger the pregnancy provision, the court still considered the effect of the pregnancy provision and prohibited her family from withdrawing life-sustaining treatment from the woman.96

In the case In re A.C.,97 the District of Columbia Court of Appeals ordered that a mother, who was terminally ill with cancer, undergo a cesarean delivery of her fetus.98 Because the court was unable to obtain an informed consent since she had been declared incompetent, it made the decision to have the procedure performed on the woman.99 Two years later, the D.C. Court of Appeals vacated that decision,100 holding that a pregnant patient near death, with a viable fetus, may decide whether or not to have a cesarean delivery unless incompetent, in which case the decision should be ascertained through substituted judgment.101 The court stated that “[w]e do not quite foreclose the possibility that a conflicting state interest may be
so compelling that the patient's wishes must yield, but we antici-
porate that such cases will be extremely rare and truly excep-
tional."

This decision was seen "as a giant step forward in the fight to protect women's rights . . . to refuse unwanted invasive medical procedures."

Originally, state court consideration of the right to refuse medical treatment included an analysis of statutory authority and constitutional provisions authorizing the removal of life-sustaining treatment by a surrogate decision-maker. Decisions were made in the best interests of the patient, which did not ordinarily extend the state interest in the preservation of life to prohibit the individual's right to withdraw life-sustaining treatment.

Specifically, in Minnesota the State Constitution provides an independent privacy right, which also supports the right to refuse medical treatment. This right "begins with protecting the integrity of one's own body and includes the right not to have it altered or invaded without consent." The Minnesota privacy right mirrors the federal privacy right as originally recognized in Griswold v. Connecticut. However, the state pro-

102. In re A.C., 573 A.2d at 1252.

103. Tracey E. Spruce, The Sound of Silence: Women's Voices in Medicine and Law, 7 COLUM. J. GENDER & L. 239, 245; see also LO, supra note 52, at 92 (discussing recent court rulings forcing cesarean sections on women and the trend away from this holding by the courts); LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME, WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973, at 250-51 (1997) (discussing the ramifications of forced cesarean sections).

104. See, e.g., In re Torres, 357 N.W.2d 332, 336-40 (Minn. 1984) (considering the decisions of other state courts to allow the removal of life-sustaining treatment).

105. See, e.g., In re K.I., 735 A.2d 448, 455 (D.C. Cir. 1999) (stating that the substituted judgment standard, which considers the totality of the circumstances, is used to "implement the wishes of the incompetent individual").

106. See In re Conroy, 486 A.2d 1209, 1225 (N.J. 1985) (discussing how the right to self-determination outweighs the interest in the preservation of life).

107. See MINN. CONST. art. I, §§ 1, 2, 10. "Government is instituted for the security, benefit and protection of the people, in whom all political power is inherent, together with the right to alter, modify or reform government whenever required by the public good." MINN. CONST. art. I, § 1; see State v. Gray, 413 N.W.2d 107, 111 (Minn. 1987) (holding that the right to privacy is applicable only to the exercise of fundamental rights, that the state constitution can provide more fundamental rights than the federal Constitution, and that fundamental rights are not limited to those expressly stated within the state constitution).


109. 381 U.S. 479, 484 (1965) (discussing how "[v]arious guarantees create
vides greater protection of the right, as guaranteed by the Minnesota Bill of Rights. Minnesota has also enacted statutes that guarantee a competent patient the right to refuse medical treatment and prohibit a guardian from consenting to "any medical care . . . which violates the known conscientious, religious, or moral belief of the ward or conservatee." In the case of In re Torres, the Minnesota Supreme Court recognized that "the right . . . to forego life-sustaining treatment [is] based upon a constitutional right of privacy and/or the common law right to be free from invasions of one's bodily integrity." Although the court upheld this right for a comatose patient, it did not consider whether this right should be extended to allow the withholding or withdrawal of life-sustaining treatment from a pregnant woman.

Cruzan prompted state legislatures and Congress to address complex issues involving end-of-life care and to further define the patient's rights. Accordingly, Congress passed the Patient Self-Determination Act to compel health care institu-

zones of privacy" in the penumbral emanations of the right to privacy within the Constitution and striking down a law which prohibited the use of contraceptives by married persons).

110. See Gray, 413 N.W.2d at 111 (citations omitted).

111. See Patients Bill of Rights, MINN. STAT. § 144.651 subd. 12 (1998 & Supp. 1999) (stating that competent patients and residents shall have the right to refuse treatment; if the patient is incompetent or the legal circumstances require a limitation on the right to refuse treatment, the conditions and circumstances of the limitation will be documented in the medical record).

112. Id. § 525.56 subd. 3(4)(a) (describing the guardian’s or conservator’s power and duties).

113. 357 N.W.2d 332, 339 (Minn. 1984) (discussing the authority to remove life-sustaining treatment and holding that a conservator can order the withdrawal of life-sustaining treatment).

114. The legislature was called into action by other cases along with Cruzan. See, e.g., id. at 341 (stating that "the legislative process would be a superior method of insuring public input into such vital questions [as maintaining the heart and lung functions of a patient with brain damage]").

115. See id. at 339-40 (concluding that a combination of statutory and constitutional law allows courts to make decisions regarding the withdrawal of life-sustaining treatment); see also In re Drabick, 345 Cal. Rptr. 840, 855 (Ct. App. 1988) (stating that the right to refuse treatment could be found in the common law and the constitutional right to privacy); Dority v. Superior Court, 193 Cal. Rptr. 288, 291-92 (Ct. App. 1983) (citing a state statutory provision defining the ability of the guardian to choose to withdraw life-sustaining support from a patient following a diagnosis of brain death); supra note 47 and accompanying text (discussing cases of statutory interpretation by the courts of pregnancy provisions).

tions to facilitate the completion of patients' advance directives. Cruzan also motivated right-to-die advocates to lobby state and federal governments to further empower terminal patients with the right to make decisions about their care. The right-to-die cause reached a turning point in 1997 with the popular vote enactment of Oregon's Death With Dignity Act. The Act allows physicians to prescribe deadly medications to their patients. However, the Act states that it is not to be "construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia." Overall, state legislatures have been cautious through a State agency... develop a written description of the law... concerning advance directives that would be distributed by providers or organizations." Id. § 4751(a)(1)(C). The Patient Self-Determination Act (PSDA) mandates that health care facilities give patients information, inquire if the person has an advance directive, and provide education to the public about advance directives. See id. § 4751(a)(2). "It must be remembered that the PSDA applies only to the competent, adult patient." Alexandra Gekas, The PSDA of 1991: What Does It Mean for Health-Care Organizations?, 2 J. CLINICAL ETHICS 205 (1991); see Karen N. Swisher, Implementing the PSDA for Psychiatric Patients: A Common-Sense Approach, 2 J. CLINICAL ETHICS 199-205 (1991) (discussing the need to develop a standard to measure decision-making capacity of patients in light of the PSDA's prompting of advance directive use).


118. Senator Danforth of Missouri was prompted by the Cruzan case to initiate the PSDA of 1991. See WOODMAN, supra note 83, at 59-60 (discussing the legislative response to the Cruzan decision); see also LO, supra note 52, at 199 (discussing the implications of the Cruzan case and the legislative response that the case prompted). Justice O'Connor's concurrence in Cruzan may suggest the use of written advance directives, initiating the legislature's enactment of the PSDA. See COMMITTEE ON CARE AT THE END OF LIFE, supra note 18, at 202-03.

119. See BATTIN, supra note 21, at 192-94 (discussing public policy issues and the right-to-die movements in the U.S.); Bopp & Avila, supra note 45, at 209-210 (discussing the substantive limitations on the right to die because "that right is neither enumerated nor fundamental").


121. See OR. REV. STAT. §§ 127.800 to .897 (1998); see also Renee Fox, The Entry of U.S. Bioethics into the 1990s, in A MATTER OF PRINCIPLES? 21, 30 (Edwin R. Dubose et al. eds., 1994) (discussing the attempts of California, Oregon, and Washington to legalize physician-assisted dying).

122. OR. REV. STAT. § 127.880.
in making decisions regarding assisted suicide, and statutes addressing care at the end of life are careful to assert that advance directives, including the Death with Dignity Act, are intended to allow a physician to end a person's life lawfully. As physicians are given the legal means to end a person's life, the profession faces its extreme discomfort with discussing end-of-life care. This discomfort may be attributed to the physician's determination to maintain life and to exhaust every possible avenue before allowing death to prevail.

2. The Right To Terminate Pregnancy

One of the most widely known and debated cases of the twentieth century held that a woman has a constitutional right to choose whether or not to terminate her pregnancy. In Roe v. Wade, the Supreme Court balanced a woman's right to choose to have an abortion with the state interest in protecting the potential human life as well as the health of the pregnant woman. The Court held that the constitutional right to pri-
vacy gave a woman the right to terminate a pregnancy during "the stage prior to approximately the end of the first trimester." The Court also recognized that "some state regulation in areas protected by [the right of privacy] is appropriate" and that a state has a compelling interest in potential life once the fetus is viable. The trimester framework defined specific guidelines that would allow the removal of life-sustaining treatment before the fetus reached viability.

The Supreme Court's ruling in Planned Parenthood v. Casey, however, altered the legal standard by which to evaluate restrictions on abortion. The Casey decision considered the constitutionality of amendments to the Pennsylvania abortion statute. The Supreme Court reaffirmed Roe v. Wade, based on stare decisis, but overruled the use of the trimester framework and fetal viability as a standard by replacing it with an "undue burden test." The undue burden test consid-

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pregnancy, each of the state's interests become compelling—the health of the mother at the end of the first trimester and the fetus at the point of viability).

129. Id. at 164 (summarizing abortion rights through each trimester of pregnancy).

130. Id. at 154. The Court discussed the requirement that state legislation limiting the right to abortion be narrowly tailored to further a compelling state interest. See id. at 155. See generally Mark A. Graber, Rethinking Abortion: Equal Choice, the Constitution, and Reproductive Politics 69 (1996) (discussing the impact of state laws on abortion).

131. See Roe, 410 U.S. at 163 (stating that the state interest in fetal life becomes compelling at viability because "the fetus then presumably has the capability of meaningful life outside the mother's womb").

132. See id. at 163-65 (discussing the trimester framework that dictates when a woman may obtain an abortion based on the compelling state interest in potential fetal life after viability).


135. See id. at 844.

136. See id. at 845-46.

137. See id. at 878-79; MacAvoy-Snitzer, supra note 10, at 1286 (stating that the state cannot regulate the termination of life-sustaining treatment in a pregnant woman before viability of the fetus); see also Benton, supra note 133, at 1826 (arguing that a pregnant woman's living will should not be suspended until the fetus is viable).

138. Casey, 505 U.S. at 877 (discussing the undue burden test as a guiding principle in assessing the state statute); see also Elizabeth Reilly, The "Jurisprudence of Doubt": How the Premises of the Supreme Court's Abortion Jurisprudence Undermine Procreative Liberty, 14 J.L. & Pol. 767, 797 (1998) (describing a pregnant woman as invisible under the eyes of the law, thereby
ers whether a law's purpose or effect is to place "a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." The Court recognized a "profound" state interest in potential fetal life and to some degree "demarcated the limitations of state authority to regulate abortion." Casey established a profound interest in potential life that was not based on the trimester framework.

The abortion right is relevant to the right of a pregnant woman to refuse medical treatment because the woman has a right to terminate her pregnancy prior to the viability of the fetus. Therefore, if the woman has an advance directive stating that she wants life-sustaining treatment withdrawn, it follows that she should be able to make the decision to withdraw treatment, terminating her pregnancy with a fetus that is not yet viable. Some legal commentators have argued that pregnancy provisions should not prohibit the termination of life-sustaining treatment for a pregnant woman because it is unconstitutional to allow state regulation of a pregnant woman's termination of treatment before fetal viability.

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139. Casey, 505 U.S. at 877.

140. Id. at 878; see also Webster v. Reproductive Health Servs., 492 U.S. 490, 494 (1989) ("There is also no reason why the State's compelling interest in protecting potential human life should not extend throughout pregnancy.").


142. See Casey, 505 U.S. at 876-78 (discussing the "undue burden" test). "[A] state's compelling interest in the life of a fetus does not vary according to the gestational age." Patricia Fauser et al., Conclusion: Perspectives on the Politics of Abortion, in PERSPECTIVES ON THE POLITICS OF ABORTION, supra note 141, at 193.

143. But see REAGAN, supra note 103, at 251-52 (discussing the limited access to abortion providers and financial restrictions that effectively abrogate a woman's right to terminate her pregnancy).

144. 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, 1124-25 (1988) (stating that a pregnant woman, vegetative or not, may choose to terminate her pregnancy under Roe).

145. See Benton, supra note 133, at 1826 (arguing that "under Roe, the state may not prohibit abortion under the guise of a living will statute"); Dyke, supra note 47, at 875-78 (describing the right to abortion as inapposite to the living will pregnancy provision).

146. See, e.g., Benton, supra note 133, at 1826 (stating that statutes that suspend a living will throughout pregnancy unconstitutionally infringe on a
The privacy right supports the right to terminate pregnancy and is protected as a liberty interest under the Fourteenth Amendment.147 Abortion implicates the privacy right because abortion rests on a woman's right to make choices about her own body, not the body of another entity.148 The right to privacy granted in the U.S. Constitution149 is recognized by the Supreme Court to be within the "penumbra" of guarantees of the Bill of Rights.150 Because "individual liberties under the state constitution may deserve greater protection than those under the broadly worded federal Constitution,"151 there is the capacity for states to further broaden the abortion right.152

State court decisions have generally held that the patient's right to refuse medical treatment is not outweighed by the state interest in preserving life.153 But when the withdrawal or withholding of treatment leads to the termination of a patient's pregnancy, the state's interest in potential life becomes

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148. See McDonagh, supra note 127, at 34-39 (viewing the fetus as a separate entity from the woman and arguing that a "balancing" of privacy rights is altered by the pregnancy of the woman).
149. See supra note 63-64.
150. See Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (asserting that the various explicit guarantees of the Bill of Rights implicitly create a protected zone of privacy).
152. See Reagan, supra note 103, at 252 (discussing limitations that states choose to impose on abortion).
153. See, e.g., McConnell v. Beverly Enters.-Conn., Inc., 553 A.2d 596, 605 (Conn. 1989) (holding that removal of a gastrostomy tube was authorized by statute and no compelling state interest outweighed the patient's rights); In re Farrell, 529 A.2d 404, 416 (N.J. 1987) (holding that the right of a competent, terminally ill patient to decline medical treatment outweighed the state interest in preserving life); In re Storar, 420 N.E.2d 64, 74 (N.Y. 1981) (holding that the state interest in the preservation of life does not outweigh the patient's interest in declining medical treatment). See generally Cantor, supra note 79, at 8-10 (discussing the balancing of the patient's interest in refusing life-sustaining treatment and the state interest in the preservation of life and preserving respect for the sanctity of life).
stronger because another potential life is dependent on maintaining the life of the mother. Commentators argue that "under certain circumstances [the courts] may be the last resort for protecting the lives of those who cannot make their own decisions," including both the patient and the fetus. Thus, it is difficult to balance the state interest in potential life with the woman's interest in deciding what should be done to her body. Furthermore, Roe v. Wade's holding that a pregnancy with a viable fetus can only be terminated when necessary to preserve the life or health of a mother has not been overruled.

II. MINNESOTA'S PREGNANCY PRESUMPTION

A. ANALYZING THE MINNESOTA PREGNANCY PRESUMPTION

The Minnesota pregnancy presumption is different than all other pregnancy provisions for several reasons. Foremost, the provision states that it will be presumed that the patient would want life-sustaining treatment in the case that she is found to be pregnant and there is a possibility that the fetus will survive to live birth. In addition, the statute allows the withdrawal of treatment if indicated within her living will or where there is clear and convincing evidence to show that this

154. See supra note 61 and accompanying text (discussing the standard of proof that must be satisfied to allow withdrawal of life-sustaining treatment without pregnancy); see also Johnsen, supra note 101, at 570-71 (discussing how courts have attempted to force pregnant women to act in the best interests of their fetuses, including eleven state court decisions forcing a woman to undergo a cesarean section against her will).

155. EDMUND D. PELLEGRINO & DAVID C. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE 170 (1988) (discussing the courts' role in decisions concerning incompetent patients); see also Blair D. Condoll, Comment, Extending Constitutional Protection to the Viable Fetus: A Woman's Right to Privacy, 22 S.U. L. REV. 149, 150 (1994) (stating that abortion laws grant to viable fetuses rights "separate and apart from those of pregnant women," which infringe on a woman's privacy right).

156. See, e.g., Michael K. Steenson, Fundamental Rights in the "Gray" Area: The Right of Privacy Under the Minnesota Constitution, WM. MITCHELL L. REV. 383, 399 (1994) (discussing the balance that is required between the state's interest and the individual's right to choose what happens to their body).


158. Some states, however, have some provisions similar to the Minnesota statute. For example, GA. CODE ANN. §§ 31-32-1 to 12 (1996) requires that the patient must have specifically indicated her wish to withdraw treatment.

159. See MINN. STAT. § 145C.10(g) (1998).
is what the woman would have wanted.  The Minnesota statute goes beyond simply making the living will void with pregnancy, it attempts to balance the woman's rights with those of the fetus. This fundamental change makes Minnesota's statute preferable over other state statutes that do not attempt to balance the mother's rights with the state interest in potential life.

The majority of state pregnancy provisions adhere to the presumption that the woman would want to continue life-sustaining treatment if she were pregnant and make all wishes expressed in the advance directive automatically void with pregnancy. These state provisions, however, do not consider that the fetus may not even survive until live birth, which would eliminate the state interest altogether. Instead, the provisions simply eliminate the right of the patient to refuse treatment without considering the strength or applicability of the state interest in potential life. Although there may be less ambiguity in such provisions, the clarity is at the expense of the mother's rights.

Apart from clear statements that an advance directive is void with pregnancy, interpreting the ambiguous language of the other states' pregnancy provisions is difficult. For example, it is unclear what is actually required for it to be "possible" that a fetus will develop to live birth contrasted with the "probability" of live birth, or a "medical certainty" that the fetus will develop to live birth. The statutes do not contain clear definitions to guide courts with their interpretation. Additionally, courts cannot rely on fetal viability for direction because such language is rarely written in the statutes. Only two states address the viability of the fetus in their pregnancy provision. Colorado requires fetal viability and a medical certainty that the fetus will survive to live birth to force continued

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160. See id.
161. See supra Part I.A.1 (discussing various state pregnancy provisions).
165. See supra note 40
treatment, and Georgia requires that the fetus not be viable and a statement within the living will to allow discontinuation of life-sustaining treatment. Both allow discontinuation of treatment if the fetus is not viable but do not allow discontinuation or withdrawal of treatment with a viable fetus. Other states probably have not addressed fetal viability because courts have recognized that there is a profound interest in potential life before and after viability, which would make the use of the viability terminology superfluous.

Advance directives rarely include an option for women to specifically express their wishes concerning pregnancy within their advance directive. The Georgia statute highlights this problem because it requires a woman's advance directive to "specifically indicate[] that the living will is to be carried out" despite pregnancy. Although the Minnesota's statute contains a similar provision, it does not require an express statement in the advance directive. Thus, the Minnesota statute favors the woman who may not have a completed health care directive by allowing the family members to present clear and convincing evidence of the woman's wishes. This alleviates the fear that a woman would completely lose her right to refuse medical treatment with pregnancy in Minnesota.

B. THE CONSTITUTIONALITY OF MINNESOTA'S STATUTE

The Minnesota advance directive statute, as amended, balances the rights and interests of the patient against the state interest within the constitutional boundaries established by the Supreme Court. The statute skillfully integrates the state interest in potential life with a woman's right to refuse medical

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171. See MINN. STAT. § 145C.10(g) (1998).
172. See id. (providing "or in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary"); see also Martin v. Martin, 538 N.W.2d 399, 409-13 (Mich. 1995) (discussing the requirements of the clear and convincing standard and finding that a guardian's testimony and affidavit did not meet the standard to allow withdrawal of life-sustaining treatment).
treatment and to terminate her pregnancy. The Minnesota statute offers needed flexibility when a pregnancy provision is applied.

1. The Right To Refuse Medical Treatment

   If a person has a valid advance directive in Minnesota, the written documentation would allow the withdrawal or refusal of life-sustaining treatment. Documentation that a woman would still want treatment withdrawn if she were pregnant supports the proposition that the woman considered the possibility of pregnancy and wanted her family members to know her wishes. If the woman does not have a living will, the patient's family would be able to present clear and convincing evidence of the woman's wishes. The clear and convincing evidence standard is not easily met, as evidenced by the *Cruzan* case. The patient's family would have to show sufficient evidence specifying that the woman would want the treatment withdrawn knowing of her pregnancy. This would effectuate the woman's option to refuse medical treatment, hence terminating the pregnancy but only before the fetus is viable without further consideration of the specific situation.

   *Cruzan* established a liberty interest in refusing or withdrawing life-sustaining treatment and upheld the use of the clear and convincing evidence standard when balancing the patient's interests in refusing treatment and the state's interest in potential life. The right to refuse medical treatment is a liberty interest and not a fundamental right. Therefore, a

173. *See Meisel*, supra note 23, at 400 (explaining the need for women of childbearing age to address whether "they wish to include a provision stating that the directive is to be operative or inoperative" within their advance directive).

174. *See Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 285 (1990) (holding that the state's clear and convincing evidence standard is constitutional and that the showing by family members that *Cruzan* made statements to a housemate that she would not want to live "as a 'vegetable'" were insufficient to meet that standard) (citing *In re Westchester County Med. Ctr.*, 72 N.Y.2d 517, 531 (1988) (requiring "proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented")).

175. *See supra* notes 78-79 and accompanying text.

176. *See supra* note 101-02 and accompanying text (recognizing a patient's right to decide whether or not to have a cesarean delivery of a viable fetus and when this right may be overridden).

177. *See supra* notes 74-80 and accompanying text.

178. *See Cruzan*, 497 U.S. at 278; *supra* note 83 and accompanying text.
compelling state interest can potentially outweigh the right to refuse medical treatment.\textsuperscript{179} The right to refuse medical treatment has been limited in some cases. However, \textit{In re A.C.} rejuvenated the recognized liberty interest by holding that the substituted judgment of the incompetent pregnant woman should be obtained before making the woman undergo a cesarean section to save the life of the fetus.\textsuperscript{180} The decision did leave open the possibility for compelling state interests that might infringe on the right to refuse medical treatment, but acknowledged that this circumstance would be "extremely rare and truly exceptional."\textsuperscript{181}

Minnesota's advance directive statute was amended to protect the patient's liberty interest while ensuring recognition of the state interest in the preservation of life. Unlike the other state statutes, the Minnesota pregnancy presumption does not infringe on a person's right to refuse medical treatment. In fact, the statute was enacted to allow women to effectuate their wishes concerning end-of-life care.\textsuperscript{182} The Minnesota statute permits the court to examine the patient's wishes to make a proper determination of whether her case falls within the exception that allows the refusal or withdrawal of medical treatment.\textsuperscript{183} Such a system promotes judicial efficiency and the patient's liberty interests.

The Minnesota statute serves as a model for other states because it effectively alleviates uncertainty by not automatically extending a woman's liberty interest to allow withdrawal of treatment if she is pregnant.\textsuperscript{184} Rather, the statute balances the woman's rights with the state interest by requiring further support of the woman's choice to withdraw treatment and terminate the pregnancy.\textsuperscript{185} The statute presumes that the woman wants health care provided to her, "even if the withholding or withdrawal . . . would be authorized were she not

\textsuperscript{179} See supra notes 85-88 and accompanying text (discussing interests that could qualify as a compelling state interest that would override the right to refuse medical treatment).
\textsuperscript{180} 573 A.2d 1235, 1237 (D.C. Cir. 1990) (en banc); cf. supra note 101.
\textsuperscript{181} In re A.C., 573 A.2d at 1252.
\textsuperscript{182} See supra text accompanying note 17.
\textsuperscript{183} See MINN. STAT. § 145C.10(g) (1998); supra text accompanying note 56.
\textsuperscript{184} See MINN. STAT. § 145C.10(g) (limiting the withdrawal of treatment in a pregnant woman by requiring express indication within the living will or clear and convincing evidence to the contrary).
\textsuperscript{185} See supra note 148 (discussing the "balancing" of privacy rights).
pregnant.” This approach insures that a pregnancy will be terminated only if the woman expresses her wishes within the living will or there is clear and convincing evidence of her desire to withdraw treatment despite pregnancy. This rebuttable presumption is in favor of protecting the life of a fetus because of the irreversibility of withholding or withdrawing life-sustaining treatment.

2. The Right To Terminate Pregnancy

The abortion right, as established in Roe v. Wade, supports the withdrawal of life-sustaining treatment resulting in the termination of pregnancy if the patient so chooses and the fetus is not viable. Once the fetus reaches the point of viability, the courts would likely find that the state interest in potential life outweighs the woman’s right to refuse medical treatment. Because a woman can choose to have an abortion before the fetus is viable, the statements in a living will that call for the withdrawal of treatment should arguably not be infringed by a state statutory pregnancy provision. In fact, the state regulation of abortion could be broadened depending on the impact on individuals balanced against the magnitude of the state interest. However, once a woman is unable to decide on her own, her right to terminate pregnancy should not be acted upon until it is determined that this is what she would have wanted. This approach is precisely what the Minnesota statute provides.

The constitutional right to privacy supports the right to terminate pregnancy. However, the Supreme Court has yet to extend the privacy right to allow the withdrawal or refusal of treatment when a woman is pregnant. Because the privacy right in the abortion context permits the woman to make the choice to abort a fetus before the fetus is viable, under a Ca-

186. MINN. STAT. § 145C.10(g).
187. See id.
188. 410 U.S. 113 (1973).
189. See supra note 145 and accompanying text (discussing how the abortion right, under Roe v. Wade, should not be infringed by a living will statute).
190. See Johnsen, supra note 101, at 570-71 (discussing the strength of the government’s interest in the life of the fetus).
191. See supra notes 151-52 and accompanying text.
192. See Griswold v. Connecticut, 381 U.S. 479, 484-86 (1965) (establishing the privacy rights within the penumbra of several constitutional guarantees).
PREGNANCY PROVISIONS

sey analysis, mandating the maintenance of a pregnant woman on life-support before viability is arguably an "undue burden" on the woman's right to refuse medical treatment.\(^{194}\) Furthermore, Casey reaffirmed that a state may not prohibit a woman from deciding to terminate her pregnancy before the fetus reaches viability.\(^{195}\)

Under Casey's test, the Minnesota advance directive statute would not impose an undue burden on the woman simply because it favors putting a woman's body through pregnancy while she is in a vegetative state. But, is it an undue burden to apply the Minnesota pregnancy provision to all pregnant women when the state has only touched upon educating the public on advance directives? Is there an actual program instituted to inform pregnant women specifically about their choices regarding their pregnancy in the case that they become incompetent? Regardless of the responses to these questions, the Minnesota statute offers a safeguard to the sweeping determination that all women are presumed to want treatment maintained. Although the clear and convincing standard is difficult to satisfy, it is still a valid opportunity to effectuate the desired treatment of a woman that has expressed her wishes.\(^{196}\) The woman maintains her privacy right to terminate pregnancy\(^{197}\) through an express statement in her living will\(^{198}\) or by clear and convincing evidence.\(^{199}\)

The vast majority of state legislatures have not drafted pregnancy provisions based on the viability of the fetus\(^{200}\) because "the State has legitimate interests from the outset of the pregnancy in protecting ... the life of the fetus that may become a child."\(^{201}\) Furthermore, state abortion statutes address

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\(^{194}\) See Planned Parenthood v. Casey, 505 U.S. 833, 878 (1992) (plurality opinion) (applying the "undue burden" standard for state regulation of abortion); supra note 138 and accompanying text.

\(^{195}\) See Casey, 505 U.S. at 878.

\(^{196}\) See supra notes 78-79 (discussing the clear and convincing standard and recognizing that states may use such standard as a procedural safeguard).

\(^{197}\) See Roe, 410 U.S. at 164 (discussing the trimester framework of the abortion right).

\(^{198}\) See MINN. STAT. § 145C.05 subd. 2(a)(10) (1998).

\(^{199}\) See id. § 145C.10(g).

\(^{200}\) Cf. COLO. REV. STAT. ANN. § 15-18-104(2) (West 1999) (requiring fetal viability to allow the continuation of life-sustaining treatment along with a medical certainty that the fetus will survive to live birth); GA. CODE ANN. § 31-32-8(a)(1) (1996) (requiring pre-viability to allow the discontinuation of treatment and a statement within the living will).

\(^{201}\) Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992) (plurality
the limitations on the right to terminate pregnancy at fetal viability. Once the fetus is viable, the pregnancy can only be terminated when "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." Because the life or health of the mother is not at issue when the mother is on life support, there is limited legal support allowing the withdrawal of life-sustaining treatment from a woman pregnant with a viable fetus.

The In re A.C. court held that a pregnant woman's terminal condition did not infringe on her decision to refuse a cesarean section because her right to bodily integrity was not lessened by her condition. Consequently, the state could not force the woman to have a cesarean section to save the life of the viable fetus. Likewise, the court suggested that the state should not force a pregnant woman to maintain life-sustaining medical treatment when her wishes are otherwise. The In re A.C. court analyzed the woman's right to refuse medical treatment and limited the state's infringement on this right. However, the court did not address the state's compelling interest in the potential life of the fetus. Nonetheless, the court considered a balancing of the state and the mother's interests to supplement the substituted judgment of the patient. This balancing included consideration of "the mother's prognosis, the viability of the fetus, the probable result of treatment or non-treatment for both mother and fetus, and the mother's likely interest in avoiding impairment for her child together with her own instincts for survival." The Minnesota statute protects the state interest in potential life while maintaining the

opinion) (discussing the legitimate state interest in potential life and its limitations).

202. See, e.g., MINN. STAT. § 145.412 subd. 3 (stating that it is unlawful to terminate the pregnancy, with certain limited exceptions, when the fetus is potentially viable).


204. 573 A.2d 1235, 1247 (D.C. Cir. 1990) (en banc) ("It matters not what the quality of a patient's life may be; the right of bodily integrity is not extinguished simply because someone is ill, or even at death's door.").

205. See id. at 1246-48.

206. See id.

207. See id.

208. See supra note 131 and accompanying text.

209. See In re A.C., 573 A.2d at 1251; see supra note 101.

210. In re A.C., 573 A.2d at 1251.
woman's right to refuse treatment if this is the choice she would have wanted given the circumstances.

III. SUGGESTED IMPROVEMENTS TO MINNESOTA'S ADVANCE DIRECTIVE STATUTE

The Minnesota statute is constitutionally sound, but it could be further improved. Minnesota's pregnancy provision does not force a woman to do anything that she has stated, written, or made known that she does not want to have done to her body, as compared to other states that mandate the continuation of treatment during pregnancy. However, like its counterparts in other states, the Minnesota statute does contain ambiguous language.

The current Minnesota pregnancy presumption states that when:

a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is a real possibility that if health care is provided the fetus could survive to the point of live birth, the health care provider shall presume that the patient would have wanted such health care.211

The Minnesota statute should define what is actually required to reach the possibility of live birth beyond simply being pregnant.212 As it stands, one could argue that the possibility that the fetus will develop to the point of live birth would be at the point of fetal viability.213 The language of the statute, however, does not require fetal viability.214 Therefore, the possibility of development to the point of live birth arguably encompasses the period before and after fetal viability.215 One can argue, however, that there is always a possibility of live birth of a fetus when a woman is pregnant. It would seem that the possibility of live birth would only end upon termination of the pregnancy. This ambiguity leaves physicians in a difficult position of deciding what the statute actually requires.

211. MINN. STAT. § 145C.10(g) (1998).
212. See supra note 38 (providing one definition of "possible").
213. See supra note 131 (declaring that the state interest in potential life becomes compelling at fetal viability).
The statute states that "in reasonable medical judgment... the fetus could survive to the point of live birth."216 This language does not create a standard beyond the chance, even if it is a minute chance, of survival of the fetus. For example, this broad language could allow continued life-sustaining treatment for a fetus when it is known that it would put the mother at risk for sustained pain.217 In balancing the woman's interests with the state interest, could the right to refuse medical treatment outweigh the state interest in potential life if the mother had to undergo extreme pain? The Minnesota statute does not address these situations. The statute could be amended to allow withdrawal of treatment without a living will or clear and convincing evidence218 if the fetus could possibly survive, but where it is known that the mother would suffer severe pain. The Minnesota statute, as written, allows the patient's family to present clear and convincing evidence that could weigh in favor of withdrawal of treatment if the situation would create suffering for the mother.

Inserting a question into the model living will form that inquires how the person wishes to be treated during pregnancy would also improve the Minnesota statute.219 This inquiry would prompt health care personnel, lawyers, and the public to offer the woman an opportunity to address her wishes for the situation within the advance directive. Written information within a living will is crucial to deciphering the wishes of the patient if she becomes incompetent. Health care personnel and the public may not have the requisite knowledge or understanding of advance directives to know that they must specifically address the pregnancy provision and understand the importance of determining the clear preferences of the patient.220

216. MINN. STAT. § 145C.10(g).
217. Cf. 20 PA. CONS. STAT. ANN. § 5414(a) (West Supp. 1999); S.D. CODIFIED LAWS § 59-7-2.8 (Michie 1993).

[L]ife-sustaining treatment and artificial nutrition and hydration shall be provided to a pregnant woman unless, to a reasonable degree of medical certainty... such procedures will not maintain the woman... to permit the... live birth of the unborn child or will be physically harmful to the woman or prolong severe pain which cannot be alleviated by medication.

Id.

218. See supra note 61 (discussing the clear and convincing standard).
219. See MINN. STAT. § 145C.16 (providing a living will form that does not specifically mention pregnancy).
220. See supra notes 24-25 (noting that advance directives are underutilized and often lack specificity).
It is important to recognize the significance of how informed health care personnel are when they care for patients at the end of life. In many circumstances, physicians and nurses are responsible for assisting in the completion of the advance directive and discussing patient's rights directly with patients and their families. Are medical and nursing schools dedicated to teaching students about advance directives and pregnancy provisions? Are practicing professionals educating new staff members about advance directives? Further education during school and in practice should be instituted by the health care profession to keep health care professionals up to date on changes in advance directive laws and the specific provisions of the state in which they are practicing. The state should also play a role in educating attorneys and the public about advance directives and their legal effect in a multitude of circumstances, including pregnancy.

Finally, the fact that the Minnesota advance directive legislation has two separate statutory schemes (the pre- and post-1998 amendment) makes educating health care personnel and the public even more imperative. Having two separate statutory schemes in place allows one statute to govern advance directives completed before the amendment, and the other revised statute to govern those completed after August 1, 1998. Health care professionals that are not adequately educated on the differences between directives executed prior to August 1, 1998 and the current version could easily misinterpret the provision. In addition, the amended advance directive statute has other changes so any person with a completed advance directive should be encouraged to update their directive to utilize the increased flexibility of the amendments. Updating is especially important for pregnant women or women of child-bearing age, since an advance directive executed before August 1, 1998 would mandate that she could not withdraw

221. See supra notes 116-17 and accompanying text (discussing the role of health care professionals in creating advanced directives).
222. See supra note 125 (discussing the physician's role in carrying through with advance directives).
223. See MINN. STAT. § 145B.011.
224. See id.; supra note 58 (describing the validity of an advance directive written before the 1998 statutory amendment).
225. See MINN. STAT. § 145B.13(3) (providing the pre-1998 amendment pregnancy provision, which is still in effect).
226. See id. § 145C.10(g) (providing the pregnancy provision for advance directives created on or after August 1, 1998).
life-sustaining treatment, making any wishes within her living will void if she were pregnant.

CONCLUSION

The Minnesota advance directive pregnancy presumption balances the woman's right to terminate a pregnancy and the right to refuse medical treatment with the state interest in potential life. The woman has an opportunity to make her wishes known in advance, as well as giving her the chance to discuss the situation with her family or health care agent. These avenues recognize that pregnant women have rights in this situation that should not be ignored simply based on their pregnancy. Nonetheless, the pregnancy provision creates a rebuttable presumption that favors the state interest in potential life unless there is evidence that this is contrary to the wishes of the patient. Even though Minnesota's statute could be improved with further clarification and definitions, the intent of the statute is clear and the foundation constitutional. Moreover, other states should amend their advance directive statutes and follow the Minnesota statute by balancing the woman's interests with those of the state. Like Minnesota's statute, these statutes would offer a legitimate, peaceful, and constitutional solution to a difficult situation.