Management of Post-Mortem Pregnancy

by

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A thesis submitted in conformity with the requirements
for the degree of Masters of Laws
Graduate Department of Law
University of Toronto

Your file Votre référence
ISBN: 0-612-84362-9
Our file Notre référence
ISBN: 0-612-84362-9

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ABSTRACT

In my thesis I deal with the legal and ethical aspects of maintaining a brain-dead pregnant woman on "life-support" by the successful delivery of her fetus. First, I analyze post-mortem pregnancy through discussing abortions-law, the law regulating general bodily interventions in pregnant women's life style and physical condition, and the legalizing of medical interventions in dead patients. I also examine the legal framework of pregnancy clauses in advance directive legislation, and probe the pregnant woman's ethical obligation toward her fetus. Next, I deal with specific issues that rise in the context of maternal brain-death. On the one hand I examine how the moral and legal status of the fetus and its gestational age affect the dilemma whether to maintain a brain-dead pregnant woman "alive". On the other hand, I look at the moral, legal, psychological, religious, and physical aspects of interfering with dead patients, the pragmatic and legal obstacles to such an intervention, the rights of next-of-kin and friends of the deceased, and the physician-patient relationship. Finally, I incorporate a relational feminist analysis and conclude my research with practical guidelines for managing post-mortem pregnancy.

ACKNOWLEDGMENTS

I wish to thank Julia, Kaye and David for giving me the opportunity to pursue my research in the excellent and enriching environment of the faculty of law at the University of Toronto.

Special acknowledgements are deserved to my supervisor, Prof. Trudo Lemmens, and to Prof. Bernard Dickens who provided substance, method, and spirit to my thesis.

Finally, I would like to express my gratefulness to the close people in my life without whom this thesis would not have been what it is.

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INTRODUCTION

A pregnancy is generally understood to last 40 weeks. The further the fetus is *en ventre de sa mere*, in terms of gestational age, the better the chance of survival if the fetus must be delivered before full term. When a pregnant woman is struck by brain-death,[1] the fetus' chances of survival are seriously and immediately threatened. Until recently, there were two choices in such a situation: letting the mother (and the fetus) naturally die without further intervention, or delivering the fetus through a cesarean section when the death of the fetus was a tragic but real result.

However, recent advances in medical technology have provided physicians with the control over time and manner of death in ways that were never previously considered by their patients. A new option has thus become available: maintaining the brain-dead pregnant woman on "life-support" by the successful delivery of the fetus.

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[1] By brain death, I mean "the irreversible loss of capacity for consciousness combined with the irreversible loss of all brainstem functions including the capacity to breathe". See Marc-Andre Beaulieu, Shashikant Seshia, Jeanne Teitelbaum and Bryan Young, "Guidelines for the Diagnosis of Brain Death" (1999) 26 Can. J. Neurol. Sci. 64; Eelco Wijdicks, "Brain Death World Wild: Accepted Fact But No Global Consensus in Diagnostic Criteria" (2002) 58(1) Neurology 20. For the development of the brain-death criterion see Sam D. Shemie, Christopher Doig and Philip Belitsky, "Advancing Toward a Modern Death: the Path from Severe Brain Injury to Neurological Determination of Death" (2003) 168 CMAJ 8. Ethically and legally we should distinguish between three different situations: 1) loss of capacity from cerebral injury with a chance of recovery 2) loss of capacity from cerebral injury with no chance of recovery 3) pregnant women who are brain stem dead. In situations 1, 2 treatment decisions are made with consent from the patient's surrogate decision makers or with assistance from next-of-kin. When the patient's wishes and views are unknown, treatment decisions are made for the patient's best interests. Usually, the mother's interests prevail over her fetus. In my thesis, I will *only* deal with the third situation. For a report of a pregnancy in which the fetus survived maternal persistent vegetative state see B. T. Ayorinde, I. Scudamore and D. J. Buggy, "Anaesthetic Management of a Pregnant Patient in a Persistent Vegetative State" (2000) 85 (3) Br J Anaesthesia 479.

Still, the length of the time a fetus can be maintained once maternal death occurs is a matter of some medical uncertainty. Reports in the literature show that medical experts have been capable of "maintaining" a fetus alive inside a brain death woman for periods as long as 63,[2] 70,[3] 100, [4] and even 107 days.[5]

These long periods of time have, of course, a good reason. Fetal survival increases from 36% at twenty-four weeks to 38% at twenty-five weeks to 61% at twenty-six weeks and 76% at twenty-seven weeks.[6] In fact, in the medical literature it is even suggested that a pregnant dead woman be maintained until "utero-placental blood flow has ceased and placental function has become impaired".[7] Should we encourage this?

Delivering a baby from a dead mother has some historical precedents[8]. Asklepios, the Greek physician was supposedly delivered after the death of his mother. Julius Caesar was born in a cesarean section performed on his dead mother.[9] However, advanced

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[2] David R. Field. & Elena A. Gates & Robert K. Creasy & Albert R. Jonsen & Russel K. Laros, "Maternal Brain Death During Pregnancy: Medical and ethical issues" (1988) 260 JAMA 816.

[3] J.E. Heikkinen, R. I. Rinne, S. M. Alahuhta, J. A. Lumme, M. E. Koivisto, P. P. Kirkinen, K. A. Sotaniemi, L. S. Nuutinen and P. A. Jarvinen, " Life Support For 10 Weeks With Successful Fetal Outcome After Maternal Brain Damage" (1985) 290 Br. Med. J. 1237.

[4] Deborah M. Feldman, Adam F. Borgida, John F. Rodis and Winston A. Campbell, "Irreversible Maternal Brain Injury During Pregnancy: A Case Report and Review of the Literature" (2000) 55(11) Obstet. & Gyncol Survey 708 [**Feldman *et al.***].

[5] I. M. Bernstein & M. Watson & G. M. Simmons & P. M. Catalano & G. Davis & R. Collins, "Maternal Brain Death During Pregnancy and Prolonged Fetal Survival" (1989) 74 Obstet. Gynecol. 434.

[6] William P. Dillon, Richard V. Lee, Michael J. Tronolone, Sharon Buckwald and Ronald J Foote, "Life Support and Maternal Brain Death During Pregnancy" (1982) 248 (9) JAMA 1089 at 1091 [**Dillon**].

[7] **Dilon**, *Ibid.* at 1089. See also William P. Dillon and Edmund A. Egan, "Aggressive Obstetric Management in Late Second-Trimester Deliveries" (1981) 58 (6) Am. J. Obstet Gynecol 685 at 688.

[8] For the history and origin of such a procedure see Erich H. Loewy, "The Pregnant Brain Dead and the Fetus: Must We Always Try to Wrest Life from Death?" (1987) 157(5) Am. J. Obstet Gynecol 1097; Robert K. Arthur, "Postmortem Cesarean Section" (1978) 132 Am. J. Obstet Gynecol 175 at 176.

[9] From a linguistic point of view the term "Cesareans" traditionally referred to actions, which were carried out on women, who had died before delivering their babies.

developments in medicine have made this proposed "treatment" to last longer with more massive intrusion on the woman's body than ever before.

Maternal brain-death is not a hypothetical scenario. It has been already reported to happen in Germany,[10] Georgia,[11] Canada,[12] California,[13] Ireland,[14] Turkey,[15] and Israel.[16]

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[10] A pregnant young woman, Marion Ploch, died in a car accident on the 5th October 1992. She was 13 weeks pregnant, so the decision to maintain her alive was for at least 12 weeks. Marion's parents feared that their daughter would be misused for an inappropriate experiment. They went to a reporter from the mass-circulation newspaper, the *Blid-Zeitung*, for help. Marion's doctor consulted other doctors, and almost six weeks after Marion's parents eventually agreed to maintain her on life-support, the efforts to save the fetus failed. A spontaneous abortion occurred, and the fetus was born dead. For a detailed description, comments and public response to this incident see Christoph Anstotz, "Should a Brain-Dead Pregnant Woman Carry Her Child to Full Term? The Case of the 'Erlanfer Baby'" (1993) 7 (4) Bioethics 340.

[11] *University Health Services, Inc. v. Piazzi* No. CV86-RCCV-464 Superior Court of Richmond Country, Georgia, August 4 1986. In this case, the court ordered that life support must be maintained for a brain-dead pregnant woman. The order of the court was supported by the child's father, but was opposed by the mother's husband. The child was delivered at twenty-two weeks, but died two days later.

[12] Sophia Park, 25 years old, lost consciousness on November 17th 1999, and was declared brain dead 10 days after. Park was 10 weeks pregnant. Park's husband and parents, a devoutly Christian family, asked their doctors at Toronto Western Hospital to have her kept on life support. The park family went to the press and accused Sophia's doctors for trying to convince them to stop the life-support. The fetus died on December 3rd, while Park was still on life-support. See Jonathon Gatehouse, "Family Fights To Save Foetus", *National Post*, December 2, 1999.

[13] On April 24, 1999, Maria Lopez was declared brain-dead. In that time, Lopez was pregnant with twins, leaving her family with the difficult decision whether to maintain her on life support for the delivery of her twins, or not. Even thought Lopez's family was advised to withdraw life-support measures, they did not, and subsequently the two children were successfully delivered prematurely through cesarean section.

[14] On May 2001, a woman who was 14 weeks pregnant collapsed and suffered a brain haemorrhage in Ireland. She soon was declared brain dead. As a result of the uncertainty regarding the hospital's obligation to the fetus, life support was maintained until further opinion was sought. Due to the lack of certainty, the relevant Health Board decided to maintain the dead mother on life support, until the fetus died *in utero*, two weeks after. Available at www.butterworthsireland.ie/newsdirect/archive/2001/june/foetus15, last visited on 17 March 2003.

[15] The Turkish Government ordered a Hospital in Istanbul to stop turning off the life-support of Nina Typol, 25 years-old pregnant German woman, who lied in coma, after being shot in the head by her fiancé on 5th February, 2003 – www.news.bbc.co.uk/1/hi/world/europe/2737015.stm, last visited on 20 March, 2003.

[16] Two legal cases of maternal brain death are reported. The husband of a twenty-eight week pregnant woman, who was in a permanent vegetative state, asked for the declaration of the court that in case of brain death the hospital would be compelled to immediately deliver the fetus. The order was issued. In another case, the husband of an eight-month brain-dead pregnant woman sought an order to deliver the fetus. The court *refused* to issue such an order. See the discussion in my last chapter, ***infra*** **notes 1-7 and accompanying text.**

No doubt, maintaining a brain-dead pregnant woman on life support is one of the advanced technologies that lead to a situation where the technical capacity develops before any moral consequences arises or any legal framework is devised, with which to decide whether we *should do* what we *can do*.[17]

In my thesis, I will discuss the moral and legal aspects of maintaining a brain-dead woman on life-support. I will ask whether it is permissible to artificially maintain a dead woman solely for the sake of her fetus, and what is the motivation for doing so. Furthermore, I will inquire whether there is any justification for this medical procedure, or is it only performed out of anxiety to try save the fetus?[18]

I will approach these questions from two different angles. First, I will look at legal frameworks related to pregnancy and to the treatment of the body of brain-dead patient, and I will examine their application to the case of a brain-dead pregnant patient. Following this analysis, I will further look into the main issues that directly rise here.

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[17] A more complex, yet real situation is where the vital organs of an irreversibly brain-damaged mother which are maintained to support a fetus are considered for organ donation. In the literature there has been a report of two such cases. See **Feldamn *et al.***, *supra* note 4.

[18] Compare Janet Gallagher, "Fetus As Patient" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press: 1989) 185. Gallagher strongly claims that "the impulse to 'rescue' the fetus from the body and control of the mother seems driven by anxiety. Only powerful emotional undercurrents could account for the drastic departure from established constitutional and common law principles demanded by fetal rights advocates...Anxiety for the fetus and glorification of high-tech rescue medicine are also reflected in battles over the bodies of pregnant women who are brain-dead, or in a persistent vegetative state because of accident or illness". *Ibid.* at 192.

In my first chapter, I will discuss abortion law. A large part will be devoted to the *Roe v. Wade* decision, and to the legal response to it. Then, I will turn to analyze Canada's abortion law, and examine it in light of my analysis of *Roe.* Finally, I will ask whether the main features of abortion law can be applied to the case of a brain-dead pregnant woman.

In my second chapter, I will deal with situations in which pregnant women experience bodily interventions prescribed by law. After introducing such phenomena, I will describe the special procedural structure of such interventions. Then, I will elaborate on two specific legal rights involved, the right to self-determination and the right to refuse life-sustaining treatment, and I will separately discuss personal decisions of pregnant women that bring to the death of their fetuses. Next, I will turn to describe three kinds of legal interventions: interventions in the pregnant woman's life-style, interventions in the pregnant woman's physical state, and intervention through the release of pregnant women from tort liability. After I argue against legal interventions in pregnancy, I will conclude my analysis by asking to apply it to maternal brain-death.

My third chapter deals with advance directives. After a short introduction on advance directives, I will describe their regulation in regards to pregnant incompetent women in the American, Canadian and English legal systems. Then, I will formulate some arguments which support and oppose the pregnancy living will legislation. Finally, I will make some recommendations on the Canadian approach to living will legislation, in general, and to pregnant women, in particular.

The fourth chapter discusses "post-mortem gift law", which provides the mechanism to permit the use of cadavers, mainly for organ transplantation. After describing the Canadian, American and English legal frameworks on this issue, I will discuss some proposals to apply the donor organ model to the case of a brain-dead pregnant woman. By this, I will support Canada's existing law and I will also show how it coincides with the legal principles I discuss in my previous chapters.

In my fifth chapter, I will discuss the main issues raised by the situation of maternal brain-death. The issues are: the moral and legal status of the fetus; the interest/right of the fetus to be born; the gestational age of the fetus; the pragmatic obstacles to maintaining a dead pregnant woman on life-support; rights/interests of brain-dead people; legal requirement for consent; the rights of next-of-kin and friends of the deceased; and the physician-patient relationship. By doing so, I will try to sketch a broader picture on the basis of which a legal and ethical policy could be framed.

In my sixth chapter, I will analyze the major concepts that a relational feminist theory would rise in the situation of maintaining a brain-dead pregnant woman on life support. These will include the concept of autonomy, field, boundary, human body, privacy and property. By discussing these concepts, I hope to provide a new and original way of thinking and talking about the questions that occur in maternal brain-death.

My seventh chapter will deal with the moral duties of a pregnant woman towards her fetus as derived from the special relations between the two. I will analyze this special

relationship from four related ethical theories: ethics of relationships, responsibilities to society, ethics of families, and ethics of care. In the end, I will also bring a religious perspective that would support my practical conclusion on such a relationship.

In my last chapter of the thesis, I will present the few legal reported cases, which directly deal with maternal brain-death, and will examine their application to the Canadian legal system. In order to establish a proper legal opinion regarding the treatment of brain-dead pregnant women, I will further ask whether an analogy from other situations of posthumous reproduction could be made. After discussing some of the direct proposals to the discussed dilemma, I will close my thesis by framing the main conclusions from my analysis, accompanying them with some practical suggestions.

CHAPTER 1: ABORTIONS LAW

Both abortion and the decision not to maintain a brain-dead pregnant woman on life support result in fetal death. Both contexts expose the tension between a woman's freedom to choose and the state's interest in the existence of the fetus. One may argue that the decision to forgo "life-sustaining" treatment does not contain the morally condemnable intent to kill the fetus, even when the woman is competent and aware of her pregnancy. When the woman dies of natural causes, her fetus will do so too. While the termination of the fetus' potential life magnifies the human tragedy in such a situation, it can be claimed that the mother is no more morally culpable for the fetus' death than she is for the condition that has devastated her own existence.

On the other hand, one can argue that the theoretical distinction between intentionally aborting a fetus and letting a fetus die is no more appropriate with the natural death of the mother, as the availability of medical technology to artificially sustain the life of the mother (and the fetus) creates the need for a more practical ethics to address the question of what we should do with the woman at the time the treatment dilemma arises.[1] Therefore, abortion law analysis will be of an important value to better understand the legal and ethical problems that occur in our situation.

[1] Anne D. Lederman, "A Womb of My Own: A Moral Evaluation of Ohio's Treatment of Pregnant Patients with Living Wills" (1994) 45 Case W. Res. L. Rev 351 at 365.

There are two main theories on the moral status of abortion. The conservative theory of abortion holds that abortion is never acceptable or, at most is permissible only if it is necessary to bring about some great moral good such as saving the pregnant woman's life. This theory is influenced by the principle of "double effect", which provides specific guidelines for determining when it is morally permissible to perform an action in pursuit of a good end in full knowledge that the action will also bring about bad results. Under this principle, in cases where a contemplated action has both good effects and bad effects, the action is permissible only if it is not wrong in itself and if it does not require that one directly intends the evil result.[2] By applying the principle of "double effect" to abortions the conservative theory of abortion allows to morally distinguish among cases where a pregnancy may need to be ended in order to preserve the life of the mother.

According to the liberal theory of abortion, abortion is always permissible, whatever the state of fetal development. This view emphasizes the freedom of choice and the right of a woman to make decisions that affect her body. An intermediate approach between the liberal and conservative approaches is that abortion is ethically permissible up to a specified stage of fetal development or for some moral reasons that are believed to be sufficient to warrant abortions under special circumstances. Such a view was framed in the leading American case of *Roe* v. *Wade*[3] and its companion, *Doe v. Bolton.*[4]

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[2] Classical formulations of the principle of double effect require that four conditions be met if the action in question is to be morally permissible: first, that the action contemplated be in itself either morally good or morally indifferent; second, that the bad result not be directly intended; third, that the good result not be a direct causal result of the bad result; and fourth, that the good result be "proportionate to" the bad result.

[3] *Roe v. Wade* 410 U.S. 113 (1973) [hereinafter *Roe*].

[4] *Doe v. Bolton* 410 U.S. 179 (1973) [hereinafter *Doe*].

Roe v. Wade

In the *Roe* case, a pregnant single woman brought a class action challenging the constitutionality of the Texas Criminal laws, which prohibited procuring or attempting an abortion except for the purpose of saving the mother's life. The appellant argued she was unable to get a legal abortion in Texas, and could not afford to travel to another jurisdiction, where it was legal under safe conditions.

In *Roe* v. *Wade*, a right to have abortion was recognized under the Fourteenth Amendment to the American Constitution. The court ruled that only where state interests are compelling, may the state promulgate regulations which limit the fundamental woman's right of privacy. Two compelling state interests were found as a woman approaches to her full term: preserving and protecting the health of a pregnant woman, and protecting the potentiality of human life. By dividing the whole process of pregnancy into three trimesters, the court explained how these interests come into effect in the decision whether to terminate the pregnancy, or not. During the first trimester of pregnancy (from conception to the end of the 12^{th} week), because an abortion may be less hazardous than giving birth, the woman and her physician are free to determine whether or not to terminate the pregnancy without regulation by the state. During the second trimester of the pregnancy (until around the 28^{th} week), the state's compelling interest in maternal health allows the states to adopt regulations seeking to promote safe abortions.

Finally, when the fetus becomes viable, usually during the third trimester, the state may prohibit abortions except when necessary to protect the health of the mother.[5]

Thus, the court made a balance between the pregnant woman's interests and the state compelling interests in each of the trimesters. In the first trimester, the woman's interests outweigh the state interest in preserving and protecting the health of a pregnant woman, and in protecting the potentiality of human life. In the second trimester, the state interest in preserving and protecting the health of a pregnant woman outweighs the other state compelling interest and the woman's interests. In the third trimester, the state interest in protecting the potentiality of human life outweighs the other compelling state interest and the woman's interests.

At the basis of this balancing of interests lies the assumption that the answer to the abortion dilemma can be found in the moral status of the fetus. This moral status is derived from a biological development, which has been roughly determined as the point of viability. Nevertheless, the court did not discuss the link between the moral status of a fetus and the point of viability. More specifically, the court did not explain the justification for such a link. Nevertheless, such a link is not an obvious thing, as the

[5] To a large extent the issue of viability is symbolic, as *ninety-eight* percent of abortions occur in the first fourteen weeks of pregnancy. See John A. Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press: 1989) 259 at 267; For a discussion on the anatomic and physiologic changes that occur during the three trimesters of pregnancies see Christine E. Haycock, "Emergency Care of the Pregnant Traumatized Patient" (1984) 2 (4) Emerg Med Clin N. America 843.

Supreme Court of Ireland stated in *AG v. X.*, "One cannot make distinctions between individual phases of the unborn life before birth, or between unborn and born life".[6]

Furthermore, it is not clear from the court's decision in *Roe* when exactly a fetus deserves moral protection and why is the viability criterion good enough to serve as an ethical judgment on the moral status of the fetus. Why not, for example, link other biological points during pregnancy to the fetus' moral status. Perhaps the fetus should enjoy moral protection much before the point of viability, for example, immediately after conception, or after twenty-four weeks where there is fifty-percent chance of surviving? Or perhaps the fetus should be accorded the moral status after the point of viability, for instance, after showing expulsion or extraction from the mother and breathing, or after showing any other biological evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles?

Although the fetus' moral status and the state interest in protecting it was used as an argument to counterbalance the protection of the women's interest, the court refused to hold that the fetus is a person within the meaning of the Fourteenth Amendment to the American Constitution. Moreover, an exception to the state interest was given in *Roe*, saying that abortions can be proscribed unless it is necessary to preserve the life or health of the mother. Indeed, this exception was later used in *Thornburgh v. American College of Obstetricians.*[7] In this case, the court examined the constitutionality of a Pennsylvania statute that allowed *in post-viability abortions* the physician to use a technique that most

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[6] *AG v. X., Per* Hederman J. at 442, **mentioned in** Asim A. Sheikh & Denis A. Cusack, "Maternal Brain Death, Pregnancy and the Foetus: The Medico-Legal Implications" (2001) 7(2) M.L.J.I. 75 at 79.

likely would result in the birth of a live child, unless the technique would present a significantly greater medical risk to the life or health of the pregnant woman. The court held that this provision is unconstitutional on the ground that the health of the woman is paramount, *even after viability*, and she cannot be forced to bear any greater risk to her health in order to save the viable fetus.

Some have argued that the *Roe* decision contained reference to another issue related to freedom of choice: the birth of an unwanted child.[8] More specifically, the question was whether one can be forced to raise an unwanted child particularly when the family is unable (emotionally or otherwise) to care for the child. However, if it is correct that *Roe* had essentially been about family planning, then the court presumably would have left the decision up to the woman and her husband, based on the constitutional right of privacy as it has done in similar situation.[9] Instead, not only did the court agree that the right to have an abortion was derived from personal privacy (that later extended to activities related to marriage, contraception, and family relationships); but the court also held that attending physicians, in consultation with the pregnant woman, are free to determine, *without regulation by the state*, that in their medical judgment the patient's pregnancy should be terminated. The emphasis in *Roe* is about a woman's control over own body, not about

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[7] 476 U.S. 747 (1986).

[8] Gregory Gelfand, "Living Will Statutes: The First Decade" (1987) 1987 Wis. L. Rev 737 at 780. Of course, the term "reproductive choice" has a broader meaning than the right to choose abortion. It also includes the decision whether to bear a child, the timing of childbearing, the means of avoiding or promoting pregnancy, the decision to give birth in a safe and supportive environment, and the techniques for childbirth.

[9] *Griswold v. Connecticut* 381 U.S. 479 (1965) **[Griswold]**. The Griswold case involved a law forbidding the use of contraceptives. Based on the right for privacy under the Bill of Rights, the Supreme Court held that such a law as applied to married people is unconstitutional

whether she wants her or her family to be burdened with an unwanted child.[10] It is difficult to draw any conclusions regarding family-planning from the *Roe* decision that would justify the court's ruling on the abortion dilemma.

Doe v. Bolton

Soon after the Roe decision, the Supreme Court heard a similar case of abortion. In *Doe,*[11] an indigent, 22-year-old married pregnant woman, who desired but had been refused an abortion after eight weeks of pregnancy, 23 other individuals (nine physicians licensed in Georgia, seven nurses, five clergymen, and two social workers), and two nonprofit Georgia corporations that advocated abortion reform instituted an action, seeking a declaratory judgment that the Georgia abortion statutes were unconstitutional and an injunction against the statutes' enforcement. The Georgia statutes limited legal abortions to specific situations requiring a showing that a continuation of the pregnancy would endanger the life or seriously and permanently injure the health of the pregnant woman, or the fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect, or that the pregnancy resulted from forcible or statutory rape.[12] In addition, the statutes required certain other procedural or evidentiary aspects of the approval and performance of abortions.[13]

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[10] Joan Mahoney, "Death with Dignity: Is There An Exception for Pregnant Women?" (1989) 57 UMKCLR 221 at 228. A proof for such a claim can be found in *Planned Parenthood of Central Missouri v. Danforth* 428 U.S. 52 (1976). In this case, the court struck down a Missouri statute that would have required a woman to obtain her husband's consent for an abortion [**Planned Parenthood**].
[11] *Supra* note 4.
[12] Ga. Criminal Code§ 26-1202 (a).
[13] *Ibid,* at § 26-1202 (b).

Although Doe did not fit into the requirements of the Georgia statutes, she had special circumstances that later made the Supreme Court assert she would be unable to care for her new child. Doe had three living children. The two older ones had been placed in a foster home because of Doe's poverty and inability to care for them. The youngest had been placed for adoption. Her husband abandoned her and she was forced to live with her indigent parents and their eight children. Doe had been a mental patient at the State Hospital and she was advised that an abortion could be performed on her with less danger to her health than if she gave birth to the child she was carrying.

Relying on *Griswold*[14] and related cases the District Court held that a Constitutional right to privacy has been established broad enough to encompass the right of a woman to terminate an unwanted pregnancy in its early stages, by obtaining an abortion. The court gave declaratory, but not injunctive, relief, invalidating as an infringement of privacy and personal liberty the limitation to the three situations specified in Georgia abortions Statutes. The appellants, claiming entitlement to broader relief, directly appealed to the Supreme Court.

On appeal, the Supreme Court modified and, as so modified, affirmed the judgment of the District Court. Following the rationale of the *Roe* decision, it was held that a pregnant woman has no absolute constitutional right to abortion and that voluntary abortion at any time and place regardless of medical standards would impinge on a rightful concern of society. However, the Court did not mention the trimester framework established in *Roe*

nor did it explain how to balance the interests involved. The court found Georgia abortion legislation to be overbroad in favor of the State and not closely correlated to the aim of preserving prenatal life. Hence, the Court ruled that endangering the life of the woman or seriously and permanently injuring her health are standards too narrow for the right of privacy that is at stake when a decision to abort is about to be made.

Following Roe v. Wade

In addition to a mass public and political response to the *Roe* decision, two kinds of judicial reactions followed from the Roe decision. The first is the expansion of the state interest in protecting potential life even before viability and even outside the realm of abortions. The second is the abandonment of the trimester framework for an "undue burden" test.

A. The protection of a pre-viable fetus beyond abortion

In *Webster v. Reproductive health services*,[15] the court dealt with a Missouri abortion act. This act required from physicians to conduct tests to determine whether the fetus is viable prior to an abortion on a woman who is twenty or more weeks pregnant. The statute also prohibited the use of public employees and facilities to perform or assist abortions not necessary to save the mother's life. The first provision before the court contained findings by the Missouri State legislature that the life of each human being begins *at conception*,

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[14] **Griswold**, *supra* note 9.
[15] 492 U.S. 490, 109 S.Ct. 3040 (1989).

and that unborn children have protectable interests in life, health and well being. The court found this provision as imposing no limitations on abortions, and conferring protections in tort and probate law on fetuses permissible legislative actions under *Roe*. By doing so, the court appeared willing to recognize the existence of fetal protection at least *outside the context of abortions*.

But the court also expanded the protection of a fetus in regards to its biological development. The court ruled that under the Missouri statute, a physician would only be required to administer those tests that are necessary or useful to a determination of viability. The majority held that the state's interest in protecting potential human life should come into existence not only at the point of viability as ruled in *Roe*, but even *prior* to that (during the *second trimester*). Thus, the court explicitly recognized that requiring physicians to perform viability-determining procedures on twenty-week-old fetuses directly conflicts with *Roe* because inevitably the requirement would result in the performance of procedures on non-viable second trimester fetuses. In doing so, the court suggested that the state's compelling interest may exist throughout the pregnancy and not, as ruled in *Roe*, only upon and after viability. In its decision, the court criticized the trimester framework of Roe as "unsound in principle and unworkable in practice"[16].

The *Webster* decision explicitly stated that it did not overrule *Roe*, but rather based its decision on a narrow interpretation of *Roe*, as one that stroke down a criminal statute of non-therapeutic abortions. According to the court, the *Roe* decision could not be applied to the *Webster* case, which dealt with a statute prohibiting public funding, and that

expanded the procedural protections for fetuses. Whether this is convincing or not, the outcome of the *Webster* decision is far beyond the *Roe* decision, as it calls for a wide protection of the state's interest in potential life even when such a potential is very small.

B. Undermining the viability criterion

Viability is, as Thomas Murray claims, a slippery concept.[17] This is especially true, when it is based on biological development of the fetus that is dependent on a scientific knowledge, which is dynamic and changing. The legal standard of viability, which was framed in the *Roe* decision, did not last long. It was altered in *Planned Parenthood v. Casey*[18]. In *Casey*, the Supreme Court considered the constitutionality of amendments to the Pennsylvania abortion statute. The Court reaffirmed the *Roe* decision, but overruled the use of the trimester criterion and fetal viability as a standard by replacing it with an "undue burden test". According to this test, a consideration has to be made 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. In the *Casey* case, a profound interest in potential life had been established. This interest, however, was not based on the trimester framework.

Although *Roe* is still the leading decision in American abortion law, it is not clear if its main components - the trimester framework and the viability criteria – are well established in the judgments following *Roe*. As I suggested, American courts deviated from the *Roe* decision in two different directions: further protecting the fetus and framing

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[16] ***Ibid.***, at 3056 (quoting *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 at 546 (1985).
[17] Thomas H. Murray, "Moral Obligation to the Not-Yet Born: The Fetus As Patient" (1987) 14 (2) Clinics in Perinatology 329 at 332.
[18] 505 U.S. 833, 878-79 (1992) (Plurality opinion).

a more flexible test for state intervention in abortion. Moreover, the popularity of the *Roe* case is questionable. A recent poll in the U.S. shows that 52% of the Americans agreed and 37% disagreed with the result of *Roe v. Wade*, while 50% identified themselves as pro-choice and 42% as pro-life.[19] With this level of division it is also difficult to credit the *Roe* decision as expressing values that are representative of American public opinion and accepted by the public at large.

Abortion Law in Canada

In Canada, the earliest statutory prohibition against attempting to procure an abortion is the 1869 Act Respecting Offences Against the Person, which made the abortion of a "quick fetus" a crime punishable by life imprisonment. In 1892, this prohibition was incorporated into the Criminal Code[20] (section 251), and survived there until 1969.

Under pressure of the medical community, section 251 was amended in 1969 to allow for a therapeutic exception to the abortion prohibition. Under the new section, the abortion had to be performed by a licensed medical practitioner in an accredited or approved hospital on a written advice of a three-member therapeutic abortion committee to the effect that the continuation of the pregnancy endangered the pregnant woman's life or

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[19] Timothy Stoltzfus Jost, "Rights of Embryos and Foetus in Private Law" (2002) 50 Am. J. Com. Law 633 at 644.

[20] Now, R.S.C. 1985, c. C-46, s. 287. Interesting to note here that the woman herself was also subject to criminal penalty although a lesser one than for the abortion provider. Section 251 reads:
" (1) Everyone who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and is liable for imprisonment for life. (2) Every female person who, being pregnant, with the intent to procure her own miscarriage, uses any means or permits any means to be used for the purpose of carrying out her intention is guilty of an indictable offence and is liable to imprisonment for two years".

health. Under this new law, whether a pregnant woman would undergo an abortion or not was wholly contingent upon the committee's assessment of the threat the pregnancy posed *to her health or life*. Nevertheless, the woman could not represent her case to the committee.[21]

It is important to note that the 1969 amendments to the Criminal Code did not change the substantive law on abortions by liberalizing the legal grounds for terminating pregnancy. As Bernard Dickens argues, these amendments only addressed the *means* of ensuring the legality of an abortion before it is performed.[22] Before 1969, a physician acting in good faith could lawfully terminate pregnancy to save life or physical or mental health. The legality of the physician's action could be tested and confirmed only *ex post facto*. By the 1969 amendments, legality of terminating pregnancy could now be established *beforehand*, by certification of a therapeutic abortion committee. A substantive approach to abortion law was established, however, by legal cases.

In the *Morgentaler* case, the Supreme Court of Canada considered, for the first time, the abortion question in the context of the Canadian Charter of Rights and Freedoms.[23] Dr. Henry Morgentaler was charged with illegally performing an abortion by the Province of Ontario. Morgentaler argued that section 251 to the Criminal Code violated several

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[21] In practice, it was found that the criteria of endangering the woman's health were applied unevenly from location to location and from committee to committee, and that additional criteria such as consent of a spouse, gestational limits, residency restrictions etc. were also required. A Committee on the Operation of the Abortion Law also reported that many hospitals did not establish committees, while others had a committee on the paper but it never met to consider applications for abortions. See Canada, Department of Justice, *Committee on the Operation of the Abortion Law, Report* (Ottawa: Minister of Supply and Services Canada, 1977).

[22] Bernard Dickens, "Legal Aspects of Abortions" in Paul Sachdev, ed., *Abortion: Readings and Research* (Toronto: Butterworths: 1981) 16 at 18 [**Dickens**].

provisions of the Charter, including: section 7, which protects the "right to life liberty and security of the person"; section 2(a), which guarantees "freedom of conscience and religion"; section 12 prohibiting cruel and unusual treatment; and section 15(1), which prohibits discrimination on the basis of sex.

The majority of the court agreed that section 251 to the Criminal Code was a profound interference with a woman's body and, thus, a violation of the woman's right to security of the person.[24] However, the court established that not all the restrictions on abortion would violate this right. Justice Bertha Wilson, for example, emphasized that section 1 to the Charter allows for the impositions of reasonable limits on the woman's right to security of the person.[25] She addressed the importance of the developmental facts of pregnancy by ruling that abortion legislation, which adopts a permissive attitude toward early term abortions and a more restrictive attitude toward late-term abortions, would probably be constitutional.

The court also ruled that the state has a legitimate interest in protecting fetal life, although it did not directly consider the question of the fetus' legal personality, that is whether the term "everyone" in section 7 to the Charter also refers to the fetus. Contrary to the American Supreme Court in *Roe* v. *Wade,* the Canadian Supreme Court neither declared

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[23] *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

[24] Justice Wilson wrote: "She is truly being treated as a means - a means to an end which she does not desire but over which she has no control. She is the passive recipient of a decision made by others as to whether her body will be used to nurture a new life. Can there be anything that comports less with human dignity and self-respect? How can a woman in this position have any sense of security with respect to her person?"- ***Ibid.*** at 173-4.

[25] Section 1 to the Charter reads: "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject to reasonable limits prescribed by law as can be demonstrably justified in a

that the right to abortion is a fundamental right, nor referred to the right of privacy in overturning section 251 to the Criminal Code. However, the *Morgentaler* decision invalidated the only abortion law in Canada - section 251 to the Criminal Code - and abortion became a medical procedure regulated by provincial regulation of doctors, hospitals and access to health-care services. A legislative response to the Morgentaler decision has been unsuccessful.[26]

Abortion law in Canada was also influenced by other judicial decisions, in which injunctions were unsuccessfully sought to prevent women from exercising their right to abortion based on the recognition of the fetus as an entity entitled to constitutional protection.

In *Tremblay v. Daigle*,[27] the appellant was 18 weeks pregnant at the time of her separation from the respondent, the fetus' father. She then decided to terminate her pregnancy. The respondent obtained an interlocutory injunction from the Superior Court preventing her from having the abortion. The trial judge found that a fetus is a "human being" under the Quebec Charter of Human Rights and Freedoms and therefore enjoys a "right to life" under s. 1. The trial judge also based his conclusion on the Civil Code's recognition of the fetus as a juridical person. He then ruled that the respondent had the necessary "interest" to request the injunction; and he concluded, after considering the effect of the injunction on the appellant's rights under s. 7 of the Canadian Charter of

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free and democratic society". *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 s. 1.

[26] Bill C-43 which asked to recriminalize abortions except where a woman's medical practitioner was of the opinion that her health or life would likely to be threatened was defeated in the Senate by a vote of 44 to 43 in January 1991.

Rights and Freedoms and s. 1 of the Quebec Charter, that the fetus' right to life should prevail. On appeal, the injunction was upheld by a majority of the Court of Appeal.[28]

A right to appeal to the Supreme Court of Canada was given and the appeal was allowed.[29] The Supreme Court declared that the substantial rights that allege to support the injunction preventing the abortion do not exist. The court found that the fetus does not enjoy the right to life conferred by s. 1 to Quebec Charter, and held that there are good reasons for not finding any fetal rights under the Quebec Charter. The court did not invoke the Canadian Charter in this case, as it was a civil action between two private parties. Additionally, the court held that the provisions of the Civil Code providing for the appointment of a curator for an unborn child and the provisions granting patrimonial interests to such child do not implicitly recognize that a fetus is a juridical person. The court added that in Anglo-Canadian law, a fetus must be born alive to enjoy rights. Finally, the Supreme Court found nothing in the Quebec legislation or case law to support the argument that the father's interest in a fetus he helped to create, gives him the right to veto a woman's decisions in respect of the fetus she is carrying.

In *Diamond v. Hirsch*[30], the respondent, a married woman, who had lived in a common-law relationship with the applicant for almost a year, was in the 8-week stage of her pregnancy. The applicant and the respondent no longer resided with one another and the woman sought an abortion out of fear from her father's reaction to her pregnancy. The

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[27] *Tremblay v. Daigle*, [1989] R.J.Q. 1980.
[28] *Tremblay v. Daigle*,[1989] R.J.Q. 1735.
[29] *Tremblay v. Daigle*, [1989] 62 D.L.R (4th) 634 (S.C.C.), 2 S.C.R. 230.
[30] *Diamond v. Hirsch*, [1989] M.J. No. 377 (QL) (Q.B.).

applicant asked for an order enjoining and restraining the respondent from having an abortion performed upon her.

In response to the applicant's argument on the unique moral status of the fetus, the court held that it was not convinced medically that an 8-week old fetus is in fact a distinct human being. The court added that there is always the possibility for an involuntary miscarriage, or that the child or the fetus when developing into a child could be born dead. Moreover, the court stated that there are many possibilities of the fetus not surviving the full pregnancy. But the overwhelming consideration, which the court found to exist in the case, was the fact that the woman as any human being has an absolute right, subject to criminal sanctions, to control her body. The choice to terminate pregnancy was fully hers.

In conclusion, these decisions reflect the courts' reluctance to see the fetus as a "person" under the existing statutes of all legislative level (from provincial to the Charter). Sanda Rodgers comes to the same conclusion after analyzing the case law. She argues that it would be unlikely that the reference to the term "everyone" in section 7 to the Canadian Charter would include the fetus.[31] Moreover, the cases I mentioned above also seem to be in accordance with the *Morgentaler* decision, thereby conferring a woman a full freedom of choice with regard to abortion, at least in early stages of pregnancy.

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[31] Sanda Rodgers, "The Legal Regulation of Women's Reproductive Capacity in Canada" in J. Downie, T. Caulfield and C. Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths: 2002) 331 at 339.

Applying Abortion-law to Post-Mortem Pregnancy

How can abortion law contribute to our discussion of maintenance of brain-dead pregnant woman on life support?

Roe's criterion on viability had a logical and biological basis. With respect to the state's important and legitimate interest in the health of the mother, the "compelling" point is approximately the end of the first trimester, since until then mortality in abortion is less than mortality in normal childbirth. From that point, the state can regulate the abortion procedure to the extent that it reasonably relates to the preservation and protection of maternal health. With respect to the state's interest in potential life, the "compelling" point is at viability, as since that point the fetus presumably has the capacity of meaningful life outside the mother's womb. State regulation for this sake can proscribe abortion during the period after viability, except when necessary to preserve the life or health of the mother.

Applying these rationales to the situation of the pregnant brain death woman creates difficulties. Following this rationale, no state intervention in the pregnant woman other than for the sake of the mother's health should be allowed during the first and second trimesters of pregnancy. However, proponents of maintaining a brain-dead pregnant woman on life-support would argue that if the woman is not being maintained on life-support, she would not reach the third trimester, where the state apparently has a

recognized interest in protecting potential life. Although it is clearly true that without life-support, the fetus would not reach the third trimester, the trimester framework does not seem to imply an obligation to continue life-support. Under this framework, the state interests, which can outweigh the mother's interests, are being examined *when the physical intervention is being considered, and not afterwards*. Maintaining a brain-dead pregnant woman on her first or second trimester is not what the court in Roe meant to create. It is separating between the act of intervention in the woman's pregnancy and the state's interest that justify it. It is taking advantage of the mother's situation and protecting, *de facto*, potential life, at a point where it is clearly not viable. Thus, it is a fierce deviation from the Roe decision.

Indeed, as I showed above, the viability criterion and the trimester framework are difficult to apply. This is part of the reason why American courts replaced them in another test ("undue burden test"), or expanded their effect when they dealt with public funding (the Webster case). Moreover, the decisions following *Roe* emphasize that there may be another way to protect the state interest in potential life without interference in the pregnant woman's body. Such a way was explicitly formed in the *Planned Parenthood* case, where the court, while rejecting the rigid trimester framework of *Roe*, ruled, that the task to promote the state's profound interest in potential life throughout pregnancy can be also fulfilled if the state take measures to ensure that the woman's choice is informed, and also take measures designed to advance this interest by

persuading her to choose childbirth over abortion. The court recognized that such measures must not be an undue burden on the right to choose.[32]

I find this alternative an adequate constitutional compromise, given the profound interest of the mother, on the on hand, and the uncertainty about the fetus' moral and legal status, on the other hand. I think this reasoning should also apply to our situation. The solution to the ethical and legal dilemma whether to maintain the woman on life support or not can be achieved ex-ante and not necessarily ex-post facto. In other words, the case should not indispensably be resolved by deciding to maintain the woman on life support or to let her (with her fetus) die. The woman should leave a directive as to what she would want to happen to her after her death. She can be advised to be maintained on life support, if she values this, but it has to be with her full consent and recognition that her body would be treated in the way she asked it to be. I will elaborate on that in my discussion on living wills. It is important to show that if such a solution was proposed by court as substitute to an abortion, there shall be no reason why it could not be applied to a perhaps lesser (physical) traumatic act than that of maintenance on life support.

The interpretation that *Roe* dealt with family planning would make it difficult to apply the *Roe* decision on a dying or a brain-dead future mother, where such an issue apparently does not arise. Although the woman's survivors would face both distress over the woman's death and financial and emotional problems of caring for a motherless child, the decision to maintain the woman on life support reflects a desire to bring a wanted child to

[32] **Planned Parenthood**, *supra* note 10.

the surviving family. In contrast to abortion, the goal of the medical intervening action is not to prevent the situation of an unwanted child, but quite the opposite.

But perhaps the *Roe* decision and the trimester framework cannot apply at all to our case. One can justifiably argue that the trimester approach in *Roe v. Wade* addresses only the abortion context where the state must consider *both* an interest in maternal health and an interest in potential life.[33] The interest in maternal health seems to be irrelevant here because the woman is beyond recovery. Roe did not address the situation where one of the compelling interests of the state no longer exists. Thus, adopting the rationales of Roe could be improper.

Are the principles framed in Canadian abortion cases more helpful? It seems to me that two basic ideas can be identified from Canadian case law. The first is the idea of freedom of choice as an absolute principle. It is the woman's right to fully control her body, to such an extent that even the biological father of the fetus can not interfere with this right. The Criminal Code seems not to give a spouse the power to veto the woman's decision to perform an abortion.[34] The second idea is the resistance of courts to interpret the existing law in a way that would confer the fetus a legal substantial status prior to birth. It is difficult to infer what the legal view would be in cases where the fetus is after the point of viability, since all the reported cases are dealing with pre-viable fetuses. Nevertheless, the courts interpretation of the term "fetus" under the Canadian legislation was not restricted to pre-viable fetuses.

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[33] Molly C. Dyke, "A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes" (1990) 70 B.U.L.Rev. 867 at 876.

I assume that applying these two ideas to our case would probably result in an outcome that would respect the woman's choice and would regard her right to control her body even after her death. It also appears to me that a Canadian tendency to protect the potential life of a fetus would be less stringent than the American approach. The trimester framework will also not count as a mandatory guideline It is reasonable to think that the more developed the fetus is, the lesser the inclination to terminate the pregnancy will be. Canadian courts may be expected to be more flexible in this context.

To sum up, the *Roe* decision of American abortion law cannot easily be applied to the case of a brain-dead pregnant woman. Its circumstances were very different from the ones that occur in the case of a maternal brain-death. Nevertheless, if it applies at all, its main rationales do not support the maintenance of a dead woman on life support in her first and second trimester. One can arrive to the same conclusion by applying the main ideas of Canadian abortion law. The core ideas there are that the freedom of choice of a woman is almost absolute, and that the fetus is not a legal entity substantially protected while *in utero*.

To realize differently means to "compel women to be not merely minimally decent Samaritans, but good Samaritans to unborn persons inside of them".[35] This would be contrary to other areas in which the law (at least in the common law system) does not expect a person to make large sacrifices to sustain the life of another who has no right to

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[34] **Dickens**, *Supra* note 22 at 22.

[35] Judith Jarvis Thomson, "A Defense of Abortion" in Tom L. Beauchamp & LeRoy Walters eds., *Contemporary Issues in Bioethics*, 5th ed. (Belmont, C.A: Wadsworth Publishing Company: 1999) 202 at 209.

demand them. Applying abortion law, as it is shaped by Canadian and American legal system, strengthens this conclusion. We might look at other legal spheres to broaden our perspective. A general observation on bodily interventions in the pregnant woman could be of an additional help.

CHAPTER 2: BODILY INTERVENTIONS DURING PREGNANCY

The state's interest in the fetus' potential life has shaped the scope of pregnant women's procreative autonomy outside the abortion arena. A growing number of courts have found that protection of the fetus justifies the imposition of medical treatment upon an unwilling mother. Courts have ordered pregnant patients to undergo medical treatment, blood transfusions or cesarean sections, in order to benefit the fetus. They have also forced the pregnant woman to refrain from doing certain things that might harm (also) the fetus, such as drinking alcohol, using drugs,[1] smoking, having poor nutrition, driving negligently, doing vigorous exercise, sniffing glue[2], etc.[3]

According to a large study made in 1987, court-ordered obstetrical interventions for a wide variety of situations have become a well-established routine.[4] The wide application of this legal mechanism is even more distressing, since it is applied in many situations where the ethical guidelines of the medical profession seem more respectful of personal

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[1] But see the recent decision of the Supreme Court of U.S. in *Ferguson v. City of Charleston*, 121 S.Ct. 1281 (2001). The court held that the practice of a state hospital to routinely examine the urine of pregnant patients for drugs and refer women, whose test was positive, to the police for criminal prosecutions, violates the constitutional prohibition against unreasonable searches.

[2] See Janet Gallagher, who discusses some extreme suggestions brought in the literature to intervene in pregnant women's life: Janet Gallagher, "Fetus As Patient" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press: 1989) 185 at 200-203 **[Gallagher]**.

[3] The following examples can reflect the danger of such legal interventions. A woman was charged with child abuse after giving birth to her second cocaine-addicted baby; her child was placed in foster care. In another case, a woman was jailed for a week after she gave birth to a brain-damaged baby; she was accused, among other things, of drug abuse. In a third case, a woman arrested for cheque forgery was found to be using cocaine; A judge sent her to jail for four months to protect her fetus. See *Time*, May 22 1989, 45.

[4] V.E.B. Kolder, J. Gallagher and M. T. Parsons, "Court-ordered Obstetrical Interventions" (1987) 316 N Eng J Med 1192. The authors found that court orders were issued in eighty-six percent of the cases in which they were sought for procedures deemed necessary for the life of the fetus, including cesarean section (15 orders sought in 11 states), intrauterine transfusions (two orders granted in Colorado), and hospital detention of the mother (two orders granted out of three sought) **[Kodler *et al.*]**.

autonomy. These guidelines call for such an intervention only in rare cases.[5] According to these guidelines, the threat of imposed intervention erodes the trusts necessary to allow pregnant women to access prenatal care and other services for their health.[6]

While some courts warranted orders following *Roe*'s[7] criterion of viability, as a biological point that legitimizes the state's interest in the fetus, others have forced medical treatment upon pregnant patients prior to that point. Most of the cases, involving a pregnant woman's refusal to treatment, rely on the viability distinction in striking a balance between a woman's right and the right of the fetus. Courts sometimes based their interventions with the pregnant woman's body on the principle of beneficence, that its practical application was not only in considering fetal welfare, but also in the state's interest to protect dependent third parties from loss of a parent.

It is interesting to note that the impact of fetal rights claims and bodily interventions in the pregnant women's bodies have fallen most heavily upon the most vulnerable groups of women. Janet Gallagher quotes a survey, which revealed that eighty-one percent of the pregnant women subjected to court-ordered interventions in the U.S. were black, Asian,

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[5] "Obstetricians should refrain from performing procedures that are unwanted by a pregnant woman. The use of judicial authority to implement treatment regimes in order to protect the fetus violates the pregnant woman's autonomy and should be avoided unless the four stringent criteria specified in this opinion are met (high probability of serious harm to the fetus in respecting the patient's decision; high probability that the recommended treatment will prevent or substantially reduce harm to the fetus; there are no comparably effective, less-intrusive options to prevent harm to the fetus; high probability that the recommended treatment also benefits the pregnant woman or that the risks to the pregnant woman are relatively small" – The American College of Obstetricians and Gynecologists, *Patient Choice and the Maternal-Fetal Relationship: Committee opinion 214* (April 1999) 61 at 63. See also American College of Obstetricians and Gynecologists, *Patient Choice: Maternal-Fetal Conflict. Washington*, DC, Committee on Ethics, 1987.

[6] Sanda Rodgers, "The Legal Regulation of Women's Reproductive Capacity in Canada" in J. Downie, T. Caulfield and C. Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths: 2002) 331 at 354-5 and the legal reports she mentions at footnotes 117-119 [**Rodgers**].

[7] *Supra* chapter 1 note 3.

or Hispanic; forty-four percent of them were unmarried; twenty-four percent did not speak English as their primary language; and none were private patients. In addition, religious minorities have been particularly affected, as in almost all cases of refusing cesarean section the women were member of some religious group or subculture.[8]

The Procedural Structure of Court-Ordered Interventions

In a significant survey from 1987 it was found that applications for legal intervention are usually successful.[9] In a later study it was also proven that rarely do cases reach the appellate level.[10] In addition, court-ordered obstetrical interventions are likely to be requested on extremely short notice and require immediate judicial intervention. A study of court-ordered obstetrical interventions reported that in seventy percent of cases in which orders were considered, hospital administrators and attorneys were aware of the situation only a day or less before seeking a court-order. Eighty-eight percent of the orders were obtained in less than six hours, and in nineteen percent of the cases in less than an hour.[11]

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[8] **Gallagher**, *supra* note 2 at 203.

[9] In a survey that was conducted in the U.S., Kodler *et al.* found that court orders had been obtained in eleven different states in order to carry out cesarean sections against the mothers' refusal of consent. In only a few of the cases (fourteen percent), had the application for the order been refused. **Kodler *et al.***, *supra* note 4.

[10] Board of Trustees, American Medical Association, "Legal Interventions During Pregnancy – Court-ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior By Pregnant Women" (1990) 264 (20) JAMA 2663 at 2664.

[11] ***Ibid.*** at 2665.

Furthermore, in such court proceedings a woman is probably under considerable psychological stress and maybe suffering from substantial physical pain as well. Her ability to articulate her interests may be seriously impaired, and it is usually unlikely that she can find adequate counsel on such a short notice, and even if she does, this counsel would not have time to prepare properly for the hearing. Moreover, there will be little or no time to obtain the full range of medical opinions or facts along with the inability of a court to understand the full range of the medical evidence, can lead to error with serious and irreversible consequences.[12]

The right to self-determination

Of course, one has to distinguish between interference in the pregnant woman's life style (such as drinking, using drugs, or other addictive substances), and intervening in the woman's pregnancy, which relates to the woman's physical state without violating her life style.[13] In *Winnipeg Child and Family Services v. D.F.G.*, Justice McLachlin, as she then was, touched upon the danger of the first category, emphasizing the difficulties when the lifestyle in question is that of a pregnant woman whose liberty is intimately and

[12] For more discussion about the procedure of court-order hearings see Laura M. Purdy, "Are Pregnant Women Fetal Containers?" (1990) 4(4) Bioethics 273 at 280-2 **[Purdy]**. See also George J. Annas, "Protecting the Liberty of Pregnant Patients" (1987) 316 (19) N. Engl. J. Med. 1213.

[13] For a different distinction see Dawn Johnson, "Shared Interests: Promoting Healthy Births without Sacrificing Women's Liberty", (1992) 43 Hastings L. J. 569. Johnson distinguishes between two models of social goals in supporting healthy pregnancies and birth outcomes. The first is the adversarial model, in which the state through its actors, like physicians, attempts to use the law to control and regulate pregnant women's behavior in the name of protecting fetal rights. The second is the "facilitative model", which is premised with the view that pregnant women and fetuses are theoretically, legally and physically inseparable and that an extended set of services provided by the state and available to all pregnant women will most effectively facilitate the goal of promoting the birth of healthy babies.

inescapably bound to her unborn child.[14] Nevertheless, in both categories the question relates to a woman's right to determine what will happen to her and her body.

The right of individuals to self-determination in health care is deeply rooted in the common law. It is founded on the fundamental right to be left alone. It is tied to the right to privacy,[15] and "turns on the subjective wishes of the patient, rather than on public opinion, state or familial preferences, or any objective test".[16] The prohibition of an unwarranted invasion of the right to bodily integrity formulated the requirement of consent for medical treatment, and the doctrine of informed consent that was developed accordingly. The doctrine of consent is regarded as a fundamental human right that can also enjoy a constitutional protection.[17]

Moreover, wide living will legislation provides individuals with the right of self-determination of what will happen to them when incompetent. In effect, all of these ethical-legal structures assure the "liberty interest"[18] of a patient not to consent to some forms of medical treatments, including life sustaining treatment, nutrition and hydration.

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[14] Justice McLachin asked: "Are children to be permitted to sue their parents for second-hand smoke inhaled around the family dinner table? Could any cohabitant bring such an action? Are children to be permitted to sue their parents for spanking causing psychological trauma or poor grades due to alcoholism or a parent's undue fondness for the office or the golf course?" - *Winnipeg Child and Family Services v. D.F.G.*, [1996] 138 D.L.R. (4th) 238 (Man. Q.B.), revd (1996), 138 D.L.R. (4th) 254 (C.A.), affd [1997] 3 S.C.R. 925 at 947 [**D.F.G.**].

[15] The right to privacy extends also to allow *a patient's surrogate* the right to refuse medical treatment for the patient. See *In re Quinlan*, 355 A.2d 647 (N.J. 1976). It has been suggested that the privacy interest in bodily integrity is even more fundamental than the privacy interest in terminating pregnancy: Janice MacAvoy-Smitzer, "Pregnancy Clauses in Living Will Statutes" (1987) 87 Colum. L. Rev. 1280 at 1290.

[16] *In re Guardianship of Browning* 543 So. 2d 258 (Fla. Dist. Ct. App. 1989) at 273.

[17] Such a constitutional protection is seen in Ireland: Asim A. Sheikh & Denis A. Cusack, "Maternal Brain Death, Pregnancy and the Foetus: The Medico-Legal Implications" (2001) 7(2) M.L.J.I. 75 at 76. I will elaborate on the doctrine of consent in my fifth chapter.

[18] Recognized basically under the "due process clause ", in the U.S. See *Cruzan v. Director, Missouri Department of Health* 497 U.S. 261 (1990).

Although courts tend not to characterize this interest as a fundamental right, and hence ask for a "clear and convincing evidence of the incompetent patient's wishes before treatment was discontinued"[19] – a requirement that *de facto* is difficult to provide - the right to refuse life-sustaining treatment is classified as a constitutionally protected liberty interest under the Fourteenth Amendment to the American Constitution.

Perhaps the most far reaching recognition of the right to refuse medical treatment has been manifested with the legal empowerment of terminal patients with the right to make decisions about their care, based on the *Cruzan* case.[20] These decisions, along with the enactment of Oregon's Death with Dignity Act,[21] which allows physicians to prescribe deadly medications to their patients, and the abolishment of the suicide crime, have created a new era. In my view, although the courts have been cautious enough not to authorize physicians or other persons to end a patient's life by lethal injection, mercy killing or active euthanasia, and despite the fact that courts were careful in making decisions regarding assisted suicide, the law has meaningfully recognized the right of individuals to make personal decisions including about their own death. I will turn to discuss these specific decisions now.

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[19] ***Ibid.*** at 280.
[20] ***Ibid.***
[21] Or. Rev. Stat. § 127.800 to .897 (1998).

The Right to Refuse Life-Sustaining Treatment

The right to refuse life-sustaining medical treatment has been developed in the Canadian law.[22] Originally, it was applied to persons in a permanent vegetative state, but it has subsequently been extended to persons in less extreme conditions, such as cognitive persons who are incompetent and terminally ill, competent and terminally ill, and even those who could be cured or have their lies significantly extended by treatment.[23]

In addition, the legal opinion is that "insistence on heroic but useless measures is no more justified for the incompetent patient than it is for the competent",[24] and more generally, the focus should be on the efficacy of the treatment *to the patient* treated and not whether the patient is competent or not.[25] In fact, two Canadian cases support the view that futile treatment, which does not benefit the patient, should not be sought, even if its cessation

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[22] In *Malette v. Shulman*, [1990] 72 O.R. (2d) 417 (C.A.), the Ontario Court of Appeal upheld a finding of battery against a physician who had administered blood transfusions to an unconscious patient with life-threatening injuries. 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; 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 in favor of Nancy's request to disconnect the respiratory acknowledging that it would lead to her death. The court ruled that if Nancy dies after the respiratory is stopped it would not be an act of suicide, rather nature taking its course. *Nancy B. v. Hotel-Dieu de Quebec et al.*, [1992] 86 D.L.R. (4th) 385, [1992] R.L.Q. 361 (Sup.Ct.).

[23] See James M. Jordan, "Parents, Children and the Courts, Note" (1988) 22 Ga. L. Rev. 1103 at 1145.

[24] Law Reform Commission of Canada, Working Paper No. 28, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1982) at 57.

[25] In its report, Law Reform Commission of Canada, Report 20, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983) at 24, the Commission recommended that physicians would not be legally bound to continue administering or undertaking medical treatment, *when such a treatment has become therapeutically useless and is not in the best interest of the person whom it is intended.*

results in the death of the patient.[26] When focusing on the patient, maintaining a brain-dead pregnant woman for the delivery of her fetus is a futile treatment.

When focusing on the fetus, letting the fetus die with its mother is not an act of assisted suicide. As Kristin Mulholland correctly argues "unlike suicide, the discontinuance of treatment is not irrational self-destruction. It is an acceptance of death, not a desire for it that motivates the terminal patient".[27] The Canadian case of Rodriguez,[28] the American cases of Glucksberg[29] and Quill,[30] as well as the recommendations of the Royal Commission on Euthanasia and Assisted Suicide[31] - all re-establish and legalize the

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[26] *Couture-Jacquet v. Montreol Children's Hospital*, [1986] 28 D.L.R. (4th) 22 (Que. C.A.). In this case, a mother and grandmother of a three-year-old patient refused to have a fourth series of chemotherapy whose chancing of arresting the child's cancer was estimated at ten to twenty percent. The court ruled in favor of the appellants and noted that the odds were heavily weighted against a successful outcome. The second case is *Child and Family Services of Manitoba v. L. and H.*, [1997] 123 Man. R. (2d) 135 (C.A.). In this case, the patient, a three-month-old child, suffered from the shaken baby syndrome, and has been in a permanent vegetative state. The Child and Family Services of Manitoba joined the recommendation of the child's physician that a DNR order be entered on the patient's chart. The patient's parents refused this recommendation and the agency went to court to seek an approval for the order. The order was granted and on appeal, the High Court of Justice concluded that "there is no legal obligation on a medical doctor to take heroic measures to maintain the life of a patient in an irreversible vegetative state" – *Ibid.* at 138.

[27] Kristin A. Mulholland, "A Time to Be Born and A Time to Die: A pregnant Woman's Right to Die with Dignity" (1987) 20 Indiana L. Rev. 859 at 865.

[28] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519. In this case, the Supreme Court upheld the constitutionality of section 241(b) to the Criminal Code, which makes it an offence to aid anyone to commit suicide. By this, the court rejected the claims of Sue Rodriguez, a forty-two-year-old, woman who suffered from a devastating neurological disease that the prohibition at the Criminal Code should be stroke down. Although Rodriguez lost in the trial and committed suicide by herself four month later, the court was sharply divided in its ruling (five to four). The controversy around the issue of assisted suicide resulted in an opposite outcome in Oregon, U.S. by the enactment of the *Death With Dignity Act* Or. Rev. Stat. § 127.800-127.897 (1995).

[29] *Washington v. Glucksberg* 521 U.S. 702 (1997). In this case, the court proclaimed that there was no fundamental right or liberty interest in physician-assisted suicide upon the Fourteenth Amendment of Due Process.

[30] *Vacco v. Quill* 521 U.S. 793 (1997). In this case, the court ruled that the criminal prohibition of the State of New York against assisted suicide does not violate the Fourteenth Amendment of Due process, thereby rejecting the argument that the law discriminated a person who is not on life-support over a patient who is on life support, as the latter can ask for the cessation of his or her treatment.

[31] Report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death* (Ottawa: Minister of Supply and Services, 1995) at 51.

distinction between "passive" euthanasia and "active" euthanasia.[32] From this distinction it is clear that there is a difference between actively killing the fetus, as in abortion, and letting the fetus (passively) die with its mother.

Personal Decisions Concerning the Death of Fetuses

It seems to me that despite of these important changes, the law has remained conservative when personal decisions affect or result in the death of fetuses. In the case of *Re T*, for example, the English court of appeal considered such decisions as an exception to the general principle of free choice regarding medical treatment.[33] In another case, it was held that a cesarean section and any necessary consequential treatment, which the hospital and its staff proposed to perform on the patient, could be lawfully performed even with the patient's refusal to give her consent, if it is vital in the interests of the patient and her unborn child.[34]

In a later case of *Re M.B.*[35], a cesarean section was recommended on a 40-weeks pregnant patient. The mother had no objection, but she suffered from needle-phobia. The trial

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[32] For a general discussion on the distinction between voluntary and involuntary ending of person's life, and between inducing death by active and by passive means, especially in the Canadian law see Trudo Lemmens & Bernard Dickens, "Canadian Law on Euthanasia: Contrasts and Comparisons" (2001) European J. Health L. 135.

[33] *In re T*, C.A. [1992] 4 All E.R. 649 at 652-653. Lord Donaldson stated in an *obiter dictum*:
"An adult patient who, like Miss T., suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable foetus" **[Re T]**.

[34] *In Re S* (Adult: refusal of medical treatment) [1992] 4 All E R 671. In this case, a competent adult woman refused to undergo cesarean section on religious grounds. The woman's decision was supported by her husband. Nevertheless, she was forced to undergo the procedure on the evidence that the only means to save the woman and the fetus' life is to carry out the cesarean section.

[35] [1997] 8 Med. L.R. 217 **[Re M.B.]**.

judge ordered carrying out the cesarean section with anesthesia. However, the English. Court of appeal delivered a reversed opinion in which it stated that:

> "...If the competent mother refuses to have the medical intervention, the doctors may not lawfully do more than attempt to persuade her. If that persuasion is unsuccessful, there are no further steps towards medical intervention to be taken. We recognize that the effect of these conclusions is that there will be situations in which the child may die or may be seriously handicapped because the mother said no and the obstetrician was not able to take the necessary steps to avoid the death or handicap. The mother may indeed later regret the outcome, but the alternative would be an unwanted invasion of the right of the woman to make the decision...".[36]

Not only did the court of appeal rule against previous decisions, but it also relied on the *Re A.C.* case, which held, under similar facts, an opposite result with a completely different justification.[37]

Indeed, the latter English case of *Re M.B.* was criticized for its wrong decision. Still, it represents the uncertainty that exists when the life of the fetus is at stake. Courts feel a need to protect the mother's interest to fully control her body and self-determine what would happen to it, but they also appear to have a sense of responsibility to the fetus, regardless of its competent mother's opinion about it. In my view, it is no more than a paternalistic approach that the courts undertake. It is the pedagogical role of courts that see themselves better judges in all areas of life, including childbearing and family planning. No doubt, these matters lie 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 nuclear right of a human being, it should let the

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[36] ***Ibid.*** at 224.

competent woman make the decision by herself and be responsible for it, instead of patronizing over her.

The case of danger to the fetus' life is, in my view, the real test for the law's protection of the woman's right to self-determination. Just as one can not be claimed to have a freedom of speech when restrained from saying irritating and annoying things, a woman can not be claimed to hold a right to self-determination if her most important decisions in life would be dominated by a group of judges. Yet, this is a normative aspiration and may not necessarily represent the current legal view. If one wants to stick to the latter without the ambition to change it, I would suggest that the law, *as of today*, tend to see the case of danger to the life of a fetus as an exception to the woman's right to self-determination. Maintaining a woman on life support for the sake of saving the life of her fetus, when it is in real and immediate danger could probably enjoy a legal support based on this analysis. I will turn now to describe the special ways in which the law seeks to protect the pregnant women's interests in cases of bodily interventions. I will identify three different means of legal protection: 1) Preventing attempts to restrict pregnant women in their life-styles; 2) denying physicians' actions for court-orders which directly relate to the pregnant women's physical conditions; and 3) exempting pregnant mothers from tort liability over damage that allegedly originated in pregnancy.

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[37] See ***infra*** **note 53 and accompanying text.**

Life-Style Legal Interventions

As I mentioned above, some of the legal interventions with the woman's pregnancy are in the form of interference in the pregnant woman's life style. By life style, I mean drinking habits, using drugs, or other addictive substances, etc`. Though they are distinguishable, life-style interventions are not necessarily more bearable than interventions directly related to the woman's physical condition. In this form of interventions, not only do courts use general principles on a woman's right to self-determination, bodily integrity, and privacy, but they also address specific legislation from which they draw their authority to restrain the pregnant woman from acting in an allegedly dangerous way. Specifically, courts use child protection laws such as the Child and Family Services Act[38] and the Mental Health Act[39] to protect fetuses from dangerous activities of their mother while pregnant. Although this legislation refers to a child as actually or apparently under six-teen years of age, courts tend to construe the legislative text to apply to a child *en ventre sa mere*.[40]

The *D.F.G.* case serves as a good example of the way in which the law can interfere with the liberty of pregnant women mainly through restricting their habitual behaviors.[41]

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[38] S.O. 1984, c. 55, s. 37.
[39] R.S.O. 1980, c. 262, s. 10(1).
[40] See for example *Re Children's Aid Society for the District of Kenora and L.J.*, [1981] 134 D.L.R. (3d) 249 (Ont. Provc. Ct.); *M. (J.) v. Superintendent of Family and Child Services*, [1982] 135 D.L.R. (3d) 330 (B.C.S.C.); *Re Children's Aid Society of City of Belleville and T.*, [1978] 59 O.R. (2d) 204 (Prov. Ct.). One of the arguments that support legal intervention with a pregnant woman is that just as the law prohibits parents from refusing to provide necessary medical treatment (and who more generally neglect them), it also should prohibit a woman from refusing treatment necessary to protect her fetus' health. For discussion on such a comparison see Lawrence J. Nelson, "Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict" (1988) 259 (7) JAMA 1060 at 1062.
[41] **D.F.G.**, *supra* note 14.

Ms. G was the mother of three children, non of whom were living with her. She was five-months pregnant and addicted to sniffing glue. Before the first order in case was issued, Ms. G. had *agreed to take treatment* for her addiction. However, the social services agency worker found her intoxicated, while arriving to escort her to the treatment center. On that occasion, the social services agency applied to have a mandatory detention order issued.

At the first instance, the court relied on the language of the Mental Health Act to protect the fetus, who was found to be "in need" for such a protection. The court ignored an expert's evidence, which supported the view that Ms. G. was competent and not suffering from any mental disorder. The court thought the case in front of it was a proper one to execute its inherit *parens patriae* jurisdiction over Ms. G, thereby extending this jurisdiction from applying only to children to also applying to fetuses. The court ruled that Ms. G. would be obtained in the custody of the Director of Child and Family Services until the birth of her child. The Manitoba Court of Appeal struck down the detention order, finding no evidence that supports the conclusion that Ms. G was incompetent under the Mental Health Act, and holding that the trial judge was wrong by relying on the doctrine of *parens patriae*. In practice, Ms. G voluntary remained at the Health Sciences Center until she delivered a healthy child who remained in her custody.

The Child and Family Services Agency was granted leave to appeal to the Supreme Court. The majority held that neither statute, liability of the pregnant woman in tort law, or the doctrine of *parens patriae* could support an order of detention and force treatment

on the woman. The court emphasized that the fetus has *no legal rights until born*, thereby the Agency was found unauthorized to act on behalf of a legal person in seeking a detention order.[42]

Justice Major, who wrote the dissent opinion, held that intervention in the woman's pregnancy would be permissible, only when four accumulative pre-conditions are met. The woman has to decide to carry the pregnancy to term; there is a proof, on a balance of probabilities, that the abusive activity which allegedly endangers the fetus, will cause serious and irreparable harm to the fetus; the remedy proposed is the least intrusive option possible; the process of intervention is procedurally fair.[43]

Of course, the fact that a woman decides to continue pregnancy to term is not conclusive. A pregnant woman may continue her pregnancy not as a result of deliberate choice but because of lack of access to therapeutic abortion, or cultural, social personal or family constraints. Thus, it seems that the "heart" of the *D.F.G.* test is at the last third elements of it. Applying them to the case of a pregnant brain-dead woman does not necessarily lead to a definitive conclusion. On the one hand, letting the woman die will inevitably result in the fetus' death. This is, of course, a serious and irreparable harm to the fetus. On the other hand, in contrast to forcing a woman to avoid a dangerous activity – a focused legal intervention that saves the fetus from a specific physical harm -, keeping the mother "alive" does not guarantee a successful outcome for the fetus. In many of the

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[42] The court stated that changing this view must be done by the legislator and not by court, since such a decision could have a far reaching impact on the lives of women as well as men who may find themselves incarcerated and treated against their will for conduct alleged to harm others.

[43] For the criticism on that test see **Rodgers**, *supra* note 6 at 351-2.

cases, the fetus dies *in utero* or shortly after its delivery. Moreover, one can argue that maintaining the dead woman on life support is not the least intrusive option possible, as there are no other options available to save the fetus. The *D.F.G.* test is designed for examining a proposed medical intervention in light of *other possible interventions*. It cannot apply to a case where there is only one possible option of intervention in the woman's pregnancy.

Interventions in the Pregnant Woman's Physical State

In addition to legal interventions in the woman's behavior or life style, another form of intervention is one that directly relates to the pregnant woman's physical condition. It includes forcing pregnant women to undergo certain medical treatments, have blood transfusions, or go through a cesarean section. Although there is a significant difference between the levels at which these various legal interventions violate the woman's liberty, courts tend to approach them in the same way. In most cases, courts use the same method of balancing the women's interest and the state interest in protecting potential life, and they also apply the same principles in nearly all of them. I will turn now to present some actual cases, which will reflect the way these interventions take place.

A. Blood Transfusions

Usually, forcing a pregnant woman to have blood transfusion occurs when her religious views prevent her from consenting to this treatment. The physicians, who want to save the life of the mother, the fetus, or both, ask for legal intervention. Although from an

objective point of view, performing a blood transfusion on an unwilling pregnant woman is not as bodily invasive as a cesarean section, it is a physical action that without a legal authorization would be considered a battery.

In *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,[44] a woman in her thirty-second week of pregnancy was ordered to accept blood transfusions if these were necessary to save her and her unborn child. The court does not describe the legal background for its decision. Rather, it mentions that the welfare of the mother and child are so intertwined and inseparable, that it would be unreasonably difficult to distinguish between them. An interesting move, which the court did in this case, was to legally compare a fetus to a child, thereby ignoring the legal significance of the common-law distinction between a child and a fetus. The court ruled that because a child could be given transfusions over the parent's objections, and since a child could sue his or her parents for injuries inflicted prior to birth, the fetus is also entitled to the law's protection, hence forcing the pregnant mother to have blood transfusion.

Sometimes, the legal intervention in the pregnant woman's body goes against her advance directive. In the English case of *In Re* T, for instance, the woman was required to have an urgent blood transfusion after she had given birth to a stillborn baby. The patient, who was a member of the Jehovah's Witnesses, had indicated earlier that she did not wish to have a blood transfusion. Nevertheless, the English court found that the woman had not considered, in her advance directive, the possibility that she might die if she did

[44] 42 N.J. at 421, 422, 201 A. 2d 537, 538, cert. Denied, 377 U.S. 985 (1964).

not received a transfusion. Consequently, the court held that her directive did not apply to the circumstances, which had arisen in her case.[45]

B. Cesarean Sections

At times, pregnant women are forced to perform more invasive and dangerous medical treatments than blood transfusion. One example for such a treatment is forcing a woman to go through a cesarean section. Due to its medical complications and to its advanced degree of intrusion on a woman's right of self-determination, bodily integrity and privacy, I will turn now elaborate on this specific legal intervention.

Cesarean section carries a very high risk of maternal death.[46] Ten to Sixty-five percent of women, who deliver by cesarean section, experience post-surgical infections.[47] Cesarean section can also cause complications for babies. The most serious risk is that of respiratory distress, a breathing difficulty caused by lung immaturity in newborns delivered too early. Cesarean section can also adversely affect the woman's future reproductive life, making rupture of her uterus in future pregnancies more likely, and repeat cesarean section for each future delivery far more probable.

Besides these physical complications, surgical delivery may also have a negative impact on a woman's ability to care for and establish a relationship with her newborn. Women

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[45] **Re T**, *supra* note 33.
[46] The maternal mortality rate is three to thirty times that associated with vaginal delivery.

after cesarean section experience more pain, weakness, and difficulty in holding and caring for their newborns. Some of them report feelings of isolation, humiliation, anger, self-blame, and deep disappointment after undergoing cesarean section.[48]

There is also a deterrent effect of forced cesarean on pregnant women. Women fearful of forced cesareans may also avoid prenatal care altogether. They can consequently decide not to return to any hospital and give vaginal birth, safely, at home.

The physical circumstances of a pregnant woman, who has to make a decision whether to consent to cesarean section or not, can be very difficult. While usually under active labor, a pregnant woman has to balance the possible bad consequences that may derive from cesarean section with an estimation regarding the fetus' potential future life. This is a very stressful situation. As Alan Fleischman explains:

> "The woman is lying in bed at least intermittent pain and probably constant discomfort; she is attached to several devices, including an intravenous infusion and a fetal monitor; and she may have received medication for pain relief that can affect her ability to analyze alternatives. This may result in the woman not being able to make a clear, rational and informed choice. Most frequently, she respects the advice of her physician and concurs with the proposed plan presented as the best course for her baby. The atypical woman who questions the certainty of the recommendation, voices concern about her own well-being, or raises a question about the motivation of the physician concerning future malpractice protection is viewed

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[47] A rate five to ten times the complication risk following vaginal birth. Common infections include intrauterine, cystitis, peritonitis, abscess, gangrene, sepsis, urinary infections, and respiratory infections. See **Gallagher**, *supra* note 2 at 207.

[48] ***Ibid.*** at 208. Gallagher also discusses the anxiety cesarean section causes to women and the relationship between psychological factors and labor and fetal distress. *Ibid.*, at 209.

> by the physician and other caregivers as a difficult, non-compliant patient who wishes to hurt her baby".[49]

In addition to these physical obstacles, there is an inherent impediment in the process of assessing the need and advocating for cesarean section. Deciding on a cesarean section involves medical judgment rather than certainty. In many times, this judgment has proved to be wrong. Study has shown, for example, that in the year of 1986 about half of the 906,000 cesareans performed were unnecessary.[50] It is also believed that one of the key factors leading to doctors' over-reliance upon cesarean sections is their enormous fear of malpractice suits if a child is born with a condition that could arguably have been prevented by surgical delivery.[51]

Notwithstanding the danger to the women's physical and mental health and the potential complications to the newborns in surgical deliveries, doctors often seek court orders for cesarean sections. In some of the cases, orders were issued regardless of the elemental difficulties in the maternal bodily circumstances and the risks that were built in the medical assessment for such surgeries. However, in most cases, courts protected women from bodily intervention without their consent, even when refraining to do so could seriously endanger the women (and) or their fetuses.

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[49] Alan R. Fleischman, "The Fetus is a Patient" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s*, (Clifton, NJ: Humana Press: 1989) 249 at 252-3 [**Fleischman**].

[50] Janet Gallagher mentions at least six cases, in which doctors have declared cesareans necessary and asked judges to order surgery, and the women proceeded to give vaginal birth to healthy children. See **Gallagher**, *supra* note 2 at 205-7.

[51] This fear has some evidence base. As Janet Gallagher mentions, obstetricians are subject to more frequent malpractice lawsuits than most other specialists, and damages in obstetrical cases, especially the "brain-damaged baby" cases, can be spectacularly high. ***Ibid.*** at 210; See also **Fleischman**, *supra* note 49 at 252.

In *Jefferson v. Griffin Spalding County Hospital*,[52] the respondent petitioned the Superior Court of Butts County for an order authorizing it to perform a cesarean section and any necessary blood transfusions upon the defendant, an out-patient resident of Butts County, in the event she presented herself to the hospital for delivery of her unborn child, which was due four days after the petition.

The woman was thirty-ninth week of pregnancy. Few weeks before the petition, she has presented herself to the respondent for pre-natal care. She was found to have a complete placenta previa, and the doctors assessed that it was a 99% certainty that the child cannot survive natural childbirth (vaginal delivery). On the basis of religious beliefs, the defendant has advised the Hospital that she does not need surgical removal of the child and will not submit to it. Further, she refused to take any transfusion of blood.

Although the defendant *did not appear* to the superior court, the hospital was authorized to administer to defendant all medical procedures deemed necessary. The authorization was set to be effective only if the defendant voluntarily sought admission to either of respondent's hospitals for the emergency delivery of her child.

In a following procedure, initiated by the State of Georgia Department of Human Resources and the Butts County Department of Family and Children Services, temporary custody of the unborn child was granted to the petitioners. The Superior Court ruled that the Department had to have full authority to make all decisions, including giving consent to the surgical delivery appertaining to the birth of the child. Although the parents

[52] 247 Ga. 86, 274 S.E.2d 457 (1981).

explained their religious resistance to the medical interventions, they were taken out of the picture. The court stated that the State has an interest in the life of the unborn, who is a living human being. The court also found that the intrusion involved into the life of the unborn parents is outweighed by the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live. Nevertheless, the court did not discuss how this potential life is going to be, and ignored the unborn potential parents' view about it. On appeal [by the parents], the court justified the infringement upon the woman's right to religious freedom and bodily integrity by stating that the life of the viable fetus was intertwined with the mother's. The court found it necessary to give the child an opportunity to live. Thus, contrary to the woman's view, which was also supported by the father of the unborn, the court denied appellant's motion.

In the case of *In re A.C*, Angie C., a twenty-fifth week pregnant woman was diagnosed as having a tumor mass on her lung and was admitted to hospital.[53] Within days, she deteriorated, and was heavily sedated so that she could continue to breathe. The hospital sought a trial court order to allow it to proceed with the cesarean operation at twenty-six weeks.

As reflected in Angie's physician's testimony, Angie apparently had agreed to have a cesarean section preformed at twenty-eight weeks gestation, when the fetus would have a reasonable chance of survival, but she had been unable to discuss an earlier date for the

[53] *In Re A.C.*, 573 A. 2d 1235 (D.C. 1990) [**In Re A.C.**].

operation before she was sedated.[54] Another evidence presented to the court was of Dr. Lawrence Lessin, an oncologist and another of Angie's treating physicians. Dr. Lessin testified that in meetings with Angie, he had *heard nothing to indicate* that, if faced with the decision, she would have refused permission for a cesarean section. Contrary to these opinions, Dr. Weingold, an obstetrician who was one of Angie's treating physicians, opposed the operation because he believed Angie had not seriously considered that she might not survive the birth of her baby. Dr. Weingold testified that at some point, Angie had said "I don't want it done". Thus, there was, in fact, considerable dispute as to whether Angie would have consented to an immediate cesarean delivery at the time the hearing was held.

Despite the contradictory evidence, and regardless the fact that there had been some testimony that the operation may very well hasten the death of Angie, the trial court determined the operation should proceed. The trial court based its decision on the state interest in protecting the life of the fetus after viability established in *Roe v. Wade*. The right to privacy was declared to encompass a right to bodily integrity, which also includes the freedom to refuse medical treatment. However, the trial court added, the state has an interest in preserving life that allows the patient's choice to refuse medical treatment overridden where the life of an innocent *third party* is at stake. The court took in consideration that such an intervention will not make so much harm to Angie since she "had, at best, two days left of sedated life; the complications arising from the surgery

[54] Dr. Hamner testified in the court: "We had talked about the possibility at twenty-eight weeks, if she had to be intubated, if this was a terminal event, would we intervene, and the expression was yes, that we would, because we felt at twenty-eight weeks we had much more to offer as far as taking care of the child." ***Ibid.*** at 1239-1240.

would not significantly alter that prognosis."[55] An attempt was made to secure a stay from the court of appeals, but the motion was denied.[56] The operation was performed and the baby died *immediately*. Angie died *two days later*. A few months later, the court ordered the case heard *en banc* and vacated the opinion of the motions division.[57] Although the case was moot in the sense that the surgery, which was ordered by the trial court, had been already performed, the court felt it important to discuss the legal consequences of this case.

The court of appeal emphasized that from the available evidence, the court could not tell whether Angie would have consented to the surgery or not. The court re-acknowledged the right of every competent person to make an informed choice to accept or forego medical treatment. The court added that in some cases, especially those involving life-or-death situations or incompetent patients, there are four countervailing interests that may involve the state as *parens patriae:* preserving life, preventing suicide, maintaining the ethical integrity of the medical profession, and protecting third parties. As only the state's interest in preserving life was at stake in the case of *A.C.*, the court emphasized that such an interest must be *truly compelling* to justify overriding a competent person's right to refuse medical treatment. The same is true for incompetent patients, who have just as much right as competent patients to have their decisions made while competent respected, even in a substituted judgment framework.

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[55] In re A.C., 533 A. 2d 611 (D.C. 1987) at 617.
[56] ***Ibid.***
[57] In re A.C., 539 A. 2d 203 (D.C. 1988).

More importantly to our case, the court went on to rule that the right of bodily integrity equally belongs to persons who are competent and persons who are not. Further, it was stated that such a right is not extinguished "simply because someone is ill, or *even at death's door*".[58] Finally, the court concluded that without a competent refusal from Angie to undergo the surgery, and without a finding through substituted judgment that Angie would not have consented to the surgery, it was an error for the trial court to proceed to a balancing analysis, weighing the rights of Angie against the interests of the state. Belson Judge, who wrote the dissenting opinion, stated that in the rare instances, in which the viable unborn child's interest in living and the state's parallel interest in protecting human life come into conflict with the mother's decision to forgo a procedure such as a caesarean section, a balancing should be struck in which the unborn child's and the state's interests are entitled to substantial weight.[59] He further added that when the unborn child reaches the state of viability, the child becomes *a party* whose interests must be considered, and declared that a viable unborn child is a *person* at common law, who has legal rights that are entitled to the protection of the courts.[60]

The *Re A.C.* case is a tragic one, not only because of the sorrowful fact that both Angie and her child died soon after the cesarean section, but especially given the serious dispute about the evidence regarding Angie's consent to the surgery. Still, it reflects a solid legal approach that recognizes the woman's right to self-determination and bodily integrity

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[58] **In Re A.C.**, *supra* note 53 at 1247 (My emphasis – D.S.).
[59] ***Ibid.*** at 1254.
[60] ***Ibid.*** at 1255.

even with the cost of the death of her *viable* fetus.[61] By vacating the legal opinion of the trial court, the court of appeal not only emphasized the importance of obtaining the competent woman's consent to bodily interventions over her body, but it also made even the requirement of consent from a competent patient to that from an incompetent patient, including one, who is "at death's door".

In the *Baby Doe* case an action was brought to compel pregnant woman to undergo a cesarean section.[62] The fetus was 36.5 weeks, and the mother refused to have cesarean section due to her religious beliefs. The Circuit Court denied relief, and appeal was taken. Both the State and the Public Guardian argued that the circuit court should have balanced the woman's rights with the ones of the unborn viable fetus, which was nearly at full term and which, according to expert testimony, would have been born dead or severely retarded if Doe delivered vaginally.

The Appellate Court of the state of Illinois held that courts should not engage in such a balancing, and that a competent woman's choice to refuse cesarean section during pregnancy must be honored, *even in circumstances where choice may be harmful to her fetus*. The court also held that a forced cesarean section, undertaken for the benefit of the fetus, cannot pass constitutional muster. The court stated:

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[61] Or as the court stated: "If the woman is competent and makes an informed decision, that decision will control 'in virtually all cases' ". ***Ibid.*** at 1249.

[62] *In Re Baby Boy Doe* 632 N.E.2d 326, 260 Ill App. 3d 392, 198 Ill Dec. 267, USLW 2632, Ill. App. 1 Dist., April 5, 1994.

> "A woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. *The potential impact upon the fetus is not legally relevant.*"[63]

Finally, in the British case of *Re M.B.*,[64] a cesarean section under anesthesia was ordered to a pregnant woman, who suffered from a needle-phobia but did not oppose the intervention. Despite of the court's intervention a wide protection was given to the pregnant woman – one that outweighed the interest in protecting the potential life of the fetus as a known state interest in the American Jurisprudence. The British court declared that a woman has an *absolute* right to refuse to consent to medical treatment for *any reason,* rational or irrational, or *for no reason at all*, even when the decision may lead to her death. Moreover, the court ignored the viability criterion regarding that interest. Butler-Sloss L.J. stated that:

> "...The foetus *up to the moment of birth* does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child *even at the point of birth.*"[65]

As discussed above, a great number of cases have been dealing directly with legal attempts to intervene in the pregnant woman's physical condition, mostly without her

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[63] ***Ibid.*** at 401 (My emphasis – D.S.).
[64] **Re M.B**, *supra* note 33.
[65] ***Ibid.***, at 227 (My emphasis – D.S.).

approval. Although the severity of the interference in the woman's right to self-determination and bodily integrity varies from case to case, courts try to balance the woman's interests with the state interest in protecting the unborn, often a viable one, in most of them. While all these cases depart from the same point - the *Roe* decision – they reach different destinies. Some are way too far from Roe, pronouncing an absolute right to refuse treatment, and consider the potential impact of the mother's decision upon the fetus as irrelevant. Others are more moderate in their holdings, thereby balancing the woman's interests with the state interest in potential life, and according the latter more weight when the fetus is viable. It seems to me that all of them reflect a tendency of courts to protect the woman's right to refuse treatment at a greater distance than *Roe*, along with an inclination to ask for a more serious harm to the fetus, if at all.

Applying this reasoning to the case of a brain-dead pregnant woman by equalizing the requirement of consent from a competent woman to that from an incompetent woman can raise the necessity of examining the woman's view on the proposed medical intervention. Whether through an advance directive or other ways from which to infer the woman's opinion about the case, obtaining the woman's consent seems to be a precondition for any possible intervention with her body. Moreover, as suggested in these cases, the death of a fetus was not necessarily considered to be an unbearable result by the law, especially if the bodily intervention in the pregnant woman, which could have saved the fetus' life, is done without her approval. Finally, as demonstrated by these cases, the debate over whether to intervene in the pregnant woman's body is one in which the mother and the State, which aims to protect potential life, are the only participants. It seems that even at

point of viability, the biological father of the fetus is out of this legal picture. If this is true, then asking for the view of the biological father of the fetus on the question whether to maintain the dead woman on life support or not, is irrelevant in the eyes of law. It is relevant only if the biological father sheds light *on the woman's view*, but not otherwise.

Intervention through Releasing Pregnant Women from Tort Liability

Another way in which courts chose to protect the pregnant woman from being bodily intervened, is through denying actions of impaired children for tort liability based on alleged harm caused by maternal conduct during pregnancy. In the *Dobson* case,[66] the defendant was twenty-seven weeks pregnant when the car she was driving collided with another. Her son, who brought the action, was born with mental and physical impairments allegedly resulting from the accident.

The Supreme Court of Canada held that an action for alleged negligence during pregnancy would not lie against the mother. The court distinguished between obligations that would be imposed on a third party tort-feasor and those imposed on pregnant women themselves. From a public policy perspective, the court ruled that imposing a duty of care on pregnant women with regard to the fetus would interfere with the privacy and

[66] *Dobson (Litigation Guardian of) v. Dobson*, [1999] 2 S.C.R. 753 [1999] S.C.J. No. 41 (QL).

autonomy rights of women and involve the court in the difficult task of articulating a judicial standard of conduct for pregnant women. In the court's view, imposing a duty of care upon the mother would not only constitute an extensive and unacceptable intrusion into her bodily integrity, privacy and autonomy, but would also constitute a "severe intrusion into the lives of pregnant women, with attendant and potentially damaging effects on the family unit."[67]

To sum up, the law protects the pregnant woman's right to self-determination and bodily integrity, whether competent or not, in three different ways: 1) preventing attempts to restrict pregnant women in their life-styles; 2) impeding physicians' actions for court-orders which were directly related to the pregnant women's physical conditions; and 3) releasing pregnant mother from tort liability over damage that allegedly originated in pregnancy. In addition to their physical and emotional immediate outcomes, it appears that legal interventions in the pregnant woman's body are also wrong for indirect reasons as well. I will end this chapter by discussing a few of them.

Duty to Rescue

One of the criticisms against judicial decisions, imposing treatment upon pregnant women, is that these decisions contradict the common-law rule to deny a duty to rescue.[68]

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[67] ***Ibid.*** at 775.

[68] Anne D. Lederman, "A womb of My Own: A Moral Evaluation of Ohio's Treatment of Pregnant Patients with Living Wills" (1994) 45 Case W. Res. L. Rev 351 at 358.

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,[69] even in cases where denying aid would result in *the death* of the endangered person.[70]

This view was also incorporated to the fetal-maternal relationship when the court ruled that the mother did not owe a duty to rescue the fetus, as the latter cannot have rights in this respect superior to those of a person who has already been born.[71] When taken strictly, this argument might not fully apply to the situation of a brain-dead pregnant woman who is being legally dead, hence, without legal rights.[72] Still, the absorption of this view into the maternal-fetal relationship reflects the idea that the law does not see this relationship as an exception to the non-obligatory nature of the duty to rescue under the common law. This is especially true considering the dubious moral and legal status of the fetus.

Implications on Physicians

Legal interventions are unfavorable not only because of how they interfere with the pregnant woman right of self-determination but also for their implications on physicians.

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[69] **In Re A.C.**, *supra* note 53 at 1243-4.
[70] See *Shimp v. McFall* 10 Pa. D & C. 3d 90 (Allegheny County Ct. 1978). In this case, the court refused to order Shimp to donate bone marrow, which was necessary to save the life of his cousin, McFall.
[71] **In Re A.C.**, *supra* note 53 at 1244.
[72] But see my criticism on such a claim in chapter five of my thesis.

The request for a court order demonstrates the physician's willingness to use physical force against a competent adult. This seems to me an unethical behavior and a violation of the physicians' fiduciary obligations to their patients. The tendency to resort to judicial intervention in cases of refusal to treatment may create an obligation for the physician to obtain a court order in any situation in which a pregnant woman's preference does not accord with the physician 's evaluation of the fetus' needs.[73]

Moreover, developing a routine of legal intervention in pregnant women's body could create a legal obligation for physicians to seek court orders. Physicians could then be found negligent for not seeking a court order in situations where a pregnant woman's decision led to fetal impairment. Likewise, physicians would most likely be required to participate in the practical aspects of enforcing an overriding of a pregnant woman's treatment decision. The new role of physicians as legal enforcers will create adversarial relationships between physicians and their pregnant patients, and would damage the treatment relation between physicians and patients.

Effect on women in general

Legal interventions in pregnancies, no doubt, affect the woman involved, but also have broad implications for all women. They shape a negative image of the refusing pregnant

[73] Sometimes, this conflict is wrongly resolved by transferring the treatment of the woman to another physician. As reported by Dr. Robert Goodlin, a court ordered a cesarean section on a dying pregnant woman against her refusal, and the refusal of her obstetrician. After an appeal to the judge, the surgery, nevertheless, was performed by another obstetrician on court order, and the nonviable fetus died two hours

woman. This image could be broadened to a larger picture of women in general. As Laura Purdy correctly writes, "Peeping out from under such judgments would be the assumption that women in general are self-centred, thoughtless individuals who cannot be expected to behave morally."[74]

In an indirect way, legal interventions with the body of a pregnant woman increase the domination of women by men, and their subordination to court orders and reviews by "the outside world", where mostly men are in positions of power and decision making. In her criticism on the *D.F.G.* case, Sanda Rodgers argues that neither the majority nor the minority explicitly considered proposed state interference in the reproductive lives of women *in a manner fully compatible with women's equality and participation in Canadian life*.[75] The court also failed to consider that state interference would be imposed on women disproportionately to men. In this regards, in addition to being discriminatory on the basis of pregnancy, which has already been recognized as impermissible sex-based discrimination,[76] court order interventions focus on the fetus, devaluing the woman and her needs except to the degree that she is reproducing.

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later. See Robert C. Goodlin, "Maternal Brain Death During Pregnancy – Letter to the Editor" (1989) 261 (12) JAMA 1728.

[74] **Purdy,** *supra* note 12 at 288.

[75] **Rodgers**, *supra* note 6 at 353.

[76] *Brooks v. Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219; *Symes v. R.*, [1993] 4 S.C.R. 695.

Conclusion

While the fetus is within the body of a woman, the power and responsibility to choose medical treatment must rest *with her*. The questions of legal interventions in the pregnant woman's body should not be questions that focus on the fetus, its status, whether he or she is a person, and whether he or she has a right to life. Rather, these are questions on the woman's rights to carry and bear children with dignity. As Janet Gallagher writes:

> "Women have been driven into hiding, tied down to operating tables, and cut open against their will. They have been frightened away from hospital and prenatal care. Legal enforcement of the primacy of the 'fetus as patient' threatens to create a climate in which pregnancy and birth are laced with intimidation, coercion, and raw physical violence."[77]

The ongoing call for protection of the fetus' life troubles me. It seems that there can be no stopping point or 'bright line' to the fetal rights demands. John Robertson, for example, argues that, under *Roe v. Wade,* it would be legally permissible to order the forced feeding of a pregnant anorexic teenager.[78] In another place, he claims that it is not unreasonable to require a woman, who *had not yet had her pregnancy confirmed*, to have a pregnancy testing or to refrain from activities that would be hazardous to the fetus if she were pregnant.[79] How far can we expect pregnant women to bear?

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[77] **Gallagher**, *supra* note 2 at 215-6.

[78] John Robertson, "The Right to Procreate and *In-Utero* Fetal Therapy" (1984) 3 J Leg Med 333 at 356.

[79] John Robertson, "Procreative Liberty and The Control of Conception, Pregnancy and Childbirth" (1983) 69 Virg L Rev. 405 at 447. More generally, Robertson argues that it is reasonable to regard mothers as having a moral duty to the babies they choose to deliver. He points out that if mothers (and fathers) have moral obligation to refrain from harming their children *after* they are born, then they have these obligations to their children *before* they are born. If it is wrong to neglect or abuse a child *ex-utero*, then it is wrong to neglect or abuse a child *in utero*. See John Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s*, (Clifton, NJ: Humana Press: 1989) 259.

Pregnant women, like other women and like other men, enjoy a right to self-determination and to bodily integrity. *As long as they appreciate it*, they deserve the right to say "no". They should not be discriminated on the basis of their pregnancy. Hence, no duty to rescue the fetus shall be owed by them, even when the fetus is about to die. Like other moral beings, women are responsible for their acts. There is no meaning to talk about protecting potential life when the mother of such a potential, who fully dominates its evolution, and whose consent to continue the pregnancy is a precondition for it to become real, chooses to risk herself with the fetus. The potential life does not exist in a void. The state's interest in potential life is, thus dependent on the mother's willingness to have *within her body* such a potential.

Forcing medical treatment on pregnant women is wrong from beginning to end. It starts with inherent procedural obstacles that are accompanied by an unstable physical situation of the pregnant mother, who is at stake. On an immediate level, it ends with the possible imposing of physical and emotional danger to the mother and her fetus. In an indirect level, it puts physicians in an adversarial role and damages their relationship with pregnant patients. It also increases the subordination of women and devalues them as a group.

Therefore, forcing medical treatment on pregnant women should be justified only in very exceptional cases. The strongest case for forcing treatment should be a one-time intervention of minimal risk to the mother, such as administering a drug, blood, or

surgery, when it follows from the circumstances, that the mother does not appreciate her condition, thereby cannot give consent to the treatment.

Approaching legal interventions in pregnant women's bodies the way I suggest can illuminate on the case of brain-dead pregnant woman, whose maintenance on life support is being considered. I have showed, above that applying the *D.F.G.* test to medical interventions here does not necessarily lead to a definitive conclusion. No doubt, letting the woman die will inevitably result in a serious and irreparable harm to the fetus. On the other hand, keeping the mother "alive" does not guarantee, like other medical interventions, a successful outcome for the fetus. Moreover, it can not be said to be the least intrusive option possible, as there are no other options available to save the fetus.

Nevertheless, a better lesson can be taught from the cases, which deal with legal interventions directly related to the pregnant woman's physical condition. As follows from these cases, it is of a great necessity to examine the woman's view on the proposed medical intervention. Obtaining the woman's consent seems to be a precondition to any possible intervention with her body, including maintenance on life-support. These cases also can support the conclusion that the death of a fetus could not necessarily be considered a non-bearable result by the law, when the proposed bodily intervention – maintaining the dead mother on life support - is done without her approval. Finally, as demonstrated by these cases, asking for the view of the biological father of the fetus on whether to maintain the dead woman on life support or not, is irrelevant in the eyes of law. It can be relevant only if the biological father sheds light *on the woman's view*, but

not otherwise. Focusing on the woman's prior wishes would naturally bring us to the next chapter on advance directives.

CHAPTER 3: ADVANCE DIRECTIVES

In the previous chapter, I discussed the importance of respecting the pregnant woman's wishes regarding the proposed medical treatment. In this chapter I will discuss the use of advance directives - a common way to ensure such respect in circumstances when a woman is no longer capable of expressing her wishes directly herself. After a short introduction on advance directives, I will describe the regulation of advance directives as they apply to pregnant incompetent women. I will include in this description the American, Canadian and English legal systems. Then, I will analyse the arguments that are invoked in the context of pregnancy living will legislation. Finally, I will make recommendations for what I see the most appropriate legal regime for Canada. My recommendations will consider the Canadian legal approach to living will legislation, in general, and to pregnant women, in particular. These recommendations will be linked also to my previous discussions on abortions and bodily interventions.

Introduction

A. Definitions

An advance directive is a legally binding document consisting of a living will, a durable power of attorney or both. Living wills are documents that give instructions to health care providers about particular kinds of medical care that an individual would or would not want to have. A living will is "the individual's written directive specifying that if the

individual becomes terminally ill or goes into irreversible vegetative state, the individual's care givers should not use artificial life support procedures."[1]

Durable power of attorney is also often referred to as a proxy directive. This directive permits individuals to appoint someone to make medical decisions for them when they are no longer able to do so for themselves. The significant advantage that a proxy directive has over a living will is that it provides a means for decision-making, even when the situation that actually arises *is not one that the patient might have contemplated,* and to which a living will might be inapplicable, or might lead to results that the patient would not have wanted.

Both a living will and a proxy directive are mechanisms by which competent individuals plan for medical decision-making, at some future time, when they might no longer possess decision-making capacity.[2] This stands in contrast to the ordinary medical decision-making process for competent patients, which is contemporaneous.

B. Purposes of Advance Directives

In his book, *The right to die*,[3] Alan Meisel identifies three general and interconnected purposes for advance directives. The first, which he finds the most important from the

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[1] Elizabeth Carlin Benton, "The Constitutionality of Pregnancy Clauses in Living Will Statutes" (1990) 43 Vand. L. Rev. 1821 at 1822.

[2] 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.

[3] Alan Meisel, *The right to die*, vol. 2, 2nd ed. (New York: Wiley law Publications: 1995) 6.

perspective of those who issue the directives, is to provide a means of exercising some degree of control over medical care. As the core concept behind living will is in the right to privacy and autonomy in medical decision making, the primary purpose of a living will is to ensure that the individual's wishes are respected.[4] Living people have comfort in knowing that that their bodies will be treated with dignity and according to their wishes, when they are dead. Under this purpose, advance directives are intended to effectuate the patient's own choice, thereby honoring the patient's right to self-determination even when she no longer possess the capacity for it.

The second purpose of advance directive is to avoid some of the more serious procedural problems associated with making decisions for patients who lack decision-making capacity, primarily by forestalling recourse to the judicial process. In this regards, advance directives promote a greater willingness on the part of the health care professionals to avoid a judicial resolution to end-of-life decision-making for

[4] 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. In 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. See Rebecca Dresser, "Relitigating Life and Death" (1990) 51 Ohio L. J. 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. See Allen E. Buchanan & Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1989) 185. This personal identity challenge to the effect of the advance directive plays a more important role, in my view, 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, hence 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.

incompetent patients. Advance directives, thus, anticipate the need for either the clinical designation of a surrogate or the judicial appointment of a guardian.[5]

The third purpose of advance directives, which is the most important one from the perspective of health care providers, is to provide immunity from civil or criminal liability. As most litigated right-to-die cases wind up in court out of the fear from liability, the statutory immunity provisions of the advance directives statutes facilitate decision-making by providing another reason for keeping cases in the clinical setting.

In addition to these general purposes, advance directives have an economic incentive. The widespread use of advance directives helps to lower the costs of providing medical treatment to those who are not likely to benefit significantly from it. Under this rational, two suggestions have been made in the literature. Individuals having advance directives would be charged lower premiums for health-insurance, or the issuance of health insurance should be contingent upon the execution of an advance directive (overlooking the fact that advance directives may request treatment as well as request to forgo treatment).[6]

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[5] Of course, 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 through either the clinical or judicial approach if the instructions do not adequately address the issues requiring resolution. 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.

[6] It is not clear, however, that it costs less to treat patients near the ends of their lives who have advance directives than to treat those who do not.

Finally, but not the least important, living wills also reduce the anxiety and stress on families and caregivers. With an advance directive, the family and health care team can be confident that they are giving the patient the treatment he or she would want. They also educate patients about the treatment choices available to them, thereby changing the patient-physician relationship from making decisions *for* the patient to making decisions *with* the patient.

Regulation of Advance Directives

Advance directives are usually regulated by legislation. Advance directive statutes allow individuals to make decisions about the kind of care they want, if they are unable to make decisions on their own, and appoint someone to make those decisions for them. They provide a mechanism, which advances the ethical principles of individual autonomy, self-determination, and bodily integrity.[7] The legislation provides the form of the document, the procedure for creating it, and the scope of its effect. The implication of the enactment of the living will legislation is the recognition by the state that, if the expression of intent is made, the incompetent adult has the right to have medical treatment discontinued, and, thus, courts should uphold the individual's living will.

[7] Nevertheless, a criticism can be raised regarding the extent to which living wills advance 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 4.**

In the American legal system, a living will ceases to be effective, when the incompetent woman, who made the living will while competent, is pregnant. In Canada and the U.K., no such exception exists. I will turn now to discuss these legal systems.

Canada

In Canada, advance directive legislation exists, almost all over the country. This legislation covers provinces of Alberta,[8] British Columbia,[9] Manitoba,[10] New Brunswick,[11] Newfoundland,[12] Nova Scotia,[13] Ontario,[14] Quebec,[15] Saskatchewan,[16] Prince Edward Island,[17] and Yukon Territory.[18] Although this legislation varies from province to province or territory, in *non* of these extensive legislative frameworks the legal effect of an advance directive is influenced by the question whether the patient, who issued the living will, is pregnant or not. Thus, it seems that without any specific regulations for pregnant incompetent women, the Canadian law treats the incompetent pregnant woman, who issued an advance directive while competent, the same way as it treats other incompetent patients, that is it respects the patient's right to control his or her care. However, the legal structure of living will legislation regarding incompetent

[8] *Personal Directives Act*, R.S.A. 2000, c. 6 , s. 1.
[9] *Representation Agreement Act*, R.S.B.C. 1996, c. 405.
[10] *Health Care Directives Act, C.C.S.M.*, c. H27.
[11] *Infirm Persons Act*, R.S.N.B., c. I-8.
[12] *Advance Health Care Directives Act*, S.N.L. 1999, c. 22, s. 2.
[13] *Medical Consent Act*, R.S. 1989, c. 279.
[14] *Substitute Decisions Act*, S.O.1992, c. 30.
[15] *Civil Code*, S.Q. 1991, c. 64, s. 11-25.
[16] *Health Care Directive and Substitute Health Care Decision Makers Act*, S.K.U. 1997, c. H-0.001.
[17] *Consent to Treatment and Health Care Directives Act*, R.S.P.E.I. 2000, c. C-17.2.
[18] *Enduring Power of Attorney Act*, R.S.Y. 1995, c. 8.

pregnant women is different in the U.S. than in Canada. I will turn now to describe the American legislation.

U.S.A

Generally, in the U.S., the living will legislation of the states differs in its allowance of use of a living will only when a patient is terminally ill, or after a prognosis showed that the patient would not recover. Although all states allow the patient to reject mechanical means to maintain breathing, the majority does not allow the withdrawal of food and water.

Legally, where a patient has completed an advance directive, the health care provider is obligated to abide by the patient's wish to the extent that the wishes stated in the advance directive can be understood. With the guidance of the Patient Self Determination Act,[19] health care facilities[20] should give patients information, inquire if the patient has an advance directive, and provide education to the public about advance directives. In any event, the advance directive serves as a guideline in decision making.

While all the states in the U.S. have enacted some form of advance directive legislation, only thirty-four of them contemplate the validity of the advance directive when a woman

[19] *Omnibus Budget Reconciliation Act* of 1990, Pub. L. No. 101-508, § 4751, 104 Stat. 1388-204 (1990).
[20] This applies to hospitals, nursing facilities, home health care providers, hospice programs, and health maintenance organizations.

is pregnant.[21] Each of these statutes has specific guidelines as to the applicability of an advance directive, when a woman, who makes the advance directive, is pregnant. The requirements in each statute are different, but they could be roughly divided into the following six categories:

1) Total disregard of an advance directive during the entire pregnancy- this category is the most frequent and appears in seventeen states.[22] Statutes under this category declare that an advance directive of a person, who becomes pregnant, has no effect during pregnancy.

2) Possibility/Probability/Medical certainty that the fetus will develop to live birth – Some states have legislation that does not give effect to an advance directive if it is probable[23], possible[24], or supported by medical certainty[25] that the fetus will develop to live birth.[26]

3) Viability of the fetus – Two states mention the viability criterion as a limit of the effect of the advance directive. Colorado requires fetal viability before voiding an

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[21] 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. **See generally** Amy L. Jerdee, "Breaking Through the Silence: Minnesota's Pregnancy Presumption and the Right to Refuse Medical Treatment" (2000) 84 Minn. L. Rev. 971 [**Jerdee**].

[22] 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 (§ 127.00 to .660)(1990 & Supp. 1998) mentions abortions as one of the things to which the durable power of attorney is not authorized to consent to.

[23] Alaska, Delaware, Montana, Nebraska, Nevada, and Rhode Island. This is also the language of the *Uniform Rights of Terminally Ill Act* of 1989, 6(c) (Supp. 1999) 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".

[24] Arizona, Arkansas, Illinois, Minnesota.

[25] Kentucky, North Dakota.

[26] For the difficulties in interpreting the language of the ambiguous terms "probable" and "possible" in this regard see **Jerdee**, *Supra* note 21 at 996-997.

advance care directive. Georgia requires that the fetus not be viable to allow the discontinuation of medical treatment.[27]

4) Physical harm/pain to the pregnant woman – In addition to the requirement of reasonable medical certainty that the fetus will develop to live birth, Pennsylvania and South Dakota ask for the assurance that physical harm or pain to the woman can be alleviated.

5) Rebutable presumption of continuation of treatment - The Minnesota advance directive law offers a unique approach. In 1998, the Minnesota legislature fundamentally revised the existing Minnesota advance directive law.[28] Prior to 1998, 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."[29]

With the 1998 amendment, the current pregnancy provision states that:

> "When a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is 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,[30] *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 provision...or in the absence of such provisions, by clear*

[27] The Georgia Natural Death Act served as an inspiration to the court in the *Piazzi* case, thereby ordering to maintain Donna Piazzi (who had not left any directive at issue) on life-support. See ***infra*** **note 33 and accompanying text.**

[28] Minn. Stat. § 145C (1998).

[29] Minn. Stat. § 145B.13 subd. 3 (1998).

[30] 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.

> *and convincing evidence that the patient's wishes, while competent, were to the contrary.*"[31]

Hence, the new approach acknowledges the state interest in potential fetal life, while still preserving the pregnant patient's right to withdraw treatment. It also encourages health professionals to discuss the issue with women, who are or could become pregnant. This view goes beyond simply making the living will void with pregnancy. It attempts to balance the woman's rights with those of the state interest in protecting the life of the fetus.

6) probability that the fetus would not to be born alive - In Ohio, life-sustaining treatment can be withheld or withdrawn, if "the declarant's attending physician and one other physician who has examined the declarant determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive."[32]

The various forms of restricting the woman's right to control her care just because she is pregnant look worrisome. Not only are women deprived from their right to determine what treatment they will have when incompetent, in some states this deprivation is done regardless the stage of pregnancy in which the incompetent woman is. This seems to be odd, as if the woman was competent, she could abort her child, at least without hesitation in her first trimester, while if she becomes incompetent during the first trimester, she

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[31] Minn. Stat. § 145C.10 (g) (My emphasis – D.S.). For discussion on the new law in Minnesota see Barbara J. Blumer, "Minnesota's New Health Care Directive" (1998) 81 Minn. Med. 1, available at http://www.mnmed.org/publications/MnMed1998/September/blumer.cfm, last visited on 17 March, 2003.
[32] Ohio Rev. Ann. § 2133.01-.03 (Anderson Supp. 1992) at § 2133.06.

cannot ask to withdraw life-sustaining treatment, thus she is compelled to save her pre-viable fetus' life.

The Constitutionality of pregnancy clauses in the U.S.

Stranger than the fact that pregnancy clauses exist is the fact that they were not found to be unconstitutional by the U.S. jurisprudence. Two judicial opinions addressed the issue of constitutionality of the pregnancy clauses.

In *University Health Services v. Piazzi*,[33] the Supreme Court of Georgia implied that it would follow the pregnancy clause of Georgia, notwithstanding the objections of a patient's family. The court granted a hospital petition to continue life-support procedures on a brain-dead pregnant woman, *contrary to the request of the patient's husband and family*. The woman's wishes were *unknown*, and no living will was involved in this issue. The court held that according to the law of Georgia, the woman was dead and, therefore, had no protectable privacy interest. In addition, the court ruled that because the pregnancy clause of the Georgia legislation determined that the living will would be ineffective during pregnancy, the woman's wishes regarding it were irrelevant. This ruling has led commentators to assume that the court's reliance upon the living will statute indicates that it might reject claim that the pregnancy clause is unconstitutional.[34] The court, nevertheless, did not say it was unconstitutional.

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[33] No. CV86-RCCV-464 (Ga. Super. Ct. Aug.4, 1986), **cited in** Molly C. Dyke, "A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes (1990) 70 B.U.L.Rev. 867 at 871 **[Dyke]**.

The second case was *DiNino v. State*.[35] In *DiNino*, the plaintiff executed a living will, adding a sentence declaring the directive was her final expression of her "legal right to consent to termination of any pregnancy", and that contrary to the Washington Natural Death Act, it "still have full force and effect during the course of her pregnancy". DiNino and her physician sought a judgment declaring that her directive was valid, and that no physician would be liable for obeying it.[36]

The court held that the issue was not justifiable, since the plaintiff was neither pregnant nor terminally ill. The only issue that was in controversy was whether Ms. DiNino could draft a declaration that differed in its terms from that provided in the Natural Death Act. Nevertheless, the state was willing to concede that the form could differ, although it argued that the directive was written too broadly. Despite this view, the court did not declare the provision to be unconstitutional.

As I showed above, Canada did not stick to the American approach on pregnancy clauses, and did not make pregnancy an exception to the individual's right to control his or her care. The English law has apparently gone through the same direction. Moreover, it considered the American approach, and rejected it.

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[34] ***Ibid.***

[35] 102 Wash. 2d 237, 684 P.2d 1297 (1984).

[36] Interesting to note that in its argument, the state conceded that an individual can draft an advance directive that contains a properly worded abortion provision, or alternatively, delete the pregnancy provision of the model directive. Of course, this concession undermines the state's objective in enacting the pregnancy provision.

U.K

Advanced directives are valid in English law provided they are made freely, without undue influence, while competent, after receiving sufficient information and are intended to apply to the circumstances which subsequently arise. However, it seems that an enduring power of attorney would not have effect in the case of maternal brain-death, as the Enduring Power of Attorney Act 1985 does not empower attorneys to make health care decisions, and their power is limited to financial decisions only.[37]

If a pregnant woman temporarily lost capacity, an advance directive would be effective, only if it authorized or rejected medically indicated and available treatment and *specifically addressed the possibility of pregnancy*. In case of a doubt, scholars have argued that a directive refusing all or the recommended forms of medical treatment is unlikely to be respected, because the courts may assume that the woman had not addressed her mind to the circumstances which have arisen.[38] This also seems to be the case in Ireland. According to the literature, due to the constitutional well recognized

[37] 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. Nicola S. Peart, Alastair V. Campbell, Alex R. Manara, Shelley A. Renowden and Gordon M. Stirrat, "Maintaining A Pregnancy Following Loss of Capacity" (2000) 8 Med. L. Rev 275 at 277 [**Peart *et al.***].

[38] ***Ibid.*** at 279.

rights of the unborn, Courts in Ireland will tend to ignore the advance directive, and protect the life of the unborn child, unless there existed a grave, real and substantial risk to the life of the incompetent mother.[39]

However, this view does not reflect a requirement by legislation, nor does it have any support in the English case law. Moreover, the English Law Commission, in its Report on Mental Incapacity *disagreed* with the U.S. approach to suspend the effectiveness of living wills during pregnancies. It has recommended that women of childbearing capacity should address their minds to the possibility of a pregnancy if they wish to execute advance directives.[40] 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."[41]

In a supplement to its previous report, the College of Obstetrics and Gynecologysts 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 related in her advance directive to some forms of treatment,

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[39] Asim A. Sheikh & Denis A. Cusack, "Maternal Brain Death, Pregnancy and the Foetus: The Medico-Legal Implications" (2001) 7(2) M.L.J.I. 75 at 83.

[40] There are two typical situations of loss of capacity from a cerebral injury: patients in a pregnant vegetative state (PVS) and patients who are brain stem dead. 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, in Virginia, U.S, the diagnosis of PVS can be made after only one month of insentience.

[41] *Report of the Law Commission on Mental Incapacity* (London: H.M.S.O: 1995) at § 5.25.

but had no opportunity to discuss treatment during pregnancy, and 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."[42]

So far, I discussed the existing laws in Canada, U.S., and the U.K. As we do not have evidence that Canada considered the American approach and rejected it by *deliberately* avoiding from enacting 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

A. Balance of Interests

On the surface, it seems that pregnancy clauses 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.

Aside from the jurisprudential questions of balancing between *rights* of a *living person* to *interests* of an *abstract* called the state (or more problematic, the fetus itself), the same balance was resolved *differently* in cases of abortions and in cases of bodily interventions,

[42] Section 3.4.2 to the supplement. See http://www.rcog.org.uk, last visited on 5 January, 2003.

which were directly related to the pregnant woman's physical condition, such as cesarean sections and blood transfusion.

In addition, the same balance resulted in different outcomes *within the states themselves*. No unified approach or coherent solution has been offered by them. In some, the fetus is given full protection and the mother's interests are struck during all pregnancy. In others, a proof for the fetus' healthy development or viability is needed in order to restrain the mother. A balance on its own seems to be a weak justification for the outcomes of such a balance.

B. Implying the Woman's Wish to Bring Her Fetus to Term

One of the arguments that supports the constitutionality of the pregnant clauses in the living will legislation, is that in contrast to *Roe*, which dealt with a case of a healthy woman, who did not want to give birth and to care for the children which 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 aborted), and she would not have to care for it.[43]

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. But more importantly, what if the mother has explicitly written, like in the *DiNino* case, that she would want to withdraw life-sustaining treatment even in

[43] Gregory Gelfand, "Living Will Statutes: The First Decade" (1987) 1987 Wis. L. Rev 737 at 780 **[Gelfand]**.

case of pregnancy? Would one still claim that she wanted to bring the child to full term? Or she is not allowed to issue such a directive? If the latter is true, then, still, this argument does not explain why she can not choose to control her treatment in such a way.

C. A Matter of Privacy

Some have addressed the constitutionality of the pregnancy clauses as a matter of privacy.[44] 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 decision making power 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 pregnancy clauses or not. Besides the fact that this argument does not really provide an answer, but rather shifts our attention to privacy questions, even assuming that it is a matter of privacy, why does the "same privacy", which a pregnant woman enjoys, lead to another conclusion when the woman 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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[44] **Dyke**, *supra* note 33 at 873.

D. 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.[45] 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.[46] But more substantially, doctors, who follow their patient's wishes, which 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

[45] This argument especially applies when the fetus is viable. See, for example, in U.K,.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 willful 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".

[46] Nicola Perat *et al.* bring three arguments against criminal liability. First, the requisite of intent is lacking. The doctor does not intend to procure a miscarriage or destroy the life of a child capable of being born alive. The intention is to withdraw treatment from the woman *in accordance to 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 said to be caused not by the act of withdrawing treatment but by the preexisting condition from which the patient was suffering. Third, patients are entitled not only to decline 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.***, *supra* note 37 at 282.

withdrawing life-sustaining treatment from a patient were lawful, we would not have needed to ask it to be done through the mechanism of an advance directive. Advance directives are necessary to perform actions that were otherwise been unlawful.

Furthermore, the House of Lords in the case of *Anthony Bland* went further to state that, perhaps, the avoiding of a request to withdraw life-sustaining treatment is an unlawful act by itself. The court said:

> "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."[47]

Arguments Against Living Will Legislation

A. Self-control in Regards to 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. 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, at exactly the

[47] *Airedale N.H.S. Trust v. Bland*, [1993] A.C. 789 at 883.

point of time when those values are infinite. They directly contravene the woman's express wish for privacy and personal autonomy.[48]

B. An Argument for Equality

While discussing pregnancy clauses, Anne Lederman brings into consideration a case of a father to a newborn child, who is in a terminal or vegetative condition, supported by artificial means.[49] 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.

Lederman further 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

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[48] See also Janice MacAvoy-Smitzer, "Pregnancy Clauses in Living Will Statutes" (1987) 87 Colum. L. Rev. 1280.

[49] Anne D. Lederman, "A womb of My Own: A Moral Evaluation of Ohio's Treatment of Pregnant Patients with Living Wills" (1994) 45 Case W. Res. L. Rev 351 at 369-370 [**Lederman**]. See also Joan Mahoney, "Death With Dignity: Is There An Exception For Pregnant Women?" (1989) 57 UMKCLR 221 at 230-231 [**Mahoney**].

the "pregnancy clause", neither living will legislation nor court decisions[50] require a father, in such circumstances, to continue treatment, so that his body may be used for the child. The argument here is that state's interest in fetus' life 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 appropriation of the father's body.

Not only do pregnancy clauses discriminate on a *sexual basis* (between incompetent women and incompetent man), 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), an incompetent pregnant woman can not 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.

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[50] See, for example, *McFall v. Shimp* 10 Pa. D. & C. 3d 90 (Allegheny Cnty., July 26, 1978). In this case, 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. *Ibid.* at 91.

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, if coming from a pregnant incompetent woman, would not be valid. Therefore, pregnancy clauses deny women the equal right of choice to act as equal participants either between men and women or among women themselves.[51]

C. Trivializing the Mother's Choice

The mother's decision not to be maintained on artificial life-support requires her to confront her own mortality, perhaps the most frightening and perplexing concept an individual must face. According to this argument, the gravity of such a consideration makes it unlikely that she makes the choice lightly. Pregnancy clauses trivialize the significance of the mother's self-defining and conscientious choice by automatically overriding it.[52] The mother may have been fully aware of her pregnancy, but have failed to specifically consider it in her living will, or she may have been unaware of her pregnancy before she became incompetent, but has been giving much thought to her decision to withdraw life-sustaining treatment. In either of these cases, due to the importance of the woman's decision, that is reflected in issuing an advance directive, good moral reasons should support an implementation of her living will even when pregnant.

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[51] For a feminist critique, which relates to the argument for equality, see the excellent piece of Katherine A. Taylor, "Compelling Pregnancy at Death's door" (1997) 7 Colum. J. Gender & L. 85. See also Karen H. Rothenberg, "Feminism, Law and Bioethics" (1996) 6 (1) Kennedy Inst. Of Ethics J. 69, at 76-77.

[52] **Lederman,** *supra* note 49 at 370-371.

D. Protecting the Pre-Viable Fetus

Contrary to abortion-law where the viability criterion serves as a justification for the state's intervention over the pregnant woman's decisions regarding her pregnancy, criticism arouse as to the fact that pregnancy legislation does not draw the line at viability. Under the *Roe* decision, until the point of viability there is no state interest that can overcome the interest of the pregnant woman to exercise her common-law and constitutional rights to privacy and bodily integrity. Nevertheless, 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 those in the later stages, for whom abortion might be prohibited under state law. Thus, the incompetent pregnant mother's interests are given less weight than in the abortion situation, without any legal justification.[53]

E. 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, rather than her own fear of suffering or experience whatsoever, when her living will became operative. Under this argument, it is possible that she believed that futile life-sustaining care would devastate her family's financial and emotional resources, preventing them from caring for themselves and for each other. Therefore, the mandate to disregard the pregnant patient's directives ignores the cost of whatever harms the woman feared would come to pass to her family.

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[53] **Mahoney**, *supra* note 49 at 225.

Pregnancy clauses in living will legislation ignore not only the woman's wishes with respect to herself but also with respect to her family.

F. Involuntary Servitude

The Thirteenth Amendment to the U.S. 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."[54]

In Canada, the Charter 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 to the Charter.[55]

Timothy Burch argues that pregnancy clauses reduce incompetent pregnant women to a state of slavery and involuntary servitude. 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."[56]

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[54] U.S. Const. amend. XIII, §. 1.
[55] *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 s. 7.
[56] Timothy J. Burch, "Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes" (1995) 54 Md. L. Rev. 528 at 555 [**Burch**].

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 the imposing of such a futile treatment, certainly for the dead mother, and in many cases, also for her fetus.

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 ninety* percent of them said it was extremely important for them to be able to decide their treatment. *Over ninety* percent 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 ninety* percent said they would.[57]

What do these big numbers from Molly's survey teach us? They surely serve as an indication of the importance of living wills regardless 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

[57] William Molloy, *Vital Choices: Life, Death and the Health Care Crisis* (Toronto: Penguin Books Canada Ltd., 1993) 218.

times of crisis. By this, not only do they honor the patient's wishes, but they respect the patient's family as well. In addition, they provide sense of security to physicians, enabling them to fulfill the patient's wishes without being threatened by lawsuit or prosecution.

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

Pregnancy clauses, which exist under the American law, should not be a model for the Canadian law. Not only do they infringe on a woman's right to refuse medical treatment just because she is pregnant, hence, discriminate them from other non-pregnant women on the basis of their pregnancy, but they also discriminate them on a sexual 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 (almost) an involuntary servitude. The woman's wished are automatically ignored just because she is pregnant.

It is important to note that the original intent of living will statutes was to permit the "natural death" of persons who would otherwise linger for years maintained by modern machinery in a vegetative but "alive" state.[58] Pregnancy clauses totally disregard the wishes of the woman and her loved ones. Such legislation compels doctors and hospitals to force intensive and intrusive treatment upon a woman, inflicting precisely the sort of indignity upon the patient and anguish upon the family and friends, that "Do Not Resuscitate" orders and living wills are meant to protect us against.

Thus, Canada should follow the British view of rejecting the American approach on pregnancy clauses in advance directive legislation. What should be the proper way to deal with incompetency in pregnant woman, who issued 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.[59] However, this suggestion ignores the woman's wishes, for which she issued an advance directive. Moreover, it is not clear from his proposal what the mechanism is for 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.[60] In his proposal on the "pregnancy clause", Gelfand discusses the principles that should lead the legislature.

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[58] **Gelfand**, *supra* note 43 at 742.
[59] **Burch**, *supra* note 56 at 565.
[60] **Gelfand**, *supra* note 43 at 802-821.

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 favor of the patient, *even if the fetus is beyond the second trimester*. Because of the conflicting interests involved, Gelfand suggests to call upon the court at this stage to make any further decision.[61]

I find this model troubling. The standpoint of this suggestion is the woman's ability to feel pain. I find it odd that a terminally ill patient, who no doubt, feels pain but is, for example, two weeks from pregnancy can decide to withdraw life-sustaining treatment, whereas an incompetent mother, who, for instance, has just entered to her second trimester, can not ask for it. Why not respect the woman's prior decisions, if one can infer from them the woman's inclinations regarding life-sustaining treatment in case of incompetency, which would occur at pregnancy? This brings me to my preferred suggestion.

Pregnant women and the proxies they appointed who make decisions about their care should have *full information* and an opportunity to make decisions about continuing a pregnancy under circumstances, in which the pregnant woman faces health problems. This could be done by forms for living wills,[62] as well as educational and explanatory material developed for patients from the beginning of pregnancy and doctors, that would

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[61] ***Ibid.*** at 816-817.

[62] For such a suggestion see A. J. Weisbrad, "A Model Integrated Advance Directive for Health Care" (1995) 4 Bioethics Bull 2.

include the kinds of medical care issues in which pregnant women may choose to give special instructions. If necessary, statutes should also require that women clearly state in their prior directive what is to occur, if they become incompetent while pregnant. If a competent woman does so, then her wishes must be effectuated at pregnancy with no exceptions, as in other situations of incompetency.

Until this mission is fulfilled, I would suggest upholding the living will of a woman even at pregnancy, especially in the first and second trimester of gestation, where the state cannot claim to have any interest in potential life. If the woman, who issued the advance directive, becomes incompetent on her third trimester, I would suggest to consult her family and friends and to try to learn from them about *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.

As I showed in my analysis on abortions and bodily interventions, the Canadian approach seems to place more emphasis on the woman's wishes and tends to give less weight to considerations about the fetus' 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 perceived under the Canadian law. My recommendation is consistent with this interpretation.

The discussion on pregnancy clauses in Canada can also sheds light on the ethical dilemma of a brain-dead pregnant woman. Many of the arguments against pregnancy clauses can apply here. Disrespect for the woman, and the woman's right to determine what will happen to her body, and what care she will have when incompetent, are the obvious ones that suit here. But also the argument for equality is appropriate. A brain-dead woman, who is given a futile treatment only for the sake of her fetus, is discriminated because of her pregnancy, her sex, and her brain-death. Metaphorically, or not, treating a brain-dead woman in such a way could be seen as positing her in a situation of "involuntary servitude".

More important than the arguments themselves to the analysis of maternal brain-death is Canada's resistance to the American trend of invalidating a living will of a pregnant woman. Though compared to the U.K. it is a passive resistance, as it lacks explicit discussion about it, Canada's resistance to pregnancy clauses is *de facto* very active. One cannot find even a single clue for accepting the invalidation of advance directives at pregnancy through all the existing legislation. It is helpful to keep that in mind for the discussion in the next chapter, where I analyze the case of a brain-dead pregnant woman from a different angle, *i.e.* that of a dead person.

CHAPTER 4: HUMAN TISSUE GIFT LAW

So far, I considered the case of a brain-dead pregnant woman as a type of a pregnancy case. I looked at it through the lens of discussions surrounding abortion, bodily interventions in pregnant women and the specific advance directive legislation as it relates to pregnant incompetent women. In this chapter, I will focus on the death component. I will question whether the dilemma of maintaining a brain-dead pregnant woman on life-support for the sake of her fetus could be resolved by the law that governs other kinds of medical procedures which are performed on the newly-dead persons, especially procedures undertaken for altruistic reasons. One such procedure is maintaining the "newly-dead" on life-support for the extraction of organs, which are aimed for transplantation. I will refer to this process as a Post-Mortem gift.

Cadavers of organ donors are commonly ventilated after death if the organs cannot be removed immediately. Human tissue gift Acts are the legal mechanism designed to regulate the use of cadavers for therapeutic purposes, medical education or scientific research and to determine the conditions under which they can be used.[1] The transfer of human tissue is considered a gift, not a sale. Commercial exchanges of human tissues are invalid in most jurisdictions as they are considered contrary to public policy.

The Regulation of Post-Mortem Gifts

Canada

Human Tissue Gift Acts widely exists in Canada.[2] In Alberta, Ontario, British Columbia and most of the other provinces, any adult person can consent in writing at any time, or

[1] This legislation also deals with "*inter-vivos*" gifts for transplants, that is the extraction of organs from living persons as well. I will not discuss this part, in my thesis.
[2] See for Alberta, *Human Tissue Gift Act*, R.S.A. 2000, c. H-15; for British Columbia, *Human Tissue Gift Act*, R.S.B.C. 1996, c. 211; for Ontario, *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H. 20; for Manitoba, *Human Tissue Gift Act*, S.M. 1987-8, c. 39; for New Brunswick, *Human Tissue Act*, S.N.B. 1986

orally, in the presence of at least two witnesses during his last illness, "that his body or the part or parts of it specified in the consent be used after his death for therapeutic purposes, medical education or scientific research."[3]

When a person has not given a consent under the circumstances above, or in the opinion of a physician is incapable of giving a consent by reason of injury or disease and his death is imminent, the statute in Alberta authorizes the spouse of the patient, her adult children, adult siblings, adult next of kin, or, finally, the person lawfully in possession of the body to consent on behalf of her for the same purposes.[4] In any case, consent cannot be given if there is reason to believe that the deceased would have objected.

Interesting to our case is the different ways in which the law defines "human tissue" under this legislation. In most of the provinces and territories of Canada the term "tissue" includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue, that is replaceable by natural processes of repair. However, in Ontario, Manitoba and Prince Edwards Island "tissue" means a part of a living or dead human body and includes an organ but, "unless otherwise prescribed by the Lieutenant Governor in Council, does not include bone marrow, spermatozoa, an ovum, an embryo, *a foetus*, blood or blood constituents."

In Quebec, there is no special statute under this model of tissue gift acts. Article 11 to the Civil Code of Quebec provides the general principle of consent. It requests consent for "care of any nature".[5] Article 19 to the code is more specific. It deals with "alienation of

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c. H-12; for Prince Edwards Island, *Human Tissue Donation Act*, R.S.P.E.I. 1988, c. H-12.1; for Yukon, *Human Tissue Gift Act*, R.S.Y. 1986, c. 89; for Nova Scotia, *Human Tissue Gift Act*, R.S.N.S. 1989, c. 215; for Saskatchewan, *Human Tissue Act*, R.S.S. 1978, c. H-15; for Nunavut, *Human Tissue Act*, R.S.N. 1990, c. H-15; for Northwest Territories, *Human Tissue Act*, R.N.W.T. 1988, c. H-6.

[3] See, for example, *Human Tissue Gift Act*, R.S.A. 2000, c. H-15, s. 4(1).

[4] ***Ibid***. s. 5(1). The Ontario statute adds the same-sex partner to the list of the people who can make decisions on behalf of the deceased

[5] *Civil Code of Quebec*, S.Q., 1991 c. 64.

the body", but applies to *inter-vivos* gifts. In a strange way, the code does not cover the issue of post-mortem gifts, that is the donations of organs from the dead. Article 11 also asks that "the risk incurred is not disproportionate to the benefit that may reasonably be anticipated". The Quebec law does not use the term human tissue, rather it requires that the body part would be capable of regeneration.

U.S.

The provincial model of "gift acts" that deal with disposing the body and its parts after death is not unique to the Canadian legal system. In the US, the Uniform Anatomical Gift Act expressly grants the right to the next-of-kin to control disposal of the body,[6] in conformity with the Common law. This "model" of statute, or one very similar to it, has been adopted by most of the states in US. It includes provisions that govern how individuals can give their bodies to medical schools/hospitals for various purposes, and also has provisions that allow family members to make those decisions.

U.K.

In the U.K., section 1(1) of the Human Tissue Act provides that if any person either in writing or orally, in the presence of at least two witnesses, has expressed a request that his body be used after his death for therapeutic purposes or for purposes of medical education or research, the person "lawfully in possession of his body"[7] may, unless he has reason to believe that the request was subsequently withdrawn, authorize the removal from the body of any part, in accordance with the request.[8]

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[6] *Uniform Anatomical Gift Act,* U.L.A. 40 1987, s. 3.
[7] There is some uncertainty as to who this person is. Such a person could be the executor nominated in a will, a close family member or the person in charge of the hospital where her body is lying. But there could be other persons that can fit to this description.
[8] *Human Tissue Act* 1961 (U.K.), 1961, c. 54 s. 1-4.

The law also provides that the person "lawfully in possession of the body" may authorize the removal of any part from the body for use for the said purposes if, he has no reason to believe that the deceased had expressed an objection to this, or that the surviving spouse or any surviving relative of the deceased objects to the body being so dealt with.

Some commentators have argued that maintaining the brain-dead pregnant woman on life support for the sake of her fetus can be considered as another form of post-mortem gift. Erich Loewy, for example, claimed that maintaining the dead woman for short period of time is just another way "of valuing the living more than the dead, reality more than its symbol."[9] In his view, it honors the memory of the deceased, supports their symbolic ongoing membership in the just community and affirms our ongoing concern for the living. I will turn to discuss the various proposals in the literature to apply post-mortem gift law to the case of a brain-dead pregnant woman.

Applying Post-Mortem Gift Laws to Brain-Dead Pregnant Women

Suggestions

In a very controversial article, Jay Kantor and Iffath Abbasi Hoskins argue that we should adopt a model that regards brain-dead pregnant women as cadaver-organ donors.[10] In both cases, "treatment" is provided for the sake of another person, prolongation of somatic functions may continue for some time, and consent requirements are less strict than those required for procedures performed on a living person. Kantor and Hoskins claim that like in the organ-donor model, where "the family may have future legal responsibilities to the

[9] Erich H. Loewy, "The Pregnant Brain Dead and the Fetus: Must We Always Try to Wrest Life from Death?" (1987) 157 (5) Am. J. Obstet Gynecol 1097 at 1099.
[10] Jay E. Kantor & Iffath Abbasi Hoskins, "Brain Death in Pregnant Women" (1993) 4 J. Clinc. Ethics 308.

recipient, which would be absent when donation is done",[11] the family of the pregnant woman will usually have close emotional ties to both the donor and the recipient.

Thus, the authors argue that if it is impossible to obtain direct evidence of the deceased's wishes, health care providers should search for "a weak" substituted judgment about the woman's values that could lead to an inference about her wishes for the fetus. When in doubt, pregnancy should continue until a reasonable effort has been made to determine the woman's wishes.

Nicola Peart and colleagues claim that maintaining the woman's bodily functions until her fetus can be born is a therapeutic purpose.[12] If the woman expressed the wish to have her bodily functions maintained until the birth of her fetus, Peart *et al.* suggest treating such a directive as a request under the Human Tissue Act 1961.[13] They argue that a pregnant woman's directive, which complies with the formalities of this Act, could be seen as a request that her body be used after her death as an incubator for her fetus.

Nevertheless, Peart *et al.* claim that there is no obligation to comply with the dead woman's request, so that even if an advance directive could be treated under the Human Tissue Act it would have very limited effect. Its only legal effect, they explain, would be that the person "lawfully in possession of her body" would not be required to consult with surviving relatives which that person is obliged to do absent a request from the deceased.

Finally, Robert Veatch suggests that if a woman signed an organ donation card and died while pregnant, it would be ethically permissible to sustain the pregnancy even over the

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[11] ***Ibid.*** at 312.
[12] Peart *et al.* claim that maintaining a brain-dead pregnant woman on life-support is neither the woman's best interests nor against her best interests. Thus, it is "therapeutic" because the woman has no real interests. See Nicola S. Peart, Alastair V. Campbell, Alex R. Manara, Shelley A. Renowden and Gordon M. Stirrat, "Maintaining A Pregnancy Following Loss of Capacity" (2000) 8 Med. L. Rev 275 at 290, 295.
[13] ***Ibid.*** at 283.

objections of her family.[14] It seems that in Veatch's view, maintaining the mother on life-support is permissible only with indirect (but conceptually related) evidence that the woman asked to donate her body, or part of it, for the sake of others in need.

Discussion

I find the organ donor model inapplicable to the case of a brain-dead pregnant woman. From a strict legal point of view, it is important to emphasize that the Human Tissue gift Act does not provide for the maintenance and treatment of corpses *prior* to the removal of parts for therapeutic purposes. Another problem that can raise here is that, according to the Human Tissue Gift Act a person may request that his or her whole body or tissue be used after death. From the language of the act it seems that a person cannot request that his or her whole body be used after death when the consent is solely given for the use of a tissue. Thus, a woman may not request that her *entire* body be used, while only *a part of her body* (the fetus) is asked to be removed.

It is also not clear what is the "gift", and who is the "recipient" of it. Assuming that the "gift" is the fetus, the result of the "donation" seems to be odd: the recipient (fetus) is the gift in itself. Moreover, the fetus, as a potential life, can not be considered a "Human Tissue"; neither because of its moral stance, nor as it is not "replaceable by natural process of repair". Finally, as I described above, in some statutes, the fetus was explicitly excluded from post-mortem gift statutes. This is the case of Ontario, Prince Edwards Island and Manitoba's post-mortem gift statutes.[15]

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[14] Robert Veatch, "Maternal Brain-Death: An Ethicist's Thoughts" (1982) 248 (9) JAMA 1102.
[15] ***Supra*** note 2.

But regardless of the legal difficulties of this argument, the rationale for it seems also flawed. Applying this model to the case of a dead pregnant woman treats the mother and the fetus as two separate entities, a donor and a recipient, ignoring the unique symbiosis between them (or within the mother).[16] In organ donation, the relationship between the donor and the recipient is formed with the death of the donor. In our case it already exists. It is an inherent biological bond.

On the one hand, unlike a donor, who is only to be remembered as a distant 'other' by those related to the organ recipient, the mother will always be present as a wife, a daughter, a sister, and a friend of the future child and of the family members. On the other hand, the fetus cannot be compared to a recipient, whose moral status is of an already existing living being. Furthermore, the medical procedure is different in the two situations. Maintaining a cadaver for organ donation is for a much shorter time than maintaining a brain-dead pregnant woman on life support. On this basis, one cannot accept Peart *et al.*'s reasoning that the process of maintaining a dead woman on life support should be considered a "therapeutic purpose". As Richard Paige correctly argues, the term "therapeutic purposes" meant to permit ventilation of a corpse, usually for several days, until a recipient of organs is found.[17] One cannot really argue that this is the case with brain-dead pregnant woman.

I am not sure I fully understand what the future legal responsibilities are to the recipient, which Kantor and Hoskins mention. Even if such responsibilities exist, it is difficult to compare them to "close emotional ties" of the family of the pregnant woman to both the donor and the recipient.

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[16] Jacqeline J. Glover, "Incubators and Organ Donors" (1993) 4 (4) J. Clin. Ethics 342 at 344.
[17] Richard Paige, "Post-Mortem Pregnancies: A Legal Analysis" (2000) 9 (3) Dispatches 2 at 5 [**Paige**].

Moreover, in the case of maternal brain-death we are dealing with a shared genetic material, rather than a tissue. This "proposed gift" is closer to "a person" than a mere gamete, and is farther than being a "replaceable" tissue. Moreover, the idea of giving it as a gift, which implies a property or quasi-property right in it, seems far.[18] The American case of *Hecht v. Superior Court*[19]as well as the French case of *Parpalaix v. CECOS*[20] and of *Mme Claire G v. CECOS*[21] regarded gametes in a property or quasi-property terms. However, when dealt with the status of an embryo, the U.S. case of *Davis v. Davis*[22] concluded that embryos are not strictly speaking, either "persons" or "property", but occupy an interim category that entitles them to special respect because of their potential for human life.

Finally, from a practical reason, I cannot see how applying the organ donor model to pregnant women promotes the proposed procedure. Although this model seems to include wide discretion for the next of kin, since it requires a less strict consent standard, in organ donation, neither partners, nor indeed the intending donor, can insist either that an organ is removed or that it is used in a general or a specific way.[23] Thus, the partner of a deceased

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[18] More generally, see *Moore v. Regents of the University of California* 51 Cal. 3d 120 (1990). In this case, the plaintiff had his spleen removed as part of his treatment for a particular form of leukemia. On discovering that a cell line had been developed from this, which had the potential to generate a lot of money, Moore sued under a variety of headings. The Supreme Court of California held that there were no, or only very limited, property rights in any cells removed from the human body. The court dealt with the case by applying the principle of consent to medical treatment rather analyzing it from property-law perspective.

[19] 20 Cal. Rptr 2d 275 (Ct. Appeal, 2nd District, 1993). In this case, William Kane had committed suicide and left behind vials of his sperm. Kane has also left instructions that the sperm was for the use of his partner, Deborah Hecht. Kane's existing child from his first marriage sought to challenge Hecht's right to use the sperm. The Court of Appeals ruled that sperm can be bequeathed in a will and that Kane had the capacity to decide upon the use of his sperm.

[20] Tribunal de Grande Instance de Creteil (1 Ch. Cir) August 1, 1984. In this case, Alain Parpalaix stored his sperm before beginning treatment for testicular cancer. After his death, his widow asked for his sperm for insemination, a request, which was refused by the sperm bank, CECOS. This refusal was based on the assertion that sperm was an indivisible part of the body and could not be heritable property in the absence of specific instructions from the person with whom the bank had the contract. The tribunal court held that by depositing the sperm, Alain Paraplaix's intentions were clear, and awarded the sperm to his wife.

[21] Tribunal de Grande Instance de Toulouse (4 Ch. Cir) March 26, 1991. In this case, having learned from the experience of the *Parpalaix* case, the sperm bank told Michel G., who was also about to undergo treatment for testicular cancer, and wished to store his sperm, that their policy was that posthumous insemination was unacceptable. Michel's widow wanted to obtain the sperm, but it was held that the legitimate desire to have a child does not create an indefensible right to a child.

[22] 15 Family Law Reporter 1551 (1989); on appeal West Law 130807 (Tenn. App.) (1990).

[23] The wording "May" in the English law can also support such a reading. **Paige**, *supra* note 17.

woman or her other relatives would not truly benefit from this analogy, as there would be no right to require letting the mother die, or maintain her on life support.

Conclusion

In this chapter, I reviewed what I called the "post-mortem gift law", as found back in statutory provisions which provides the mechanism to permit the use of cadavers for therapeutic purposes, medical education or scientific research. After describing the Canadian, American and English legal frameworks on this issue, I brought three main proposals to apply the donor organ model to the case of a brain-dead pregnant woman.

Analyzing these proposals has brought me to conclude that due to difficulties in the language of the statutes and due to substantive differences in the rationales of both processes and their participants (donor/recipient/mother/fetus), the organ-donor model should not be applied to the case of a dead pregnant woman. As Hilde Nelson writes, it is one thing to have organs taken out of one's body before burial, and quite another to have that body subjected to unremitting intensive treatment for weeks and even months.[24]

A discussion of the post-mortem gift law indicates nevertheless the importance that the law attaches to the body of a deceased. If a deceased did not ask that his or her body be used for any of the purposes mentioned in law, no other person is entitled to ask for it, especially if there is a reason to believe that the deceased has been objected to it. Respecting the deceased wishes joins our interpretation of the Canadian abortion law and the law governing bodily interventions in pregnant women on the respect to the women's choices and right to self-determination. This is also something I noted when I discussed

[24] Hilde Lindemann Nelson, "The Architect and the Bee: Some Reflections On Postmortem Pregnancy" (1994) 8 (3) Bioethics 247 at 259.

the fact that Canada seems to avoid the enactment of pregnancy clauses, which would otherwise limit the pregnant woman's liberty. With these discussions in the background, I will consider in the next chapter the core issues that are raised in the context of the dilemma whether to maintain a brain-dead pregnant woman on life-support.

CHAPTER 5: MATERNAL BRAIN-DEATH - MAIN ISSUES

Up to this point, I approached the debate surrounding maintaining a brain-dead pregnant woman on life-support by looking at comparable *situations*, dealing with medical interventions in the woman's pregnancy or in the deceased's body. In this chapter, I will discuss the main *issues* raised by the situation of maternal brain-death. These will include the moral and legal status of the fetus, the interest/right of the fetus to be born, the gestational age of the fetus, pragmatic obstacles to maintaining a dead pregnant woman on life-support, rights/interests of brain-dead people, the legal requirement for consent, rights of next-of-kin and friends of the deceased, and the physician-patient relationship.

The Legal and Moral Status of the Fetus

> "Like the family, the fetus is a condensed symbol. The fetus simultaneously stands for the desire to regain traditional society, and for hostility to feminism and freer sexuality which threaten that world...Further, the desire to protect the fetus – itself thematized as amiraculous meeting of nature and God – is connected with the view that the world is changing in ominous and threatening ways, ways that even deny life itself the opportunity to come into being."[1]

Moral Status

What is the moral status of the fetus? The literature is divided in this question, ranging from arguing that the fetus has full moral status as persons who have been already born,

[1] Allen Hunter, "In the Wings: New Right Ideology and Organization" (1981) 15 Radical America 113 at 132.

to holding that fetuses have only a partial moral status (and therefore partial set of rights),[2] or even a more extreme view, *i.e.* of Peter Singer, which holds that moral status depends on capacity for moral agency, hence fetuses are similar to animals corresponding to their gestational stage. I will examine this question from two perspectives: The fetus as a human being and as a person.

A. Human-Being

Many are willing to concede that an individual life begins at fertilization, but not that there is a psychological human being at fertilization. The concept of humanity is a confusing one, as it can bear two distinct meanings. On the one hand, it can mean biological human life, that is a group of characteristics which set the human spices apart from non-human spices. On the other hand, "humanity" can be used to mean a way of life that is distinctively human, and characterized by psychological, rather than biological properties. These characteristics can consist of the ability to use symbols, to imagine, to love, and to engage in higher intellectual skills. In this regard, the fetus is human only under the first meaning.

B. Personhood

Another concept that is attached to the moral status question is whether the fetus is a person. The literature suggests a list of demanding criteria for being a person. The list consists of the requirement for self-consciousness, freedom to act and the capacity to engage in purposeful sequences of actions, having reasons for actions and the ability to

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[2] Tom L. Beauchamp & LeRoy Walters, *Contemporary Issues in Bioethics*, 5th ed. (Belmont, CA: Wadsworth Publishing Company, 1999) 191.

appreciate reasons for acting, ability to communicate with other persons using a language, capacity to make moral judgments, and rationality. There is a broad consensus that more than one of these criteria is necessary to qualify as a person.[3]

Applying these requirements to the fetus leads to the conclusion that the fetus is not a person. However, it also leads to the determination that brain-dead people are not persons, and should not necessarily be protected from an unwanted medical procedure.[4] I believe there is still a difference between these categories. Unlike a fetus, the deceased has held the status of personhood earlier in life, and classifying the dead as non-person would be stripping away a status that was previously recognized, rather than declining to bestow a new one.[5]

The law also views the fetus as non-person. *Under Roe v. Wade*, the word "person" as used in the Fourteenth Amendment does not include the "unborn". Since *Roe*, there have been many attempts in the U.S. to amend the constitution to grant fetuses the status of persons, to persuade Congress to declare fetuses persons without a constitutional amendment, and even to include fetuses in the Civil Rights Act of 1964. These efforts

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[3] See Mary Anne Warren, "On the Moral and Legal Status of Abortion" in Joel Feinberg ed., *The Problem of Abortion*, 2nd ed. (Belmont, CA: Wadsworth, 1984) 102. Warren claims that consciousness, reasoning, self-motivated activity, advanced communicative abilities, and the presence of self-concepts are at least jointly sufficient for being a person.

[4] Biologically, this can be true. If the brain is taken to be the "seat" of all thought process, governing, not only conscious but also emotions, aesthetic sensibilities, capacity for social interaction and spiritual awareness, then irreversible loss of brain function may constitute the death of a person. However, as Douglas Sharder argues, a human being is a composite of two intimately related but conceptually distinguishable components. A human being is a biological entity (homo sapiens) and a person. As persons, the argument goes, we may also be subject to different sorts of death. Thus, he sees brain death as the death of a person, and the cessation of heart beats the death of biological entity. Douglas Shrader, "On Dying More Than One Death" (1986) 16 (1) Hastings Center Report 12 at 13.

[5] See *infra* my discussion on the status of dead persons.

were all unsuccessful.[6] In our previous chapters, we saw that the Canadian courts were also reluctant to declare the fetus as a person.[7]

Legal status

At Common law, the fetus is not a person entitled to legal protection, although courts have consistently referred to the power of legislature specifically to address this issue.[8] When in conflict with its mother, the fetus has no independent right to protection, and the fetus' interests are usually protected under "the umbrella" of the state. The fetus and the pregnant woman are one entity, in fact as well as in law.[9] Though the fetus is protected by the criminal law,[10] and the civil law,[11] it has a peculiar status while it is *in utero*. The

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[6] James M. Jordan, "Parents, Children and the Courts, Note" (1988) 22 Ga. L. Rev. 1103 at 1123 (FN 73) **[Jordan]**.

[7] See also *R. v. Sullivan and Lemay*, [1991] 1 S.C.R. 489, where two midwives assisted in a home birth but were unable to complete the delivery due to the woman's complications. On the way to hospital, the baby was delivered but not alive. The Supreme Court of Canada ruled that the midwives could not be convicted for criminal negligence causing death to the baby, as it held that the term "person" in section 203 to the *Criminal Code* (now 220) does not include a fetus not yet born alive; In *Tremblay v. Daigle*, [1989] 2 S.C.R. 530, a man attempted to get an injunction to prevent a woman from terminating her pregnancy on the grounds that the fetus was a "human being" and had a "right to life" under section 1 to *Quebec Charter of Human Rights and Freedoms*. The injunction was denied by the Supreme Court of Canada because the fetus was not recognized as a juridical person in the Canadian law.

[8] Sanda Rodgers, "The Legal Regulation of Women's Reproductive Capacity in Canada" in J. Downie, T. Caulfield and C. Flood eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths: 2002) 342.

[9] Winnipeg Child and Family Services v. D.F.G., (1996) 138 D.L.R. (4th) 238 (Man. Q.B.), revd (1996), 138 D.L.R. (4th) 254 (C.A.), affd [1997] 3 S.C.R. 925 at 945 **[D.F.G.]**.

[10] Especially with the enactment of statutes, which give the fetus greater protection by recognizing the killing of a fetus as a crime *separate* from homicide. See, for example, in California, where the legislator went far beyond this protection of the fetus and defined murder as the "unlawful killing of a human being, *or a fetus*, with malice aforethought" Cal. Penal Code § 187 (West. Supp. 1986).

[11] Mainly through actions for prenatal injuries. For Examples in the area of succession and workman's compensation, where the fetus' interests seem to be protected prior to birth, see Nicola S. Peart, Alastair V. Campbell, Alex R. Manara, Shelley A. Renowden and Gordon M. Stirrat, "Maintaining A Pregnancy Following Loss of Capacity" (2000) 8 Med. L. Rev 275 at 293 **[Peart *et al.*]**; for a recognition of a duty of care owed to the fetus by an Australian court see *Watt v. Rama*, [1972] V.R. 353; See in U.K., the *Congenital Disabilities (Civil Liability) Act 1976*, c. 28 § 1(1) which confers on a person the right to sue those who caused him or her injury before its birth; For a detailed discussion on the legal protection of the fetus see Timothy Stoltzfus Jost, "Rights of Embryos and Foetus in Private Law" (2002) 50 Am. J. Com. Law 633.

fetus is regarded as a distinct organism living symbiotically with its mother.[12] Sometimes it is also referred to as an organism *sui generis*, which prior to birth lacks the full attributes of a legal person.[13]

The maternal-fetal relationship has been described as the "not-one-but-not-two" model.[14] This model puts emphasis on the shared needs and interdependence of the woman and her fetus, whose relationship is seen as characterized by connectedness, mutuality and reciprocity. This model of maternal-fetal relationship is the dominant one in Canada[15] and in the U.K.[16]

The dependency relations between the mother and her fetus are important not only for the fetus, but also for the mother. While sharing her infertility problems with Lora Brown, in the film "*The Hours*", Kitty sincerely admits: "You can never call yourself a woman till

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[12] **Peart et al.**, *Ibid.* at 287.

[13] This is the case in England: *Paton v. Trustees of The British Pregnancy Advisory Service and Another*, [1978] 2 All E. R. 987 at 989; *Re F (in utero)*, [1988] 2 All E.R. 193; In Israel, the *Capacity and Gurdianship Law 1962* states in section 1 that every *person* is in capacity of having rights and obligations birth till death. Nevertheless, section 33(a)(6) allows the nomination of a custodian to the fetus.

[14] For an elaborate discussion on this model and two other models, see John Seymour, *Childbirth and The Law* (N.Y: Oxford University Press, 2000) 191-202.

[15] **D.F.G.**, *supra* note 9 at 945; See also Melaine Randall, "Pregnant Embodiment and Women's Autonomy Rights in Law: An Analysis of the Language and Politics of Winnipeg Child and Family Services v. D.F.G." (1999) 62 Sask. L. Rev. 515.

[16] *A-G's Reference* (No. 3 of 1994), [1997] 3 All E. R. 936 *per* Lord Mustill at 943. In this case, the House of Lords described the maternal-fetal relationship as one with "an intimate bond", and that the mother and the fetus are two distinct organisms living *symbiotically,* not a single organism with two aspects. The court saw the fetus as a unique organism and, thus was reluctant to apply to such an organism the principles of a law evolved in relation to autonomous beings.

you're a mother". Being pregnant is what makes a woman to be a woman. It is related to her feeling of self-defining her sexuality and gender. As Ronald Dworkin writes:

> "Her fetus is not merely 'in her' as an inanimate object might be, or something alive but alien that has been transplanted into her body. It is 'of her and is hers more than anyone's' because it is, more than anyone else's, her creation and her responsibility; it is alive because *she* has made it come alive."[17]

As I showed earlier, a descriptive analysis of the law leads to the conclusion that the fetus has no legal rights. A normative analysis can lead to the same result. The notion of independent fetal rights is predicated on an idea of disembodied fetus, which somehow floats in an existence separate and apart from the woman's body, which provides the fetus sustenance.[18] This dualistic view, which posits a maternal-fetal conflict, not only assumes antagonistic rights between pregnant women and her fetus, but also lends itself to advocating a range of state policies and legal interventions (like the one in the *D.F.G.*

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[17] Ronald Dworkin, *Life's Dominion. An Argument About Abortion, Euthanasia and Individual Freedom* (N.Y:Vintage Books, 1993) 55 (My emphasis – D.S.).

[18] Iris Young puts it her nice words: "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". Iris M. Young, "Pregnant Embodiment: Subjectivity and Alienation" in Iris M. Young ed., *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory* (Bloomington: Indiana University Press, 1990) 160 at 167.

case) that are inherently adversarial in their approach to regulating the lives of pregnant women.[19]

Recognizing fetal rights strips women of their autonomous agency and privacy which are key elements for personhood. Women lose their right to effectively refuse even the most intrusive violations of their bodies, their ability to make non-coerced choices about every day life: eating, drinking, recreation, sexuality.

Even if the fetus does not have rights, he or she may still have interests. One suggestion that has been offered in the literature is to claim that a fetus has no autonomy-based interests, but only beneficence-based interests.[20] This is because the fetus lacks the capacity to generate its own values and beliefs, which, in turn, would generate autonomy-based obligations.

Alan Fleischman goes through this route. He proposes to abandon the "rights" discourse and instead to talk in utilitarian terms of interests.[21] In his view, the proper course of

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[19] Moreover, commentators have argued that when the state subordinates a pregnant woman's choice to the rights of her fetus, the state is viewing the woman and her fetus as two distinct entities with hostile interests. See Molly C. Dyke, "A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes (1990) 70 B.U.L.Rev. 867 at 886; See for example in *AG v. X., Per* Hederman J. at 442 where the Supreme Court of Ireland stated: "...one cannot consider the unborn life only as part of the maternal organism. The extinction of unborn life is not confined to the sphere of private life of the mother or family because the unborn life is an autonomous human being protected by the Constitution", **mentioned in** Asim A. Sheikh & Denis A. Cusack, "Maternal Brain Death, Pregnancy and the Foetus: The Medico-Legal Implications" (2001) 7(2) M.L.J.I. 75 at 79 **[Sheikh & Cusack]**.

[20] Frank A. Chervenak & Laurence B. McCullough, "Clinical Management of Brain Death During Pregnancy" (1993) 4 (4) J. Clin. Ethics 349 at 349; The Civil Code of Louisiana proclaims that " Natural personality commences from the moment of live birth". La. Civ. Code. Ann. Tit. 1 § 25.

[21] Alan R. Fleischman, "The Fetus Is a Patient" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press, 1989) 249 at 254.

action is the one that maximizes good consequences, reached by an analysis in terms of risks and benefits of treatment for the parties concerned, third parties and society in general.

However, as Fleischman points out himself, the flaw of such an approach lies in the difficulty to predict outcomes that derives from the fact that diagnostic and therapeutic procedures applied to the fetus involve significant uncertainty and clear risks to both the fetus and the woman.

Assuming that such an approach is feasible, I prefer to focus my analysis in a more concrete way. In my next section, I will examine one such beneficence-based interest/right, that is the interest/right to be born, and more generally, the interest/right to life.

Interest/Right to Be Born

If the fetus has right or interest to life, doctors might have a duty to maintain the dead woman's bodily functions for the sake of the fetus.[22] What is the scope of the interest in protecting potential life? Is there a right to be born?

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[22] **Peart *et al.***, *supra* note 11 at 293. This would limit the right of the person responsible for burying the mother, commonly the next of kin, as the latter would not be entitled to possession of the body until the child is delivered (or died *in utero*). Another way to protect the fetus would be to claim that the fetus has an interest to be born healthy. Such an argument is brought by John Robertson. This is an uncommon argument and I will not discuss it here. It is important to mention that when defined as an interest to be born healthy rather than as a right to life, the first has a weaker moral weight than the latter, and this is also acknowledged by Robertson himself, who asserts that this interest does not automatically override of its mother's interests. John Robertson, "Reconciling Offspring and Maternal Interests During Pregnancy" in

Section 7 to the Canadian Charter of Rights and Freedoms states that: "Everyone has the right to life".[23] In other section of the Charter, the subject of the rights is termed "individual", "person", or "citizen".[24] From a linguistic perspective, interpreting the term "everyone" to also include the fetus can be bearable. However, when given the opportunity to broaden the right to life to fetuses, Canadian courts did not go in this direction, and no direct application of this section to the fetus has been made.

As I indicated above, the American courts also refused to include the fetus under the term "person" of the Constitution, thereby preventing the fetus independent protection of legal rights.[25] The same applies to Europe. While already-born persons have an absolute right to live under article 2(1) of the European Convention of Human Rights 1950, the European Commission has held that a fetus may not have a right to life, but if it does, that right must be limited at the very least by its mother's right to life.[26]

Indeed, the core element of the right to life is in the claim not to be killed *unjustly*.[27] Letting the mother (continue) dying is not unjustly killing the fetus. The death of the

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Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press, 1989) 259 at 261.

[23] *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being schedule B to the Canada Act 1982 (U.K.), 1982, c. 11 s. 7.

[24] The same wording applies at the French version of the Charter. While the subject of the right to life is termed "chacun", the Charter bears other subjects as well such as "citoyen" and "personne".

[25] *Supra* note 6 and accompanying text.

[26] *Paton v. UK*, (1980) 3 E.H.R.R. 408 at 415.

[27] Judith Jarvis Thomson, "A Defense of Abortion" in Tom L. Beauchamp & LeRoy Walters eds., *Contemporary Issues in Bioethics*, 5th ed. (Belmont, C.A: Wadsworth Publishing Company: 1999) 202 at 206 [**Thomson**].

fetus' mother ceased the potential life of a fetus. The decision not to maintain the dead woman on life-support does not directly violate the fetus' right to life.

An alternative claim would be that even if the fetus has right to life, this right is liberty (or negative) right, that is a right to be free from pressure, duress or control – not a right to require action such as maintaining the mother on life support.[28] Judith Jarvis Thomson argues that having a right to life does not guarantee having either a right to be given the use of or a right to be allowed continued use of another person's body – even if one needs it for life itself.[29]

I would like to support this argument by joining the distinction the court made between negative and positive rights in the *L. and H.* case.[30] In this case, the patient, a three-month-old child, suffered from the shaken baby syndrome which resulted in a permanent vegetative state. The Child and Family Services of Manitoba joined the recommendation of the child's physician for a DNR order. The patient's parents refused this recommendation and the agency went to court to seek an approval for the order.

The agency won, and on appeal, the High Court made a distinction between two kinds of rights. The first is the "negative" right to refuse treatment; *i.e.* that patients are empowered to say to their physician not to interfere with their body without consent. The

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[28] See Sheila A.M. McLean, "Creating Postmortem Pregnancies: A U.K. Perspective" (1999) 6 Jur. Rev 323 **[McLean]**.
[29] **Thomson**, *supra* note 27.
[30] *Child and Family Services of Manitoba v. L. and H.*, (1997), 123 Man. R. (2d) 135 (C.A.)

second is the "positive" right to demand medical treatment, which is less recognized by law, and only in situations related to public health and safety.

Applying this distinction to our case would make a dramatic difference between the argument of not killing intentionally the fetus and imposing a massive life-support "treatment", which is not in the interest of the *patient* (the mother), for the potential life of the fetus.

Even if the fetus does not have a right to life, he or she may still have a right to be born. Morally, such a right carries less weight than the right to life. But more importantly, it assumes that the child to be born will have life full of equality. However, as D. Gareth Jones argues:

> "Although the benefit to the fetus may initially appear substantial (its life may be saved, when without intervention it would die) the fact that it will most probably be born prematurely (with the attendant risk of health impairment and disability), and may subsequently require repeated and prolonged medical treatment leads one to question whether there is in fact a clear benefit to the fetus and subsequent child".[31]

It seems that in our case the right to be born should be balanced with the outcomes of this birth. This leads us to my next examination on the gestational age of the fetus.

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[31] D. Gareth Jones, *Speaking For The Dead: Cadavers in Biology and Medicine* (Aldershot, UK: Dartmouth Publishing Company Ltd.: 2000) 98 [**Jones**].

The Gestational Age of the Fetus

Children born from postmortem pregnancies will be premature – sometimes quite severely premature – and so are at risk for serious ailments, ranging from brain damage to lung disorders. One can argue that even if there is a duty to maintain bodily functions for the sake of the fetus, it still depends on the stage of the fetus' development, when maternal brain-death occurs, and on the clinical prognosis for the fetus.[32] It is expected that the more mature the fetus is at that time, the greater its chances are of surviving unharmed until birth.[33]

Of course, having decisions related to the potential well being of the fetus is in itself debatable, as it is not clear whether a reduction in "quality of life", produced by physical and mental handicaps, is an appropriate consideration for the decision to terminate pregnancy. Moreover, the following questions rise in this context: Is there enough scientific knowledge to establish the chances of survival? Are the courts equipped to assess an expert testimony on such medical knowledge? In the *Piazzi* case, the court was

[32] However, sometimes it is difficult to assess a clinical prognosis to the fetus, or such an assessment could take days to weeks, while in the meantime, the dead woman has to be maintained "alive". Lyndon M. Hill, Daniel Parker and Brian P. Oneill, "Management of Maternal Vegetative State During Pregnancy" (1985) 60 Mayo Clin Proc 469.

[33] But see Deborah M. Feldman & Adam F. Borgida & John F. Rodis & Winston A. Campbell, "Irreversible Maternal Brain Injury During Pregnancy: A Case Report and Review of The Literature" (2000) 55(11) Obstet Gynecol Surv 708. In this report, the authors claim that successful outcomes can occur even when the brain injury of the mother occurs *much earlier* than twenty-four weeks of gestation.

convinced by the experts' evidence that the fetus has high chances of survival. The fetus survived only for two days.[34]

Pragmatic Obstacles to Maintain Brain-Dead Pregnant Patients

When on life-support, brain-stem dead patients tend to run into a host of medical problems. They often develop cardiac asystole (cessation of the heartbeat) within seven days, despite continued full cardio-respiratory support.[35] Many suffer from hypotension, loss of central autoregulation[36], pituitary insufficiency, glucose intolerance, thermovariability, infectious complications resulting from prolonged assisted mechanical ventilation, and chronic bladder instrumentation.[37]

[34] University Health Services, Inc. v, Piazzi No. CV86-RCCV-464 Superior Court of Richmond Country, Georgia, August 4 1986 [**Piazzi**].
[35] **Peart et al.**, *supra* note 11 at 294.
[36] A. Vives, F. Carmona, E. Zabala, C. Fernandez, V. Cararach and X. Iglesias, "Maternal Brain Death During Pregnancy" (1996) 52 Int. J. Gynecol & Obstet 67 at 69.
[37] I. M. Bernstein, M. Watson, G. M. Simmons, P. M. Catalano, G. Davis and R. Collins, "Maternal Brain Death During Pregnancy and Prolonged Fetal Survival" (1989) 74 Obstet. Gynecol. 434 at 436; Esther Santos, "Sheila's Death Created Many Rings of Life" 93 Nursing 44 at 46; Jay E. Kantor & Iffath Abbasi Hoskins, "Brain Death in Pregnant Women" (1993) 4 J. Clinc. Ethics 308 at 308-9.

In addition, intensive medical care is necessary to ensure that the fetus' needs are met,[38] and, accordingly, considerable effort and resources must be made.[39] An argument can be made that a just society cannot and should not afford to direct thousands of dollars per day, for an indefinite number of weeks or months - and in Vegetative Permanent state patients for years - on the care of one individual under conditions of moderately scarce medical resources.

Insistence on continuation of pregnancy also has been reported to bring emotional trauma and invasive publicity to families.[40] Not only must families and friends go through the premature death of the woman herself, but one can suggest that they are also subjected to the genuinely horrifying knowledge that her body is being appropriated by strangers against her explicit wishes, used as an object in their symbolic warfare. This emotional

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[38] See James J. Finnerty, Christian A. Chisholm, Helen Chapple, Ivan S. Login and Joan V. Pinkerton, "Cerebral Arteriovenous Malformation in Pregnancy: Presentation and Neurologic, Obstetric, and Ethical Significance" (1999) 181(2) Am J Obstet Gynecol 296 at 298 [**Finnerty *et al.***]. The authors explain: "Cessation of spontaneous respiration (part of the definition of brain death) requires ventilatory support. Maternal blood pressure must be supported to avoid decreasing uteroplacental flow. Panhypopituitarism may develop with diabetes insipidus and adrenal insufficiency. Loss of hypothalamic thermoregulation may lead to either hypothermia or hyperthermia. Nutrition support, including parenteral nutrition, is important for fetal growth. Last, strict infection control precautions are necessary because sepsis develops more easily".

[39] The cost of maintaining a brain-dead pregnant woman over an extended period to produce a child is estimated to cost half a million US dollars or more. – **Finnerty *et al***, *Ibid.* at 300; Maintaining Donna Piazzi cost at least 1, 200$ (U.S.) per day, and keeping her baby in the neonatal unit was 1,200$-3,800$ (U.S.) a day. **Jordan**, *supra* note 6 at 1110 (FN 25); See Jeffery Spike, "Brain Death, Pregnancy, and Posthumous Motherhood" (1999) 10 (1) J. Clin. Ethics 57 at 60. Spike estimates the cost to be at least 2000$ (U.S.) a day; See also Hilde L. Nelson, "The Architect and the Bee: Some Reflections On Postmortem Pregnancy" (1994) 8 (3) Bioethics 247 at 251 [**Hilde**]. Nelson mentions that the cost of maintaining a postmoertem pregnancy is 3,200$ (U.S.) per day; For a possible solution to the high cost, see the Pennsylvania law, which implicitly acknowledges its "taking" of the incompetent pregnant woman's body by providing "just compensation" in the form of payment for the expenses associated with continued medical care: 20 Pa. Cons. Stat. § 5414 (c)(1) (Supp. 1999).

[40] Janet Gallagher, "Fetus As Patient" in Sherrill Cohen and Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press: 1989) 185 at 194 [**Gallagher**].

stress also applies to critical care nurses. In the chapter on feminist analysis (no. 6) I have brought direct examples to such a distressful experience.[41]

Finally, mishandling dead or abuse of dead bodies can be punishable by criminal penalties and by tort liability for "outrage" or reckless infliction of emotional distress.[42] Caution from possible legal responsibility can also serve as a pragmatic obstacle to health-care providers for the maintenance of the dead woman on life-support.[43]

Rights/Interests of the Brain-Dead Person

A. Legal analysis

One of the claims, which support the maintenance of a brain-dead pregnant patient on life-sustaining treatment, is that the patient is already dead.[44] If the woman is dead, the

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[41] See *infra* in my sixth chapter.

[42] **Gallagher,** *supra* note 40. See, for example, in the *Criminal Code*, R.S.C. 1985, c. C-46, s. 182. For a civil responsibility, see *Lacy v. Cooper Hospital: University Medical Center*, [1990] 745 F. Supp. 1029 (D.N.J.).

[43] Sometimes, the fear from future sanctions can result in an opposite response. As Dr. Walter Bishop advised physicians in an article he wrote on that subject: "Perform the procedure even without consent, because (a) even if you are sued, the likelihood of being found liable is slim and (b) the courts may well hold next that you may be sued, if you fail to perform the section, by the legal representative of the child (and that case maybe yours)". Walter G. Bishop, "Postmortem Cesarean Section: Discussion" (1978) 132 (2) Am. J. Obstet Gynecol 177 at 179.

[44] But see Mari Siegler & Daniel Wikler, "Brain Death and Live Birth" (1982) 248 (9) JAMA 1101 and Robert M. Veatch, "Maternal Brain Death: An Ethicist's Thoughts" (1982) 248 (9) JAMA 1102. The authors discuss the confusion, which rises in situations of maternal brain death and the difficulty in talking about the woman as dead while maintained on life support. Some authors suggest to solve such a confusion by calling the "newly dead", who is being maintained on life support, a patient in "a persistent brain death". See Jeffery Spike & Jane Greenlaw, "Ethics Consultation: Persistent Brain Death and Religion: Must a Person Believe in Death to Die?" (1995) J. L. Med. Ethics 23 (3) 290 at 292 [**Spike & Greenlaw**].

argument goes, she is not a person anymore.[45] Nor does she have interests or rights.[46] Questions of autonomy cease to have relevance.[47]

Indeed, brain death is recognized as legal death. *The Uniform Determination of Death Act* (hereinafter: UDDA), proposed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research follows the Harvard Medical School Ad Hoc Committee's recommendations in this matter[48] and provides a model for legislating the brain-cessation criterion as legal death.[49] This model was endorsed by the American Medical Association and the American Bar Association and has been adopted in various forms of legislation by forty-four states in the U.S. (including the District of Columbia). In Canada, the model was also approved to be legal by the Canadian Congress Committee on Brain Death,[50] the Canadian Medical Association and the Canadian Neurocritical Care Group.[51] Section 1 to the UDDA states that:

> "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead."[52]

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[45] **Peart et al.**, *supra* note 11 at 292.
[46] David R. Field., Elena A. Gates, Robert K. Creasy, Albert R. Jonsen and Russel K. Laros, "Maternal Brain Death During Pregnancy: Medical and Ethical Issues" (1988) 260 JAMA 816 at 821 [**Field**]; Norman Frost, "Case Study: The baby in the Body" (1994) 24 (1) Hastings Center Report 31. But see Stephen Wear & William P. Dillon and Richard V. Lee, "Maternal Brain Death During Pregnancy: Letter to the Editor" (1989) 261 (12) JAMA 1728 [**Wear**].
[47] **Peart et al.**, *supra* note 11 at 292. See also **Field**, *Ibid.*
[48] The Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. *A Definition of Irreversible Coma* (1968) 205 JAMA 337.
[49] *Uniform Brain Death Act,* Uniform Laws Ann. 12:63 (West 1493; West Suppl 1997) [**UDDA**].
[50] Canadian Congress Committee on Brain Death. *Death and Brain Death: A New Formulation for Canadian Medicine* (1988) 138 CMAJ 405.
[51] Marc-Andre Beaulieu, Shashikant Seshia, Jeanne Teitelbaum and Bryan Young, "Guidelines for the Diagnosis of Brain Death" (1999) 26 Can. J. Neurol. Sci. 64.
[52] **UDDA**, *Supra* note 49.

However, one can still argue that the UDDA does not set the brain-cessation criterion as the *only* method of assessing death. Rather brain-death is an *optional* criterion for determining legal death *within the discretion* of the patient's attending physician. The medical profession remains free to formulate acceptable medical practices and to utilize new medical biomedical knowledge, diagnostic tests and equipment. If this argument is sound, women diagnosable as brain dead can legally be treated as still alive because heart beat and respiration are artificially maintained.

The history of the UDDA may support such an argument. In the Bill of this act it was stated that death criteria should not prohibit "the use of other medically recognized criteria for determining death, as long as such a determination is made in accordance with accepted medical standards" (section 2).[53] The original version of the statute specifically asked for *at least* one of the criterion for the determination of death, and in the explanation of the bill it was emphasized that the bill provides that each criterion is not exclusive in determining death, "allowing for the exercise of medical discretion".[54]

Even if one does not accept the argument that a "breathing" brain-dead patient should be treated as a living person, the view that a brain-dead patient is deprived of rights or interests, which is referred to by *Finnerty et al.* as "the cadaveric model", is distressing. Such an approach goes against most of our societal norms, which accord great respect and reverence for the dead people and sanctity for their bodies. Moreover, it has far

[53] Senate File No. 209, S.J. 452 available at http: // www .legis. state.ia.us/ GA/78GA/ Legislation/ SF/ 00200/SF00209/Current.html, last visited on 17 August, 2003.
[54] *Ibid.*

reaching dangerous implications. Dr. Guy Benrubi, writes in his comments to *Finnerty et al.*:

> "If, in fact, we accept the cadaveric model, does that mean that anyone can harvest organs without permission? Does it mean that we will have harvesting companies who will be lurking right outside emergency departments and following patients into the hospital? Would health maintenance organizations sign contracts with harvesting companies for exclusive harvesting use of organs in patients who die under their plan? Would people get discounts if they decide to sign up with certain harvesting providers once they sign with their health maintenance organization? Would we have harvesting companies contracting with the state to harvest organs from executed criminals, and would that, in fact, lead to an increased number of executions with harder chances for appeal?"[55]

A milder approach to the "cadavric model" consists of the claim that dead persons have rights, but they deserve less consideration than rights of living persons. However, when trying to look more closely to the rights involved, it is difficult to make such an argument. The right to privacy, autonomy, but most importantly the right to be treated humanly with dignity are not subject to degrees of gradation. These are fundamental rights than due to their nature they demand protection by strict scrutiny. In my view, they should not be hinged upon the question whether their potential holder is dead or alive.

The inquiry on the interests of dead people also relates to the distinction between harm and wrong. Usually, it is argued that since dead people do not experience pain, they cannot be harmed. However, I would claim, dead people can be wronged. If we lie to our

[55] 181 (2) Am J Obstet Gynecol 301 at 302.

friends, we may not harm them, but we wrong them, even if the lie is completely undetected. Morally we are doing something wrong. Likewise, the dead can be wronged even if they can not be aware of it, and even if they did not give this a thought while alive, asking to be treated differently.[56]

Moreover, claiming that the dead persons do not have the ability to suffer or to feel pain can lead not only to the conclusion that dead people can not be harmed, but, conversely, to the outcome that the simple preservation of somatic life in such patients cannot be to their benefit or in their interest.

But the idea of harming the dead goes deeper. In his book, *Speaking for the Dead: Cadavers in Biology and Medicine*, D. Gareth Jones argues that a "now-dead" person has interests that go beyond her life time, based on what he calls the intrinsic value of the cadaver.[57] Jones claims that we cannot assume that because a woman was pregnant at the time of becoming brain dead, she would inevitably want the pregnancy continued after her death. Maintaining a brain-dead woman on life-support without specific consent is, in his view, an act of disrespect towards the "now-dead", treating her as no more than a human incubator.[58]

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[56] **Spike & Greenlaw**, *supra* note 44 at 293. See also Jacqeline J. Glover, "Incubators and Organ Donors" (1993) 4 (4) J. Clin. Ethics 342 at 343 **[Glover]**.

[57] **Jones**, *supra* note 31. See also D. Gareth Jones, "Making Human Life Captive to Biomedical Technology: Christianity and the Demise of Human Values" (1995) 11(4) LLU Center for Christian Bioethics Update 1 available at http:// www.llu.edu/llu/bioethics/llethup114a.htm, last visited on 17 March, 2003 **[Gareth]**.

[58] Compare **Jordan**, *supra* note 6 at 1154. Jordan correctly argues that in some circumstances the burden of maintaining a corporeal existence degrades the very humanity in normally serves.

Nicola Peart *el at.* agree with Jones so long as the woman's wishes are known. However, if her wishes are unknown they do not consider that the moral obligation to respect cadavers is a strong enough ethical reason for discontinuing a treatment that would save the life of the fetus. In their view, respect for the autonomy of the dead when her wishes are unknown is an unwarranted extension of the concept of autonomy, and it disregards the fact that the benefit of continuing treatment to the fetus outweighs any harm to the dead woman.[59]

By focusing on the preservation of well-being rather than on the exercise of choice, the interest theory to rights leaves open the possibility of ascribing legal rights to dead people.[60] According to this theory, because various aspects of the well-being of dead people can receive essential protection through legal norms, those creatures can be classified as potential right-holders. Ascribing such rights is possible by subsuming the immediate aftermath of each dead person's life within the overall course of his or her existence through highlighting the ways in which the dead person still exists after his death (e.g. the continuing influence of the dead person on other people and on the development of various events, the memories of her that reside in the minds of people who knew her or knew by her, and the array of possessions which he accumulated and then bequeathed or failed to bequeath). Although the appropriateness of classifying a dead person as a potential right-holder, under this view, will last for only a certain period of time, a "recently dead" pregnant woman who is about to be maintained on life-sustaining treatment falls into this period of time.

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[59] **Peart et al.**, *supra* note 11 at 297.
[60] Matthew H. Kramer "Do Animals and Dead People Have Legal Rights?" (2001) 14 Can.J.L & Juris. 29.

Even if one does not agree that the newly-dead have rights as much as the living, one can still claim that some interests of the living person (such as not to be harmed) survive after her death.[61] Such an argument is brought by Buchanan and Brock.[62] The authors claim that surviving interests cannot be construed as rights of *self*-determination because this *self* no longer exists. Instead, they argue, the former self has a "right of disposal" over "what is to happen to one's living, non-person successor" – a right we should conceive "as something like a property right in an external object". Of course, this right of disposal asserts interests in treatment decisions for the new(non) person as well as interests in disposition of the dead body.[63] Maintenance on life-support is one such decision.

More generally, the law's recognition in caring for the dying, along with freeing them from suffering rather than simply to postpone death reflects the fundamental respect that the law shares for the sanctity of life but also for the "sanctity" of its end.[64] Not only when an individual is declared dead, any "best interests" that this individual had in receiving medical treatment can no longer (strictly speaking) exist, but the English case

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[61] This is especially true in regards to interests in future child rearing. See Janice MacAvoy-Smitzer, "Pregnancy Clauses in Living Will Statutes" (1987) 87 Colum. L. Rev. 1280 at 1297-8.

[62] Allen E. Buchanan & Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge: Cambridge University Press, 1989) 166.

[63] It is important to see the distinction they make between the self-determination interest of a self in what happens to *the same* self (person) from the interest of a self in what happens to a thing that is not only not the same self, but not self (person) at all. This distinction has a moral implication: the former interests have greater moral weight than the latter.

[64] Sheila McLean even uses a stronger language when she argues that we have an interest in avoiding condoning an assault on the dead person. See **McLean**, *supra* note 29 at 341.

of in *Re A.*[65] also established that treatment after death would be a "continuing indignity" to the dead.

Performing procedures on the dead without consent may be considered contrary to public policy. This argument has been raised in the general context of posthumous reproduction and in the more particular case of the use of gametes of deceased person. The English Warnock Committee stated in its report that the use by a widow of her dead husband's semen for AIH is a practice which "we feel should be actively discouraged".[66] In its response to the Warnock Report, the English government recognized that "many people are uneasy about this practice" and did not feel it should be actively encouraged.[67] This uneasiness is probably the explanation for legally declaring the posthumous child as being fatherless.[68]

B. Moral intuitions

Our moral intuitions towards dead persons of "feeling uneasy" are believed to have three major components.[69] An initial component is the close identification of people and their

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[65] *Re A (minor)* [1993] 1 Med. L. Rev. 98, per Johnson J. In this case, the hospital sought clarification over the disconnection from a ventilator of a child, who was declared brain stem dead. The court stated that "...it would be wholly contrary to the interests of A, as they may now be, for his body to be subjected to the continuing indignity to which it was currently subject. Moreover, it would be quite unfair to the nursing and medical staff of the hospital, who were finding it increasingly distressing to be caring for a dead child." *Ibid.*

[66] *Report of The Committee of Inquiry into Human Fertilization and Embryology Cmnd.* 9314/1984 ¶ 109.

[67] **McLean**, *supra* note 29 at 336.

[68] See *The Human Fertilisation and Embryology Act* 1990, (U.K.) 1990, c. 37, s. 28. But see *R v. Human Fertilisation and Embryology Authority, ex parte Blood* [1997] 2 All E R 687 (Successful actions of a widow to export gametes of her dead husband outside the U.K. for insemination and to have the deceased husband registered as the child's father).

[69] **Jones**, *supra* note 31 at 42.

bodies. D. Gareth Jones argues that our recognition of each other depends upon recognition of an array of physical characteristics, which are distinctive features during life, and are not extinguished immediately on death. 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.

The second component concerns other people's responses to the cadaver. By "people", Jones refers to people who knew the deceased while alive and who have memories of that person. According to this view, the cadaver represents an array of built-in memories that can never be completely separated from it. These memories convey a sense of respect for a cadaver and its enshrined associations. Disrespect of the cadaver, on the other hand, evokes a sense of revolution.

A third component concerns the deceased person's relationships with relatives or friends, who are now grieving the death. From that perspective, respect for the cadaver is respect for the relative's (or the friend's) grief. Jones mentions that *the reality* of the cadaver also plays a substantial role during the grieving process.[70] More generally, the wrong that is

[70] Some argue that maintaining the deceased on life support helps to the grieving process. It "gives a family time to accept the reality of a sudden and unexpected event and to prepare for what would otherwise be a precipitous plunge into grief"- **Spike & Greenlaw**, *supra* note 44 at 292; See also Kathleen J. Ascioti, "Sheila's Death Created Many Rings of Life" 93 Nursing 44 at 47: "The first 2 weeks after Sheila was declared brain-dead were the most difficult. Her husband visited daily. He was terribly distraught. Sometimes we'd find him lying next to Sheila, sobbing uncontrollably, his arms wrapped around her, clutching for the life that no longer existed."

done to the dead is experienced by others on behalf of the dead.[71]

C. Psychological Inclinations

Because of its strong moral base, respect for the dead is reflected in our daily psychological inclinations. Maintaining a brain-dead pregnant woman on life support for the delivery of her fetus, while her body is in a permanent process of deterioration, is a painful emotional act. The experience with the German case of Marion Ploch, for example, can teach us a lesson about the public reaction to such a procedure.[72] "SS-Nazi Pig", "Concentration Camp Dr. Mengele", "Dr. Frankenstein", "Zur Leichengymnastik ("To the Gymnastics for corpses"), "Now Human- Instead of Animal – Experiments" are only few examples for such a reaction.[73]

This psychological response can also reflect the view that people may not accept brain-death as death. They attribute a moral status of a living person to the newly-dead. The concept of human dignity keeps playing an important role here.

D. Religious convictions

Another possible explanation for this strong reaction can be found in religious convictions. The feeling of "continuing indignity" to the dead patient, presented by the

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[71] **Glover**, *supra* note 49 at 344.
[72] For the *Ploch* case, **see generally** note 10 to my introduction to the thesis.
[73] Christoph Anstotz, "Should A Brain-Dead Pregnant Woman Carry Her Child to Full Term? The Case of the 'Erlanfer Baby'" (1993) 7 (4) Bioethics 340 at 344-5.

Re A. case, I discussed above, is indeed very strong. It also has religious perspectives. The notion of human dignity is premised on the idea that human beings deserve to be treated humanly as creatures, who are being observed by God, their creator. It is the nature of this *special interaction between creatures and creator* that shapes the duty to act with dignity toward the first. This duty does not derive from an isolated intrinsic value of human beings, as it is wrongly assumed. D. Gareth Jones elaborates on this point in the following way:

> " All human beings are to be viewed as having an inalienable dignity, stemming from our creation by God and revealed supremely in the redemption made possible by Christ. It rests not on what human beings can accomplish in material, social or spiritual terms, but on the rock of God's love. Consequently human dignity is always based on what individuals are in the sight of God and never on what they may be able to do for society, for mankind, or even for God. From this follows that those who are of no functional value to society still retain a dignity, since they remain important *in this sight and purposes of God.* Elements of this dignity are also to be found in those who have died, but a short time ago were one of us".[74]

Indeed, in some cases religious convictions have made the legislator to insist on treating patients even when they can be considered legally dead. In New-York and New Jersey, for example, the law now requires physicians to honor the objections of family members to cease treatment of their beloved ones and to continue medical care *despite evidence of loss of brain function.*[75] The importance of religious beliefs and the idea of remaining "in the sight of God" lead me to another element of our attitudes towards the dead, that is the idea of bodily continuity and personal identity.

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[74] **Gareth**, *supra* note 50 at 11.

[75] New Jersey statute annotated, 26–6A-5, suppl 1994 (1987); New York Compilation Codes Regulations, Rules 7 REGS, title 10, section 400.16 (d), (e)(3)(1992).

E. The Idea of Continuity

Bodily Continuity

Although the pregnant woman is dead, under the proposed medical intervention, her body continues to be "alive". One might hold that bodily continuity is what matters in personal identity over time. As long as the same body is living, the same person is "alive". In the Judeo-Christian tradition "a man not only *has* a body, he *is* his body".[76] Furthermore, death rituals presuppose that the person dies when the person's *body* is declared dead, not before, and that therefore it is appropriate to bury (or cremate) the corpse. The distinction between the death of the body and the death of a person is sharply reflected in brain death where the body of the "dead" is still living and breathing.

Presupposition of Unity

But the sense of continuity in one's personality is not restricted only to the existence of one's body. It is broader. In fact, it is presupposed in every act we do. Not only do our present actions really impact on our future, but we also perceive them as such. Unless we function on that basis, we would not have been able to do anything at all. Our anticipation for their effect in the future is the basis for all of our actions. This anticipation is an intrinsic nature of the human being. As Robert Olick argues:

> "Why should I rise each morning and labor through the day if I will be a different person at the end of the day; if my weekly paycheck goes to the bank account of a future person who is not me; or if my pension, savings and investments will benefit a future person who is not me?"[77]

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[76] William F. May, "Attitudes toward the Newly Dead" (1973) 1(1) Hastings Center Studies 3.
[77] Robert Olick, *Taking Advance Directives Seriously* (Washington, D.C.: Georgetown University Press, 2001) 140 [**Olick**].

It is a rational presupposition of the moral life that X's actions have meaning for a future person who will still be X. Whether the future is a "lived" one, where we see ourselves alive, or a "dead" one where we anticipate we will be dead, is irrelevant to the premise of this presupposition. Therefore, the presupposition of unity makes it difficult to think that once the woman is dead, she is no longer the same person she was.

Narrative Embodied in a Single Life

Another angle from which we can look at the brain-dead person is through her history. Following Alasdair MacIntyre's conception of the unity of life as "the unity of a narrative embodied in a single life",[78] we might see ourselves as subject of a history (past, present and future) in which choices, actions, and relationships play a central part.[79] According to this view, what binds the various stages of a person's life is a *narrative* that makes that life intelligible. This narrative includes the aspect of our natures, which involves moral agency.

On the one hand, the intelligibility of an individual's life story presupposes that its chapters are part of the life of the same person and hence, presupposes personal identity over time. On the other hand, we cannot make sense of the stages of a person's life without a story. Narrative, intelligibility and personal identity exist in relationships of mutual presupposition. We cannot speak exclusively on one without the others. Moreover, because a life of a person is connected in important ways to the lives of others,

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[78] Alasdair MacIntyre, *After Virtue* (South Bend, Ind.: University of Notre Dame Press: 1984) 218.

[79] As Robert Olick explains, while criticizing the opposite approach: "The successor new person S2 has no personal history. His personal life begins as a severely demented dying patient whose life will be extremely short. He has no family, no friends, no one who has been a part of his life and is able to act on his behalf in a way that takes a personal history into account" – **Olick**, *supra* note 69 at 148.

such as family members, friends, etc., the narrative of that person is a *part of their narrative*. The brain death of the pregnant woman is not just an event in her life; it is an event in the lives of family and friends as well. It is a story of her life and theirs.

F. The Human Body

Death carries within it a personal intrinsic value that is manifested in the human body. We consider a person and her body inseparable. We recognize each other *because* we recognize each other's bodies. While this applies supremely during life, some important aspects of this identity continue following death. This important value leads to what Robert Wennberg calls the "overflow principle":

> "We do not treat human corpses as garbage, because the corpse is closely associated with persons: it is the remains of a physical organism that at one time supported and made possible personal life".[80]

All that remains of the person is the cadaver, and yet our respect for that person and for the memory of that person leads to respect for the person's remains.

Moreover, the dead body is an integral part of the initial grieving process. Thus, we show disrespect to the "newly-dead" when we allow that person's body to be medically treated in the absence of any consent on the person's part prior to death, or in the absence of any close relatives and friends to argue the case for the deceased (and not for themselves).

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[80] **Mentioned in Jones**, *supra* note 31 at 57.

Is a dead pregnant woman's body different than other women's bodies and men's bodies? To help this discussion, it may be instructive to have a sense of what it means to be on life support. Without a sense of what it means to be in those physical conditions, it may be hard to fully appreciate the arguments on medically "treating" the dead.

The *Karen Quinlan* case provides a nice illustration.[81] Although in a vegetative state, Karen Quinlan at the time of her trial, had a catheter inserted in her bladder, a respirator tube in her trachea, and a nasal gastro feeding tube in her nose and throat. Karen had received over 300 blood gas tests, a brain scan, an angiogram, an electroencephalogram, a lumber tap, and several other tests. She was emaciated and in a classic "decorticate posture", with her feet drawn up near the buttocks and extended, her forearms drawn in against the chest, her joints severely rigid and deformed, and her hands at right angles to the forearms. To battle the constant risk of infection, antibiotics were administered and tests for infection constantly made.

Karen was almost constantly sweating, often profusely, and body rashes occurred, so she was constantly being moved and bathed. Heat lamps were used to treat the skin lesions known as decubiti, or bed sores, that were generated by her constant repose. She went through awake-and-sleep cycles, and made stereotyped cries, yawns, and spastic movements, but was never conscious. Can this be called a dignified treatment of a woman's body? Would we want all this for a potential life that might even not survive or

[81] *In re Quinlan*, 137 N.J. Super. 227, 237-45, 348 A. 2d 801, 807-11 (1975), modified, 70 N.J. 10 355 A.2d 647, cert. Denied, 429 U.S. 922 (1976).

suffer from physical and mental disabilities for life? I believe we should be tougher in our permissibility for it.

Consent

A. The Rule

The notion of consent is a fundamental doctrine in law and medical ethics, and its origin lies in the common law maxim, according to which medical intervention (invasive or not) can only be provided where the consent of the individual (usually the patient) to be treated has been obtained.[82] The requirement of consent derives from the "greatest right"[83]– the right to inviolability of a person and to bodily integrity.

In the *Malette*[84] case the court held that, as a matter of common law, a medical intervention in which a doctor touches the body of a patient would constitute a battery if the patient did not consent to the intervention.

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[82] *Schloendorff V. New York Hospital*, [1914] 211 N.Y. 125, 105 N.E.2d 92 (N.Y. Ct. App.); See also *The Council of Europe Convention for the Protection of Human Rights and Dignity of Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Medicine* (European Treaty Series 164, 4.IV. 1997) prescribes at article 5: " An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and the nature of the intervention as well as on its consequences and risks".

[83] *Pratt V. Davis*, [1095] 118 Ill. App.

[84] *Malette v. Shulman*, [1990] 72 O.R. (2d) 417 (Ont. C.A.).

B. Exceptions to the Rule

Under the common law, two general exceptions exist to the rule of consent. According to the first, a health care provider who is faced with a true emergency (usually not anticipated) can administer treatment without express consent.[85] Under this exception, the treatment is usually necessary to save the life of the patient or to avoid health complication when the patient cannot provide consent. However, it is well established that the "emergency exception" does not apply where the reason for undertaking the procedure without consent has more to do with convenience than with an immediate need for treatment.

According to the second exception, a treatment can be administered without consent if there is an explicit legislative provision mandating it. Two types of legislation are often cited in this regard: mental health legislation and legislation concerned with public health protections such as the prevention of spreading a communicable disease.[86]

Another common exception to the rule of consent is "the best interests" test. According to this test, the intended medical intervention should serve the interests *of the person on whom it is proposed.* Third party interests are technically irrelevant.[87]

Maintaining a brain-dead pregnant woman on life-support is not an emergency case that is necessary *for the patient* (the dead woman). Certainly, it does not aim to save the life

[85] See *e.g. Civil Code of Quebec*, L.Q. 1991, c. 64, s. 13.
[86] See, for instance, *Public Health Act*, R.S.A 2000, c. P-37, s. 29-36.
[87] **McLean**, *supra* note 29 at 329 and 332.

of the patient. Perhaps its goal is to save others' lives but this was not the original purpose of the exception to the consent requirement.

Does maintenance of the dead woman on life support serve her interests, specifically her interest in having a child after her death?[88] I would hesitate giving an affirmative answer to this question. As Aziza-Shuster suggests, people need to produce merely for themselves, or there could be more to the reproductive experience than personal interests like rearing the child or being aware of the child's existence.[89] If this what stands behind the right to reproduce, than maintaining a brain-dead pregnant woman on life support could be not serving her interests.

Not only is there not explicit legislation that supports performing life-sustaining treatment on the woman without consent, there is one that legally forbids it. I will turn now to discuss the statutory provisions in this area.

C. Statutory Requirement

The notion of the consent requirement has been adopted by the Canadian legislation. In Ontario,[90] for example, according to the Health Care Consent Act, a health practitioner, who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless:

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[88] Even if one argues that dead people do not have rights, the argument on interests can still be claimed.
[89] E. Aziza-Shuster, "A Child At All Cost: Posthumous Reproduction and the Meaning of Parenthood" (1994) 9 (11) Human Reproduction 2182 at 2184. I will discuss the right to posthumously reproduce, in my last chapter.
[90] *Health Care Consent Act*, S.O. 1996, c. 2, Schedule A.

> " (a) He or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent, or (b) He or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf ".[91]

"Treatment" here is defined very broadly as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose; it includes a course of treatment, plan of treatment or community treatment plan. Maintaining a brain-dead pregnant woman on life-support can, of course, fall into the definition of "other health-related purpose". Other provincial legislation applies the same principles, and broadly defines the medical treatment, which is subject to the requirement of consent.[92]

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[91] *Ibid*, s. 10(1).

[92] For the law in British Columbia, see *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C 1996, c. 181. There, the legislator discusses a "health care", that is defined the same as in the Ontario legislation. However, health care acts are divided into major and minor ones. The "major" ones include a surgery, any treatment involving a general anesthetic, major diagnostic or investigative procedures, or any health care designated by regulation as major health care. The "minor" ones are health care, which are not major ones and that include routine tests to determine if health care is necessary, routine dental treatment that prevents or treats a condition or injury caused by disease or trauma. The general rule is that a health care provider must not provide any health care to an adult without the adult's consent and must not seek a decision about whether to give or refuse substitute consent to health care, unless the health care provider made every reasonable effort to obtain a decision from the adult. However, in regard to major health care, a health care provider may provide major health care to an adult without the adult's consent, if after consulting with the adult's spouse, relative or friend or with any other person, who has relevant information, the health care provider decides that the *adult* needs the major health care, and is incapable of giving or refusing consent to it, or when the adult does not have a substitute decision maker, guardian or representative who is authorized to consent to the major health care, or when someone chosen under section 16 has authority to consent to the major health care and gives substitute consent, and the health care provider complies with the conditions the other above. *Ibid,* s. 14(1)(a); For the law in Nova Scotia, see *Hospitals Act*, R.S.N.S. 1989, c. 208. There, a "patient" is defined as "a person who receives diagnosis, lodging or treatment at or in a hospital". The definition is very broad and includes any treatment performed in the hospital. According to this definition, a patient must not necessarily be alive. The general rule is provided in sec. 9(1) to the provincial statute. It states that "where a person in a hospital requires medical or surgical treatment and is incapable of consenting to the required medical or surgical treatment for any reason and such person does not have a guardian or there is no one recognized in law who can give consent on his behalf to the required medical or surgical treatment, then the Trial Division of the Supreme Court or a judge thereof may upon *ex parte* application by the Public Trustee authorize the required medical or surgical treatment". Under this section, series of requirements has to be fulfilled and eventually the health provider is not allowed to perform the treatment without consent. Instead, the issue is decided by court; For the law in Quebec, see *Civil Code of Quebec*, L.Q. 1991, c. 64 s. 11. According to this section, "no person may be made to undergo care *of any nature*, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent". However, "if the person concerned is incapable of

Thus, a health care provider is not allowed to maintain a dead patient on life-support without obtaining the woman's earlier consent or the consent of her substitute decision-maker, family members, guardian or court. This is not only a legal requirement, but also an ethical one.[93] But perhaps the requirement for consent can be satisfied merely by implying it, or just presuming it? I will turn now to examine this question.

D. Implied and Presumed Consent

Consent can be express or implied. An express consent from the dead must, naturally, refer to the time before the patient arrived to the hospital – by directive or by signing a consent form. An implied consent is, of course, less clear and more complex situation. Some examples of implied consent will help. One such example is that the procedure will be done unless the patient or her next of kin objects.[94] Another example is that a discussion before the procedures can lead to the conclusion that the patient consented.[95] Thirdly, one can imply consent by a reasonable person test.[96] Another form of implied consent is by signing or consenting to go through a certain procedure one may infer the consent to undergo any other procedures, which may become necessary during the course of the main procedure consented to.

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giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place". Here also we encounter a very broad definition to acts that require consent ("care of any nature"), that clearly can include the maintenance on life support for future delivery.

[93] See for example in England. The *NHS Management Executive's document A Guide to Consent for Examination or Treatment* (1990) states at chapter no. 4: "Principles of consent are the same in maternity services as in other areas of medicine. It is important that the proposed care is discussed with the woman, preferably in the early antenatal period when any wishes she expresses should be recorded in the notes, but of course the patient may change her mind about these issues at any stage, including during labour". See also Canadian Medical Association, *Code of Ethics*, s. 12.

[94] This form of consent is more common in Europe and especially in regard to organ transplantation.

[95] *O'Bonsawin v. Paradis*, [1993] 15 C.C.L.T. (2d) 188 (Ont. Gen. Div.).

[96] Such a test was exercised in *Canadian AIDS Society v. Ontario*, (1995) , 25 O.R. (3d) 388 (Gen. Div.).

Stephen Wear *et al.* argue that implied consent might be assumed in the case of maternal brain-death, provided that the woman already invested months of pregnancy toward the birth of her fetus.[97] Is being pregnant a sufficient circumstance to infer consent to serve as an incubator? In my view, there are general and specific reasons to reject such a conclusion.

When possible, express consent is ideally preferable for two reasons.[98] According to the first, implied consent leaves the patient out of the process, and therefore, runs counter to the philosophy underlying the law with respect to consent. The second reason is that express consent provides better evidence (as opposed to reliance on implied consent) that the patient has given her permission for the proposed treatment.

But besides the doubtful base, upon which the presumed consent rests, there are several specific reasons to ask for an explicit consent from the woman. Traditionally, our case does not fall into the classical types of implied or presumed consent. Indeed, it is unreasonable to believe that, prior to brain-death, a young woman had already considered the situation of brain-death at pregnancy. Although there are various aspects of her 'narrative' that could give a sense of what she likely would have wanted, these aspects are not solely directed to the case of maternal brain-death and do not differ from ones that

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[97] **Wear**, *supra* note 46.
[98] Erin Nelson, "The Fundamentals of Consent" in J. Downie, T. Caulfield and C. Flood eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths: 2002) 111 at 114.

relate to other bodily interventions which do not involve the special issues raised by the first.

Secondly, there are many people who from an ideological, religious, or other personal belief strongly oppose any use or interference with their body after their death. One can not fully respect their convictions by only presuming or implying their consent rather than asking for it explicitly.

Thirdly, it is possible that the pregnancy was unintended and unwanted, or even forced on the woman. It certainly will not do to assume that because the woman did not have an abortion she has chosen to continue the pregnancy: her personal code, poverty, or lack of access to the procedure might have blocked this option.

Fourthly, the woman may not have wished to produce a motherless child, and burden her grieving partner with sole care of a small infant. Neither may she have desired to extend the grieving process for her family and friends, as they watch her body being artificially sustained for a period of weeks or even months.[99] In my view, continuing treatment is a more invasive and potentially disrespectful procedure than terminating treatment and thereby also ending the life of the fetus. A physician cannot simply assume the woman would want her pregnancy continued after brain-death only from the fact that she is pregnant. Clear evidence would be required to justify such an assumption.

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[99] **Jones**, *supra* note 31 at 98.

My analysis leads to the conclusion that implied or presumed consent are insufficient for processing the maintenance on life-support. I will finish this part on consent by joining Hilde Nelson, when she writes:

> "Even if in life and health she joyfully and willingly assented to the pregnancy, we cannot assume that now, under very different circumstances, she would desire intensive support of her cadaver to achieve that end. While she might have wanted, for example, to bring a third child into a close and loving two-parent family, she might not at all have wanted to burden with a third child a grieving single parent who is already overwhelmed by the care of the two who exist. Nor would she necessarily have wanted to produce a motherless child particularly if, as our catalog of cases suggests, the father's ability and willingness to rear the child can't be counted on."[100]

Obtaining express consent on behalf of the woman involves confronting her relatives and friends. I will turn now to examine the role of this group in our case.

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[100] **Hilde**, *supra* note 39 at 253.

Rights of the Biological Father, Next-of-Kin, Family and Friends

What right, if any does a biological father of the fetus, next-of-kin, other family member or friends of the pregnant patient have in the situation of maternal brain-death? Should there be a hierarchy for surrogate decision making, as in the Human Tissue Gift Act, for example.[101] Daniel Schafer, in his article, "On Deliveries Carried Out on Corpses",

discusses the importance of relatives in the process of obtaining informed consent for such medical treatment.[102] But do relatives always have a right to decide? What is the source of such a right? Does it derive from their legal status as maternal and fetal surrogates, their quasi-property rights "in the deceased", or their being the spokespersons for their own interests?

Stephen Wear *et al.* suggest two exception to the relative's right.[103] The first, where the family refuses to maintain the pregnant brain-dead on life support when extended

[101] The Hierarchy there is as follows: 1) a person designated orally or in writing in an advance-directive or durable power of attorney for health care decisions 2) a guardian authorized by the court 3) the spouse 4) an adult child or adult children of the patient 5) a parent or parents 6) an adult brother or sister 7) any other relative in order of blood relationship. But see **Wear**, *supra* note 46 at 1728-9. The authors argue that preference should be given to what they call the "husband-father". However, they don't address the question of the preference within this category assuming that they are two different persons.

[102] Daniel Schafer, "Ueber Leichenentbindungen am Ende des 20. Jahrhunderts: Historische Aspekte ethischen Handelns bei toten Schwangeren" (1998) 10 Ethik Med 227 (Article in German). Sometimes, there is no time to ask the family and physicians make the decision alone, driven by the urge to save the fetus. In Israel, for example, it was reported in a recent case of a Bedouin dead woman whom her physicians decided to deliver without consulting the family members. The woman was in her eighth month of pregnancy when died. Although in retrospective her family's objection to an autopsy could have had revealed their attitude towards the delivery of a fetus from their deceased daughter, the physicians did not seek for their consent. The child died a day after its delivery - http://www.ynet.co.il/articles/1,7340, last visited on 13 May 2003; http://images.maariv.co.il/channels/1/ART/477/314.html , last visited on 15 May 2003.

[103] **Wear**, *supra* note 46.

support, "even for a few *weeks*",[104] would markedly enhance the chance and quality of fetal survival. The second, when the family demands "maintenance" while fetal survival is unprecedented and, even if gained, would be accompanied by profound fetal morbidity.

John Robertson attempts to put the husband of the deceased at the picture, but accords him little weight.[105] He argues that the husband of a brain-dead pregnant woman does not have the *power to control* "the dispositions of human remains".[106] Nor does his right to reproduce carry any right to have the body or resources provided for such a right.[107]
But what is the base for the exceptions of Wear *e al.* and Robertson's argument?

The case law supports the general view that the father of the child has no power to override the woman's autonomy regarding decisions on pregnancy.[108] My analysis on bodily interventions in pregnant women also revealed that the law keeps the biological father (genitor) out of the picture, even regarding complicated and hazardous decisions to the fetus, such as cesarean sections and blood transfusions.[109] This approach should apply also to the case of a brain-dead pregnant woman. Although she is not alive, the focus

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[104] They clarify this term with an example of four weeks of "maintenance" from the twenty-second week of gestation to the twenty-sixth.
[105] It is not clear why Robertson focuses on the husband, instead of the biological father of the fetus. In the *Piazzi* case, for example, these were two different persons. See **Piazzi**, *supra* note 34.
[106] John A. Robertson, "Posthumous Reproduction" (1994) 69 Ind. L. J. 1027 at 1053.
[107] *Ibid.* at 1055. This seems also to be the view of Sheila McLean when she argues that the requirement of a partner of a deceased to use the gametes of the first is not denied to the survivor, merely the ability to do so with a specific person (now deceased): **McLean**, *supra* note 28 at 341.
[108] *Paton v. British Pregnancy Advisory Service Trustees and Another*, [1979] 1 Q.B. 276 at 281; *C. v. S* [1988] 1 Q.B. 135; *Re F (In Utero) (Wardship)*, [1988] 2 F.L.R. 307 (C.A.).
[109] The case may be different regarding research involving pregnant women and fetuses. The American rules with respect to research that "holds out the prospect of direct benefit solely to the fetus" also ask for the consent of the father. However, when the father is unavailable, incompetent or temporary incapacitated the research can still be performed without his consent. *No parallel provision applies to the mother.* Hence, even in this area of intervention, obtaining consent from the mother seems to outweigh the same requirement as applies to the fetus' father. See *Code of Federal Regulations*, 2002, Title 45, Part 46,

should be on the woman's wishes and ideology regarding the pregnancy and the proposed medical intervention. The biological father should only be allowed to contribute to a full understanding of these and should be allowed to reflect on these, not determine this understanding.

Sometimes, it is the tragic event that makes the family members learn for their first time about the pregnancy.[110] When such circumstances occur, it is not reasonable to expect from the family members to have a readily available and clearly developed standpoint on the woman's pregnancy and the proposed treatment.

The more complicated situation is when a controversy takes place regarding the rights and duties family members and friends have once their beloved one is dead.[111] Sheikh & Cusack support Peart *et al.*'s view that "the person responsible for burying the deceased, commonly the next-of-kin, would not be entitled to the possession of the body until the child is delivered or had died *in utero*."[112] Thus, in their view, it is the healthcare providers who will have the lawful retention of the deceased patient's body in the circumstances of being obliged to preserve the life of the unborn.

Subpart B § 46.204(e), available at http://www.access.gpo.gov/nara/cfr/waisidx_02/45cfr46_02.html, last visited on 24 July, 2003.

[110] See for example the two cases presented by **Finnerty *et al.***, *supra* note 38.

[111] In the *Piazzi* case, for example, there was a controversy between the fetus' biological father who asked to maintain the dead pregnant woman "alive" and the mother's husband who opposed to it: **Piazzi**, *Supra* note 97; In the *Mapes* case, there was a disagreement between the mother's boyfriend and her parents. While the first was to sue the hospital that has kept his comatose girlfriend on life support for the delivery of their child, the latter asked for such a treatment: Reported at the Daily Telegraph in 1996, **mentioned in** Richard Paige, "Post-Mortem Pregnancies: A Legal Analysis" (2000) 9 (3) Dispatches 2.

[112] **Sheikh & Cusack**, *supra* note 19 at 80.

The Law Reform Commission of Canada, in its 1983 report, suggested that the incompetent patient's physician should be the central figure in the decision-making process, and that, although there should be consultation with the patient's family, the ultimate responsibility must lie with the physician.[113]

Of course, the ideal decision-making model for incompetent patients should reflect a consensus among the physician, other involved health care providers, and the family. When such a consensus does not occur, I would not claim that it is the responsibility of physician to have the final decision. Instead, I would support the view that the decision should reflect as much as possible the woman's wishes. When no such view can be identified, I would object to the procedure, unless two conditions are met. The fetus is in a very progressed stage of development (on the third trimester), and there exists at least one positive view[114] that supports the maintenance on life-sustaining treatment. My suggestion is derived from my previous analysis of abortions law and the legal view regarding bodily interventions on pregnant women, along with the requirement of consent and its application to the case of maternal brain-death.

The Physician-Patient Relationship

Formerly, the physician could only treat the mother and had to assume that in maintaining her health, the health of the fetus would be enhanced. The fetus itself was

[113] Law Reform Commission of Canada, Report 20, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1983) at 64-5.
[114] By this, I mean a positive assertion rather than avoidance to decide.

largely beyond the diagnostic and therapeutic reach of the physician. The assessment of fetal condition was made by *indirect* methods.[115]

However, advances in knowledge of fetal physiology and the development of new technology have enabled physicians to see the fetus in a *direct* way.[116] This has made physicians believe and act as the fetus was their "second patient".[117]. Thus, if one of them dies, the doctor's duty to the other patient remains, and what matters is the patient's best interest.[118]

The medical model of maternal-fetal relationship has shifted emphasis from unity to duality".[119] This shift has also made a change in the physician-patient relationship. In this new situation, treatment medically indicated for one patient can be contradicting for the other, yet both patients must be treated. The Duality model makes conflicts between duties of beneficence and nonmaleficence that physicians owe to both patients.

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[115] Some examples for such method include palpating the fetus through the maternal abdominal wall and uterus, measuring hormonal milieu through maternal urine and serum, estimating statistical risks from parental medical histories.

[116] For example, seeing the fetus in detail with ultrasound, assessing its condition with amniocentesis and fetal heart rate monitoring, and to operating it *in utero*. The medical ability to visualize the fetus shaped the discussion on separate moral and legal status to the fetus and was shaped by it. For such a discussion, see *supra* **notes 2-21 and accompanying text.**

[117] Lawrence J. Nelson, "Compelled Medical Treatment of Pregnant Women: Life, Liberty, and Law in Conflict" (1988) 259 (7) JAMA 1060.

[118] Compare **Sheikh & Cusack**, *supra* note 19 at 79.

[119] Susan S. Mattingly, "The Maternal-Fetal Dyad: Exploring the Two-Patient Obstetric Model" (1992) 22 Hastings Center Report 13; Still, the "Unity Model" is considered the dominant view by the medical profession. *The Ethical Guidelines on Court-Authorised Obstetric Intervention: A consideration of the Law and Ethics* from 1996 states that "The aim of those who care for pregnant women must be to foster the greatest benefit to *both the mother and fetus* with the least risk to *both*" (sec. 4.3.1) and that "In caring for the pregnant woman an obstetrician must respect the woman's legal right to choose or refuse any recommended course of action and *at the same time* maintain the medical obligation to promote the wellbeing of the mother and the child" (sec. 4.3.5) (My Emphasis) – http:// www.rcog.org.uk , last visited on 5 January, 2003.

Hence, maintaining a dead pregnant woman on life-support undermines the traditional physician-patient relationship. It makes physicians feel obligated to withdraw their commitment to act in the best interest of the patient and, instead become the fetus's practitioners.

After discussing the important issues that rise in the case of a brain-dead pregnant woman I will pass to analyze the dilemma of post-mortem pregnancy from a relational feminist approach, which I find highly appealing.

CHAPTER 6: RELATIONAL FEMINISM ANALYSIS

In this chapter, I intend to analyze the major concepts that relational feminist theory would rise with respect to the issue of maintaining a brain-dead pregnant woman on life support. By applying some of the main concepts of relational feminist theory I will confront the traditional liberal theory. This theory regards a brain-dead pregnant woman in isolation from her family and separate from her fetus. As a dead person, the theory denies the pregnant-woman from any rights or interests and considers her to be non-autonomous, with doubt a person.

With the help of relational feminist theory, I would like to suggest some new ways of approaching these issues, or better: a new language to talk about this situation. My analysis is based on the idea that the use of words and their divisions into categories construct the way we - as social entities that communicate and interact with each other by language – think we have to decide in such cases.

The issue of maintaining a brain-dead pregnant woman on life support touches upon many deeply rooted concepts. *Autonomy* is the most obvious one. The notion of autonomy is traditionally perceived as control over one-self. Such a control or "self-rule" implies an unconditional capacity to make personal decisions. It also involves a call to act with respect and humanity towards the autonomy holder. By applying feminist relational theory, my goal would be to establish a broader meaning to the concept autonomy, so that it would include the brain-dead persons. By arguing that brain-dead persons are

autonomous, I would claim that although their autonomy may be construed not as fully as living persons, it would definitely necessitate an ethical stance towards them that would prevent others from ignoring them as being "legally" dead.

The second concept I will analyze is the metaphor of field which relational feminist adopt from contemporary theories in science and theology to capture the social component of autonomy and to explain how living creatures in the world co-exist. I will ask to apply the metaphor of field to the dilemma of "prolonging" the life of a brain-dead pregnant woman. I would suggest looking for the field that consists of a dead patient and that is shaped by all of the interactions that surround her in this new and conflicting situation. By doing so, I will demonstrate the complexity of the dilemma I propose to examine, but more specifically, the different fields and social structures that operate simultaneously on the dead pregnant patient.

Boundary is the third concept that I will examine. I will analyze it from two perspectives: the boundary between the dead pregnant patient and the fetus, and the boundary between the dead pregnant patient (with the fetus) and the rest of the world.

My question about the potential boundary between the dead pregnant patient (with the fetus) and the rest of the world will be analyzed by the fourth concept, the human body. I will argue that the human body (dead or alive) has a social role, and that due to this role, protection of the dead body is *a societal* value to be implemented in the same manner that

applies to living persons. I will also demonstrate how this view is reflected in the law, which is a major participant in constructing this societal value.

My fifth concept will be privacy. In this part, I will introduce the notion of privacy, and I will discuss the dichotomy between the private-public domains. I will bring the relational feminist critique to this dichotomy, and I will examine its application in the situation of a brain-dead pregnant woman.

The final part of my analysis will be devoted to the concept of property. Two possible contexts for property claim would rise in my case. The first will relate to potential claims of the dead patient's relatives on their "property rights" in her. The second will involve the question whether the fetus is the dead pregnant patient's property. Before examining these questions, I will generally discuss the concept of property. I will, then apply the feminist' critique to regard potential life as property. The second part of my analysis will include a brief description of legal decisions that exemplify how courts mistakenly rule that next-of-kin have property rights in the dead. I will provide an explanation for this error and my conclusion would be to reject the language of property in this regard.

A. Autonomy

Central to the debate over the use of a brain-dead body is the concept of autonomy. A major reason for many of the problems identified with the autonomy ideal, especially in regard to dead people is that the notion of autonomy is commonly understood to represent

freedom of action for agents who are paradigmatically regarded as independent, self-interested, and self-sufficient.[1] As such, it is easy to categorize dead people as not being autonomous or as people who are not entitled to autonomy (due to their death).[2] The familiar critique by feminists to the liberal approach to autonomy is that it takes atomistic individuals as the basic units of a political and legal theory, and, thus, fails to recognize the inherently *social nature of human beings.*[3]

The case of a brain-dead pregnant woman can support this criticism by demonstrating the fact that usually a brain-dead woman is not the only person at stake. She exists in a very special and unique *social context.* This context includes the fetus, who although does not enjoy a legal status as a person,[4] its "best interest" and the protection of its potential life is one of the most important factors in the decision-making of what is the "right" thing to do with the dead pregnant patient.[5] It also includes the patient's parents, the biological

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[1] Compare Martha Albertson who asserts that dependence is inherent to the human condition – Martha A. Fineman, "Cracking the Foundational Myths: Independence, Autonomy, and Self-Sufficiency" (2000) 8 The Journal of Gender, Social Policy & Law 13 at 18.

[2] Such a conclusion mistakenly reflects the "individualistic" value of autonomy: "It is not even quite right to ask what are the conditions that create individual autonomy because the question implies that autonomy is some kind of essence, which while dependant upon certain conditions for its appearance, is, nevertheless intelligible in isolation from those conditions once it has made its appearance" – Jennifer Nedelsky, "Relational Autonomy and The Trap of Social Determinism: Perspectives from Science and Theology" in Feminist Theory: Challenges to Legal and Political Thought (Course Materials) (Toronto: University of Toronto, Faculty of Law, 2002) 40 at 55 [**"Nedelsky, Perspectives"**].

[3] Jennifer Nedelsky, "Reconceiving Autonomy" (1989) 1 Yale J l & Fem 7 at 8 [**"Nedelsky, Reconceiving"**]. Some argue that individuals experience a tension between the need for connection and the need for independence. Relational feminists oppose to this dichotomy – see Cynthia Willett, *The Soul Of Justice: Social Bonds and Racial Hubris* (Ithaca and London: Cornell University Press: 2001) at 25 [**"Willett"**].

[4] See my discussion on the *D.F.G* case, below.

[5] I put "best interests" in quotation marks since according to feminist relational approach there is no such a thing as the sole interest of the fetus. See my discussion on the maternal-fetus conflict, below.

father of the fetus, the "legal" father of the fetus (if he is other than the "biological" father), and other family members. Moreover, there are the health care-givers, who on the one hand face the emotional burden and the different (and sometimes polar) relations with the patient's families and friends, and who on the other hand have (probably) a moral obligation to provide treatment to the fetus.

In addition to this, one should bear in mind that the decision whether to go on with the procedure is also influenced by the location of the intensive care unit, its staff, their professional knowledge and experience to perform such procedures, their ethical and religious convictions, the financial abilities of patient's family and the unit's funding resources, the legal statutes and decisions that govern the specific jurisdiction where the patient is hospitalized, and so on. The fact that each of the parties involved has many directions of influence makes it impossible to examine the woman's autonomy in isolation from a constant and changing social shape and interaction she is engaged with.

In my view, *the case of maintaining a brain-dead pregnant woman highlights the most powerful evidence to the social interaction people have. This case reflects, maybe in the strongest way, that it is in the patient's own "capacity", as a social brain-dead person, to shape and change the social beings that surround her, and that are part of her social unique existence in the intensive care unit.*

Interesting to point here the psychological and moral intuition family members and clinical care nurses have when interacting with brain-dead people. The application of the

criteria of irreversible brain failure in defining death builds on advanced technology and expert knowledge, contrasting with everyday notions of death. People still tend to associate death with the "lifeless" cold body lacking bodily signs of life, not with a warm, breathing, perspiring brain-dead person. Since the dividing line between a dying and a brain-dead "patient" is not clear cut for most people, it is difficult for the families of some deceased and to some extent to clinical care nurses to accept such diagnosis, particularly when for purposes of the delivery of the fetus the deceased is actively monitored in the intensive unit and, if necessary, subject to cardiopulmonary "resuscitation".

Here are some examples of emotional reactions of clinical care nurses who were asked to care for brain-dead pregnant women[6]:

> "...Sometimes I forgot she was brain-dead and I would *talk to her*...(Ann Fetcho);
> ...I was always aware that I was caring for *two people*...Usually when a person is declared brain-dead in our unit, the life support is discontinued. Keeping the mother alive was a double standard to me...(Jane Dilliard)
> ...I found it difficult to deal with the callous way that other care providers not involved in her direct care were reacting to her. They were so insensitive to her as *a human being...I worried for her being alone. I gave her back rubs and touched her arm so she would know I was there*...I have two children and I think about what I would want. Do I want ten thousand people trooping through my room every day when I am so vulnerable? I believe it was important to *treat her as a person*...(Debra J. Belles)
> *...I talked to her and tried to make her look as good as she could for her own mother (the child's grandmother)* when she visited...(Theresa Mylet)

[6] Carol Diehl, JoAnn Haas, Karen Moore Schaefer, "The Brain-Dead Pregnant Woman: Finding Meaning to Help Cope" (1994) 13(3) Dimens Crit Care 133 at 135-136 (My emphasis- D.S.).

Indeed, treating the brain-dead woman with respect as a living person is, in my view, a direct outcome of the autonomy she enjoys as a person who interacts and engages within a social net of interrelations under these special circumstances. This view is not in accordance with the claim that "feeling of autonomy is an inseparable component of the capacity to autonomy",[7] simply because of the patient's incapability to feel autonomy (or more accurately to feel autonomous). Jennifer Nedelsky argues that the focus on feeling or internal experience in this regard defines whose perspectives is taken seriously, and "by turning out attention in the right direction it enhances our ability to learn what fosters and constitutes autonomy".[8] She explains that the capacity of autonomy does not exist without the feeling of it, that the feeling of autonomy is our best way to understanding the structure of the social relations that support it, and that focusing on the feeling of autonomy defines as authoritative the voices of those whose autonomy is at issue.

I find this explanation troubling. First, it appears to exclude not only dead people from the categorization of "autonomous" people, but also people with mental ailments, children, and maybe people whose intellectual or cognitive abilities to grasp and feel the "sense" of autonomy are not well "developed". In my view, all[9] of these people constitute and are part of a complex web of social interactions that shape and form their capacity of autonomy, at least in its weakest form that necessitates acting towards these autonomous

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[7] Or as Jennifer Nedelsky puts it that "capacity (to autonomy) does not exist without feeling" – **"Nedelsky, Reconceiving"**, *supra* note 3 at 25.

[8] *Ibid.*

[9] By dead people I refer specifically to the "newly dead" that are in the intensive care unit and serve as "objects" to such procedures as to be maintained on life support for the delivery of a fetus, but also to other procedures like organ transplantation, practicing resuscitation procedures, forensic examination, harvesting gametes or hormones etc'.

persons with respect and humanly.[10] Thus, I find that what is important is not the passive feeling of the capacity to autonomy but rather *what gives (or potentially can give) the feeling of autonomy or the sense of it*, that is the capacity to engage in meaningful relations even when one is considered legally dead.

Second, the ingredient of "feeling autonomous" seems also problematic due to its subjective nature. Jennifer Nedelsky mentions one form of this problem. She acknowledges that relations that foster the feeling of autonomy may vary considerably across cultures and over time within one culture.[11] Another form of this problem can be reflected with our difficult way to understand, compare, and evaluate feelings in general considering their complexities.[12]

Since our perceptions of acting towards people is deeply rooted, *inter alia,* in the notion of autonomy I would not recommend to form a new, but different term that would apply

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[10] An interesting question can arise in regard to the fetus. While the fetus does not engage in social interactions, to define his connection with the mother solely as a biological one can be underinclusive (especially compared to pregnant animals and their newborns). See also my discussion on the maternal-fetal conflict.

[11] **"Nedelsky, Reconceiving"**, *supra* note 3 at 25-6. Judy Scales-Trent, while referring to the white men who came to Williamsburg to learn about the racist history there asks: "How hard is it for them to exercise autonomy within a culture that works so hard to create and maintain categories we call 'race'?... given this context, to what extent can white Americans distinguish their own norms from those strong social norms that structure their consciousness?" – Judy Scales-Trent, "Oppression, Lies, and the Dream of Autonomy" (1999) 40 William & Mary L. Rev 857 at 863; see also **Willett**, *supra* note 3 at 170 who argues as follows: "Many of us are overwhelmed by social forces that restrict our ability to feel what we want to feel, to express our deepest desires, and to hold on to our most precious relationships. Moreover, it is not clear that the legal protection of a private "sanctuary" could provide a realistic barrier against hyper-modern forms of social power."

[12] A good example for this problem is seen in D. Allison's piece "Skin" - Dorothy Allison, *Skin* (Ithaca, NY: Firebrand Books: 1994). Allison's story evokes the question whether there is a genuine feeling of autonomy, and whether it can make a person (in this case – Allison) choose to unpack the way the past shaped his or her current being.

to brain-dead people. Hence, my suggestion would be to reconceive the common notion of autonomy which derives from an insulated perspective of the self by focusing on the social structure that fosters and enhances the capacity to (actually *or potentially*) feel autonomous. By this, I will ask to abandon the subjective component of the actual feeling of autonomy, as it creates serious difficulties to infer autonomy in many important situations like the one that when a brain-dead pregnant woman is being considered to be put on life-support for the delivery of her fetus.

Another critique that feminists raise against the liberal notion of autonomy is derived from the traditional view that autonomy is an individual value, and thus takes the meaning from the recognition of (and respect for) the inherit individuality of each person. According to this critique, when autonomy is identified with individual independence and security from collective power (such as the power of the state or the patient's family to insist on maintaining the brain-dead pregnant woman on life-sustaining treatment for the future interests of the fetus), the choice is posed between admitting collective control and preserving autonomy in any given realm of life.[13]

Here again I find the feminists' answer convincing: such a dichotomy between autonomy and collective power forecloses a whole range of social arrangements.[14] I have mentioned above some of the complex webs of interconnections that form the social behavior and decision making in the case of a brain-dead pregnant woman. This process of decision-

[13] **"Nedelsky, Reconceiving"**, *supra* note 3 at 14.
[14] *Ibid.*

making is characterized by free choice.[15] Choice is impossible in dichotomy. A liberal approach would probably state that, once dead, the pregnant woman is not autonomous, and thus, the only other option that is left is to maintain her for the collective, or other individuals' purposes.

However, as one can see, in reality, this is not so. The story doesn't end in the woman's death. Actually, it starts then. It is influenced by the woman's past interactions but also by her present ones. While she is lying on the bed and pronounced brain-dead a whole bunch of complex inter-relations effect her situation. She is regarded formally and legally dead, but she is perceived emotionally and psychologically alive. She is considered a motionless and lifeless creature, but she raises strong reactions towards her. She is still a mother, a wife, a daughter, a friend, a co-worker and a patient. All of these factors shape the decision making on whether to maintain her "alive" (just) for the sake of the fetus.

B. Field

The complex interactions that characterize our case can also reflect, in my opinion, the metaphor of "field" which is emphasized by the feminist relational theory. By looking to contemporary theories in science and theology that deal with "the creative forces of the

[15] However, this is not a simple conclusion as the more one emphasizes the way human beings are embedded in and constituted by web of relationships, the more one can run the risk of social determinism. The feminist relational theory attempts to solve this risk by importing the metaphor of "field" that encompasses the idea of choice" and "decision" merely from new theories in theology, physics and biology that deal with the "creative forces" of the universe. See "**Nedelsky, Perspectives**", *supra* note 2.

universe", relational feminists found the metaphor of field to capture the social component of autonomy. Feminist revealed that in this literature the relational context was the key to articulating the nature of the creativity that was in question. Thus, for example, Brian Goodwin's work, that was inspired, *inter alia*, by the chaos theory, explicitly articulates the idea that the organism is the "*dynamic vehicle*" of biological emergence.[16] In this view, the organism is grounded in relationships, which operate at all different levels of our beings. Goodwin's conclusion is that the capacity of complex system to generate novelty is primarily a function of the way the parts are related to one another and the dynamic organization of the whole, meaning their interrelation.

Goodwin finds two properties for the field: 1) the behavior of a dynamic system that is 2) extended in space.[17] What is important to stress is that *the system*, and not its parts or their properties is the one that is characterized by generativity. The creativity resides *in the field* and not in the particulars that are part of the field. The relational feminists will further argue that the capacity of autonomy exists within *certain kinds* of social fields.

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[16] Interesting to note that this model was found applicable even to ant colonies. In my view, the biological order of the organism reflected in its relational organization can also challenge the requirement of actual feeling of autonomy I have discussed above– see text accompanying *supra* notes 7-12.

[17] Brian Goodwin, *How The Leopard Changed Its Spots: The Evolution Of Complexity* (Princeton, NJ: Princeton University Press, 1994) at 51 [**"Goodwin"**]. Perhaps the space Goodwin is talking about is represented by the box, that Starhawk's uses as an example for a "safe space" – see Jennifer Nedelsky, "Law, Boundaries, and The Bounded Self" (1990) 30 Representations 161, at 174-6 [**"Nedelsky, Boundary"**].

Applying this notion to our case leads to the conclusion that there is no meaning to search for autonomy in the dead woman. The autonomy is in the field that she constitutes and is constituted by her. The case of maintaining a brain-dead pregnant woman on life support deals with a very strong generative power. I think that what makes it strong is the deep contrast between the woman's death and the potential life of the newborn. The power is manifested by all of the interactions that surround her in this new and conflicting situation. It is not the woman herself. It is the whole pattern of interrelations that shape, constitute, and that are also being shaped by this power. Goodwin advises us that the capacity for creative interaction ("self-organization") is the network of relationships. By this, Professor Nedelsky adds, there may be a variety of forms of fields that generate creative capacity.[18] Such a variety is best manifested in the difficult case that involves a brain-dead pregnant woman.

I will turn now to suggest that the physiological capability of maintaining a brain-dead pregnant woman "alive" and thus fulfilling her *right to procreation* is also a form of respecting her autonomy. I am inspired by Brian Goodwin's comments on autonomy in biological creatures. Goodwin states that "these properties of active self-maintenance, reproduction and regeneration express a quality of autonomy in organisms: they are due to processes that occur within organisms such that *the whole has characteristics distinctive to its particular species*".[19] Hence, for a "double-standard" reason, advocacy to maintain the dead woman "alive" can not seriously be based on the claim that she does not have autonomy, while on the other hand to maintain her "alive" is justified as a

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[18] **"Nedelsky, Perspectives"**, *supra* note 2 at 56.
[19] **Goodwin**, *supra* note 17 at 175. (My emphasis- D.S.)

fulfillment of her right to procreate and the manifestation of what she would have wanted (and thus – to respect her autonomy). The origins of these two claims seem to contradict one another. This contradiction of course also emphasizes the complexity of this case: respect for autonomy can result in two opposite consequences. Nevertheless, it also suggests the variety of fields that one situation (brain death of a pregnant woman) is involved with.

Moreover, I find the metaphor of field with its social emphasis very appealing to the specific situation of brain death. I will turn now to devote a special discussion on this specific state. In my view, development of biological and medical knowledge has led to a conception of death as *a process*, characterized by more or less recognizable stages with diffuse boundaries.[20] I will argue that death is a *social* process conceptualized as the progressive ceasing of social functions (such as producing and consuming for instance). In my view, this process is social since it is characterized by corresponding social rules associated with each stage of "social death". These social rules indicate the appropriate ritual treatment towards the body at each stage.

More specifically, defining death according to the absence of neurological signs, like in brain death case, implies abandoning the concept of death but also the concept of a "moment" of death. Although from a legal perspective death is a moment in time, in a brain-death the procedural character of death becomes more manifest, since no precise

[20] This also applies to the relational theory. See my discussion on boundaries, below.

moment of death can be determined (something extending both forward and backward from the moment of a verbal declaration of death).

The concepts of living/deceased/corpse are thus social categories corresponding to different stages that each involves particular sets of relations (rule systems). Therefore, in order to effectively address the question whether a brain dead pregnant woman should be maintained "alive" or not, we need to move away from the familiar Western understanding of autonomy, which regards the self as simply some special kind of property to be preserved, and we should import the notion of field as a social one.

The metaphor of field helps us to build a *relational conception* of the self. Under this conception, relational selves are inherently social beings that are shaped and modified within a web of interconnected relationships. The continuation that is reflected in the process of dying, especially when a brain dead pregnant woman is on the one hand legally dead, but on the other hand capable of being maintained "alive" for the delivery of her fetus, would thus have a better understanding under this new metaphor.

C. Boundary

The case of a brain dead pregnant woman enables us to carefully examine the notion of boundary in two contexts: boundary between the brain dead pregnant woman and the fetus; boundary between the brain dead pregnant woman (with the fetus) and the rest of

the world. Let me say a few words on the metaphor of boundary before I address these contexts.

Boundaries serve as the means of comprehending and securing the basic values of freedom or autonomy (in its traditional meaning).[21] The metaphor of boundary is closely related to the notion of property and privacy.[22] Jennifer Nedelsky describes the evolution of the concept of boundary by discussing the symbolism of property in the American constitutionalism as an important means of having control over one's life, of expressing oneself, and of protecting oneself from the power of others. She concludes her analysis by arguing that property helped to construct the concept that the most autonomous man is the most perfectly isolated. Given that autonomy is a capacity (as opposed to a static condition), it must be developed.

Relational feminists see the construction of relationship as essential for this development.[23] By this, the metaphor of boundary, that served the idea that what fosters autonomy is *the protection against intrusion*, seems inappropriate for relational feminists.[24] The argument is that the boundary metaphor consistently inhibits our capacity to focus on the relationships it is in fact structuring. Hence, Jennifer Nedelsky's

[21] **"Nedelsky, Boundary"**, *supra* note 17 at 161.
[22] See below my separate discussion on property and privacy.
[23] **"Nedelsky, Boundary"**, *supra* note 17 at 167.
[24] *Ibid.*

suggestion is to go behind the boundary metaphor and to unpack what it stands for.[25] Is she right?

I agree that if one sees the construction of relationship as what enhances autonomy, the metaphor of boundary is not useful. However, Jennifer Nedelsky's suggestion is unclear to me. She acknowledges that one of the general problems with the boundary metaphor is that it "obscures the questions it was intended to answer, it closes down rather than invites inquiry."[26] Moreover, when talking about boundaries in regard to child-parent relationship she writes:

> "...They focus the mind on barriers, rules, and separateness, perhaps even oppositional separateness. They do not direct attention to the nature of the relationship between the parent and the child...; in addition, boundary imagery teaches both parents and children that security lies in walls...boundaries structure relationships, but they do not help us to understand or evaluate those structures, and often the structures are undesirable".[27]

Jennifer Nedelsky's conclusion is that "the imagery acknowledged with the boundary is too well-established, too wall-like, to closely tied to a separative self."[28] Therefore, she calls us to look behind the metaphor of boundary. But how can this new metaphor of "looking behind" (the old metaphor) be done? And if this is her conclusion, why stay with the metaphor of boundary at all? Why not to call to get rid of it? Perhaps the reason Professor Nedelsky wants to leave the metaphor of boundary and only change its

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[25] *Ibid.*, at 172
[26] *Ibid.*, at 173.
[27] *Ibid.*, at 174.
[28] *Ibid.*, at 175.

conventional interpretation is the same reason that makes her stay with the notion of autonomy – that is the fact that these notions and categories are so deeply rooted in our tradition that one can not abandon them from our daily discourse and thinking. Such a reason has made Sara Hoagland to assert a more radical argument; *i.e.* that is not only one cannot abandon these categories but one cannot also change their (traditionally accepted) meaning.[29]

In regard to the category of boundary, I would also like to suggest a probably radical argument, but opposite to Hoagland's argument. I think we should seek to completely abandon the notion of boundary while talking about and thinking of autonomy in its relational meaning. Unlike the term "autonomy", that can bear various interpretations, the category of boundary carries inherently a meaning of separateness that is contradictory to the social construction under the relational theory. I agree with Jennifer Nedelsky that our conceptions of boundaries structure relationships. But their structure of relationships is in light of what separates one from each other rather than what connects them. In my view, it is difficult to imagine a linguistic meaning to the metaphor of boundary that will emphasize the later. It is more "efficient" to adopt a new metaphor to the idea of developing relationship as a way to enhance autonomy, even within a gradual and long process of time. I believe that by using more frequently this new metaphor, the bricks of the wall in the old metaphor will fall apart.

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[29] Sarah L. Hoagland, *Lesbian Ethics: Towards New Value* (Palo Alto, Calif.: Institute of Lesbian Studies, 1990).

As the reader could probably guess so far, I do not think there are boundaries between the brain dead mother and her fetus or between the brain dead mother (with her fetus) and the rest of the world. Applying the feminist relational theory here will help me make my point.

The concept of boundary between the mother and the fetus touches upon the delicate problem of maternal-fetal conflict. This conflict is raising the following questions: what is the relation between the mother and the fetus? What does this relation entail on the moral and legal status of the fetus? While above I was concerned with the social relations a brain-dead woman has in general, here, I will focus on the relations between a brain-dead pregnant woman (with the emphasis of her being pregnant) and her fetus. I will try to answer the questions I raised by looking to some of the writings of the feminist relational theory.

Cynthia Willett's writings on the relations between the mother and her fetus appeal to me. Willett mentions some of the alternatives to the metaphor of boundary in regard to mother-child relation.[30] Both the mother and the child are "*whole creatures*" in "*communion*" with one another; the mother is in a political and economic power in relationship with various others (including fathers, domestic workers, or employers), all of whom *mediate her relationship with her child*; the mother and the child enjoy a

[30] **Willett**, *supra* note 3 at 164-5.

multifaceted social relationship. Thus Willet is arguing against separating the child from the mother.

Indeed, carrying a baby is perhaps the most intimate physical-emotional relationship there is.[31] Mary Shanley talks about the limits of the language to convey such a relationship.[32] She quotes Gwendolyn Brooks' poem about abortion, " *The Mother*":

> "You are dead. / Or rather, or instead, / You were never made. / But that too, I am afraid,/ Is faulty: oh, what shall I say, how is the truth to be said? "

Shanley brings Barbara Johnson's analysis of that poem. Johnson notes that the poem continues to struggle to clarify the relation between "I" (the woman) and "You" (the fetus), but in the end, the language of the poem can no more distinguish between "I" and "You" than it can come up with a proper definition of life. Shanley also sheds light on the mother-fetus relation with Iris Young's writing.[33] She quotes Young:

> "...While for observers pregnancy may appear to be a time of waiting and watching, when nothing happens, for the pregnant subject pregnancy has a temporality of movement, growth, and change...the pregnant woman experiences herself as a source and participant in a creative process. Though she does not plan and direct it, neither does it merely wash over her; rather, *she is this process, this change*".

It is in these writings that I am inspired to claim about the "one" entity of the mother and the fetus (especially in the case where the fetus is not yet viable). But also the law, that is part of the field in which the brain dead mother (with her fetus)'s interactions take place,

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[31] Jennifer Nedelsky, "Property In Potential Life? A relational Approach To Choosing Legal Categories" (1993) 6(2) Can. J. L. & Jur. 343 at 364 [**"Nedelsky, Property"**]
[32] Mary L. Shanely, Making Babies, Making Families (Boston: Beacon Press: 2001) at 112 [**"Shanely"**].
[33] *Ibid.* (My emphasis-D.S.)

structures these relationships and shapes this concept. The way the law grants rights to the fetus only after it has left the maternal environment (including rights that relate to the time *prior* of the birth of the fetus) contributes to the perception of the fetus as integral part of woman.

The same ideas are expressed in court cases. Many states in the U.S. recognize (viable) unborn children as having rights to sue for stillbirth, but not for damages occurred before. In the Canadian *D.F.G*[34] case, the court ruled that the law does not recognize the unborn child as a legal or juridical person possessing rights.[35] The court emphasized that:

> "...Before birth the mother and unborn child are one in the sense that 'the life of the foetus is intimately connected with, and cannot be regarded in isolation from, the life of the pregnant woman'. It is only after birth that the foetus assumes a separate personality. Accordingly, the law has always treated the mother and the unborn child as one. To sue a pregnant woman on behalf of her unborn foetus therefore posits the anomaly of one part of a legal and physical entity suing itself."[36]

Once the child is born, alive and viable, the law may recognize that its existence began before birth for certain limited purposes. While talking on the imposition of duty of care on the mother owed to the unborn, the court in *D.F.G.* said that such a duty may create a conflict between the pregnant woman as an autonomous decision-maker and her fetus.

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[34] *Winnipeg Child And Family Services v. D.F.G.*, [1997] 3 S.C.R. 925 [**"D.F.G"**].

[35] If the mother was killed as a consequence of negligence on the highway, may her family sue not only for her death but also for that of the unborn child? I think our intuition responses negatively to this question. Such a question was hypothetically raised by Justice McLachlin in the *D.F.G.* case.

[36] Section 27 to Justice McLachlin's decision.

In my opinion one cannot avoid this conflict when one is also considered with the "best interests of the fetus" as an argument in favor of maintaining the brain dead pregnant woman "alive". Can we really speak of the interests of the fetus as separated from the interests of the mother? Surprisingly, the "best interests of the fetus" rule is a very strong one. It derives from a fundamental concern to the fetus' future life – or more accurately, it is concerned with the quality of the growth and development of the fetus, which the pregnant woman is carrying.[37]

In the case of a brain dead pregnant woman the "best interests of the fetus" rule seems to have a more important role. The chances that the fetus would survive *in utero* to 24 weeks were estimated 50%. To be born at 24 week carries a 75% chance of either death or significant developmental disability after an ordeal in the intensive care unit, 50% chance of survival, and 50% chance of significant disability for survivors.[38] Applying the best interest standard here requires that we do everything in our power to maximize the length of time of *in utero* development, including use of medical and surgical interventions. However, with all these efforts the chance for a good medical outcome is at most 10-12.5%. Can and should we act according to this rule and make every effort to save the fetus? Can one really separately talk about the interest of the fetus without considering its carrying mother? I think not.

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[37] As Goodwin has put it "quality is what we live for"- **Goodwin**, *supra* note 17 at *ix*. He further explains: "it is the relational order among components that matters more than material composition in living process, so that emergent qualities predominate over quantities" – *Ibid.*, at *xvi*.

[38] Survival *in utero* to 32 weeks carried only 10% chance, and only with the "maintenance" of the mother's physiological functions longer than any other recorded attempt, but this would mean little risk of significant morbidity or mortality for the fetus.

Perhaps we should interpret this rule differently. We shall not ask what the (sole) interests of the fetus are. Instead, we should ask for *the respect and appreciation for the child to be born.* By this, we will not be concentrated on the mere present survival of the fetus, that will be best assured by prolonging the time of its *in utero* development. Rather we would focus on the future conditions of its care taking, its welfare and its emotional and physical health.

Is there a boundary between the brain dead pregnant woman (with the fetus) and the rest of the world? I would like to answer this question from a unique perspective, to which I will devote a separate analysis. This would be the perspective of the human body.

D. The Human Body

The issue of maintaining a brain dead pregnant woman "alive" is strongly connected to the general concept of the human body. The body is a space where a matrix of rights and rules define and regulate the individual's and other's relationships to her body. In an earlier discussion, I supported the view that the human body (dead or alive) is a social construction. As Cynthia Willett puts it:

> "Sociality goes deeper into the natural realm than we have acknowledged. As human beings, we need to be loved and respected through the proper signs of touch and of the gaze. We experience these needs through our bodies. The body is itself part of our social presence. Respect for our body as part of our self is a need of our spirit. The mind/body divide not only removes us from the impact of the body on the mind; it removes us from social contact. This divide is useful to those who can find no other way to

> respond to the pathos of the social world than through stoic withdrawal."[39]

In my previous chapter I strongly argue that the need to be loved and to be respected does not end with a person's death. The body of a brain dead woman still has a social function even when she is laying spiritless in the intensive care unit.

Here also the law is part of this field of interconnections with the human body. The law shapes this field by special rules and norms. The law actually does not treat the person's "body" only as an anatomical or physiological entity attached to the person. By forbidding the selling, destroying or giving away of the body, the body is understood by the law not as an object or simply a property, but as something that is socially constituted.

Hence, I will argue that protection of the dead body is *a societal* value to be implemented in the same manner that applies to living persons. To use Catherine Keller's words: "our skin does not separate – it connects us to the world through a wondrous network of sensory awareness...through my sense I go into the world, and the world comes into me."[40] The skin of a brain dead woman keeps interacting and structuring the (new) field in which she and her social environment are part of. Even though it may not actively connect the brain-dead pregnant woman with others, it still keeps her engaged with

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[39] **Willett**, *supra* note 3 at 214; see also Anthony Farley, "The Black Body As Fetish Object" (1997) 76 Oregon L. Rev 457 at 487:" The body is a form of connection, a way of knowing pleasure and humiliation, of experiencing the self in others". He further writes: "the body is the lens through which we encounter the world: more than symbol. More than the bread and wine of Christ, the body is a knowing connection, it is the telling thing, the medium of experience. Expression, being and knowing" - *Ibid.*, at 488.

[40] **"Nedelsky, Boundary"**, *supra* note 17 at 177.

others, shapes their attitude towards her, and forms different reactions on them as well. Literary speaking, the skin of a brain-dead person remains warm. Her body is still sweating. She looks like a living person. Her existence is as strong as it was a few moments ago when she was alive. Through her skin she remains in the world.

E. Privacy

The case of maintaining a brain dead pregnant woman on life support for the delivery of her fetus emphasizes a strong sense of the notion of privacy. Is there a bigger interference to the privacy of a human being (dead or alive) than that of "using" its body as means, maintaining his body alive for the sole benefit of others?

Indeed, privacy is strongly related to autonomy. In its origin thinking individual autonomy was conceived of as protected by a bounded sphere, defined primarily by property where the state was not allowed to enter.[41] In this regard, Judge Major's ruling in the *D.F.G* case that "once the mother decides to bear the child the state has an interest in trying to ensure the child's health"[42] is prima facie violating her privacy. Autonomy (to the individual) is conceptualized in the traditional liberal thinking as "private" as opposed to the "public" represented by the "state" (or the power holders). This individual-collective conflict can have a moral consequence.

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[41] **"Nedelsky, Reconceiving"**, *supra* note 3 at 17.
[42] **D.F.G**, *supra* note 34 at section 95 to the Judge's decision.

However, our case challenges, the dichotomies private-public, and individual-state. Although the hospital as a "public" entity has the physical capacity to interfere in the pregnant woman's (perhaps) most private sphere, it will do so only with the consent or following the request of her substitute decision-makers. The latter are neither the "state" nor do they belong to the "public". Thus the "taking of property" (of the brain dead woman) is a pure private act. The fact that her maintainance on "life" support cannot be directly performed by private actors but through the health-care system does not categorize the act to a public act. One should abandon the narrow analysis that focuses on the *players* of the act and instead concentrate on the *act itself.* In this regard, the dichotomy private-public can lead to wrong moral judgment on whether to allow the "public" sphere interfere with the "private" sphere.

Another way to look at post-mortem pregnancy is by seeing the woman's family, friends and fetus – who all form and shape the interference in her privacy – as a collective. However, this collective should not be seen as a potential threat to the brain-dead pregnant woman (the individual), but somewhat a constitutive of her, and hence a source of her autonomy in her current special condition, as well as a danger to it.[43]

[43] **"Nedelsky, Reconceiving"**, *supra* note 3 at 21; See also **Willett**, *supra* note 3 at 170: "we need to alter our focus from the individual-in-opposition-to-the-state to the individual-in-relationship with local and transnational systems of economic and cultural power". In regard to the danger to the pregnant woman's autonomy, Judge Major in *D.F.G.* ruled that "it is a fundamental precept of our society and justice system that society can restrict an individual's right to autonomy where the exercise of that right causes harm to others" – **D.F.G**, *supra* note 34 in section 131 to the Judge's decision. An interesting question is whether the pre-viable fetus is harmed. This might be a corollary question to the question whether the pregnant woman as dead mother can be harmed by the procedure. I touched upon this question in my previous chapter.

As Emanuel Kant asserts, privacy also entails relationships of respect. It is also strongly connected to the metaphor of boundary: where we treat bounded spheres as indexes of personhood, respecting those boundaries constitutes respecting persons.[44] Because of the difficulties that rise with the metaphor of boundaries, Jennifer Nedelsky suggests to focus directly on the patterns of relationship that foster and express respect for people's needs, rather than on "respecting boundaries". As I showed in this chapter, applying her suggestion to our case would clearly make a strong claim against maintaining the pregnant woman "alive" for the sake of her fetus.

I would like to end my discussion on the concept of privacy by looking again at the law. I want to demonstrate how it shapes our attitudes also in this regard. For this purpose I will analyze our case from an abortion-law perspective, but shed a feminist light to it.

The right to make decisions regarding one's own body, as abortion, is conceptually derived from the right to privacy. I would argue that if the pregnant woman were alive, she could choose to have an abortion before viability age. Courts acknowledge that there is a significant difference between the circumstance in which a woman chooses to abort a fetus and one where the fetus will develop to full term and will be born. This difference is reflected in the "viability" criterion for abortions. According to this criterion, on which I elaborated in my first chapter, no one could (legally) intervene to override a pregnant woman's wishes and force her to carry the pregnancy to term. The "viability" criterion is

[44] **"Nedelsky, Boundary"**, *supra* note 17 at 176.

a good example of how the law shapes the discourse of the boundary metaphor. The law is influencing the field in which it is part of. This field is broader than the one that encompasses the case of a brain dead pregnant woman. It involves interactions and social interrelations in regard to the general concern about touching and physically intervening with a pregnant women's body within her first term. In my view, the analogy to abortion-law may be very useful.

While abortion involves the woman's deciding which is the better (or less worse) of two options, in our case we do not know if trying to save the baby adds to the tragedy in the woman's death or ameliorates it. In my view, maintaining the pregnant woman alive would carry a significant emotional cost. The family will have to watch the slow deterioration of her body. The family will also worry about the fetus's survival. The nurses that will be also involved in the prolonging process will suffer from stress. The tragedy of losing the brain dead pregnant woman and her fetus she carries the same time will be seen, in retrospect as *one tragic event* mourned by the family as a group. Maintaining a pregnant woman to save the fetus can thus result in experiencing two tragic events with a continuing sense of grief.

F. Property

Two possible contexts for property claim can arise in the case of maintaining a brain dead pregnant woman "alive". The first relates to potential claims of the woman's relatives on their "property rights" in her. The second involves the question whether the fetus is the

pregnant woman's property. Of course, one can connect these contexts and argue that if the woman's family has property rights in her, then, allegedly, they also have property rights in the fetus as well.

By determining if X has a property one has to ask what kinds of powers or entitlements should flow from defining an object as someone's property. By property I mean to that which is recognized to be ours and cannot be easily taken from us. This represents the connection between property and what are seen as the sources of its security – law and government.[45] Property is a right that requires collective recognition and enforcement. It defines what the society (or the state) cannot touch.[46] Thus, it defines a sphere in which we can act largely unconstrained by collective demands and prohibitions.

Property provided an ideal symbol for the conception of autonomy as the protection from the intrusion of the collective. Traditionally speaking, property helped to build the image that autonomy goes together with isolation.[47] Property is connected to the metaphor of boundary and conceived in boundary terms. It gives us control, provides privacy and security.

I will turn now to analyze the two contexts of property claim I presented above. I will do so by bearing in mind the following questions: what patterns of relationship among

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[45] I will touch upon this connection, below.
[46] "**Nedelsky, Boundary**", *supra* note 17 at 161.
[47] *Ibid.*, at 166.

people and the material world we want, and what patterns seem true to both integrity and integration.[48] I will start with the second context, which I find easier to deal with.

The idea of treating the fetus as property evokes concepts such as buying and selling, contracting and bargaining over. The application of these concepts to the human body is a major concern for Feminism. The concern is related to the objectification of women, treating them as "baby-making" machines, the exploitation of poor women, and the increasingly destructive commodification of all living things.[49] Jennifer Nedelsky, specifically argues that treating potential life as property will undermine the sense of children as gift of life, and that a property regime for potential life will actually exacerbate the inequalities and the problems of alienation to which women are already subject.

In my view, the sense that the potential life (the fetus) "belongs" to the pregnant woman reflects the idea that she should feel attachment to that fetus. But to protect and to respect such an attachment which constitutes part of her humanity does not necessarily have to end up by saying that she owns the fetus.[50] Protecting such a feeling of attachment can be done without using the ownership, possessing and potential selling and bargaining concepts that are associated to and derived from ascribing a property right to the pregnant

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[48] *Ibid.*, at 183.
[49] **"Nedelsky, Property"**, *supra* note 31.
[50] Jennifer Nedelsky makes the same argument more generally in regard to children: "we say that children are 'ours', that they 'belong' to us. But we do not confuse this sense of intimate connection with ownership" - **"Nedelsky, Property"**, *supra* note 31 at 358.

mother in her fetus. The same argument should be made regarding the claim on property rights to the woman's family. I will turn to examine this claim now.

The right to property in the dead body has a firm base in many rulings, especially in the U.S. In this regard, the law ascribes quasi-property interests to family members of a deceased, usually focused in due burial. I will briefly describe the legal analysis surrounding this issue. In my description, I would like to suggest that not only do courts mistakenly rule that next-of-kin have property rights in the dead, but the property reasoning of courts is getting much more frequent than it was, strengthening the "property rights" of next-of-kin, rather than weakening them or transferring them to other category of rights.

In *State v. Powell*,[51] the Supreme Court of Florida challenged a law authorizing cornea removal by medical examiners without first consulting the next-of-kin. The court examined at length the "property right" of the next-of-kin in a dead body and rejected the argument that cadavers are constitutionally protected private property. The court found that the right of the next-of-kin to a tort claim for interference with burial does not rise to the constitutional dimension of a fundamental right traditionally protected under either the United States or Florida Constitution. Instead, the court relied on rational basis review and upheld the law, finding that it was rationally related to the legitimate purpose of restoring sight to the blind.

[51] *State V. Powell*, [1986] 490 So. 2d 1188 (Fla.).

In *Georgia Lions Eye Bank, INC. et al. V. Lavant,*[52] the mother of an infant, who had died of sudden infant death syndrome, brought suit against hospital and an eye bank for the wrongful removal of corneal tissue of infant following death pursuant to statute of Georgia authorizing removal for transplant of corneal tissue of decedents. The Supreme Court of Georgia ruled that in Georgia, there is no constitutionally protected right in a decedent's body, and that the statute authorizing removal for transplant of corneal tissue of decedents, if no objection is made by decedent in his life or by his next-of-kin after death, is, thereupon, constitutional.

However, In *Brotherton v. Cleveland,*[53] the court has recognized a property claim to a dead body and initiated a change in this regard. Using an analysis similar to that suggested by petitioners in *Powell*, the court found that such a claim is entitled to the protection of the Due Process Clause and thus invalidated an Ohio provision which was analogous to the Florida law upheld by the court in *Powell*. Although the court acknowledged the difficulty in calling the claim of the next-of-kin "property," it maintained that the next-of-kin had a "legitimate claim of entitlement" which rises to the level of constitutional protection.

A stronger move was made in a recent case in *Newman v. Sathyavaglswaran.*[54] In this case, the parents of deceased children brought action against coroner, alleging

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[52] 335 S.E.2d 127, 255 Ga. 60, 54 A.L.R.4th 1209 (1989).
[53] 923 F.2d 477 (6th Cir. 1991).
[54] *Newman v. Sathyavaglswaran*, [2002] 287 F.3d 786 (9th Cir.).

deprivation of property without due process, based on removal of children's corneas without notice or consent. The mere argument of the parents was the taking of their property without due process of law in violation of the Fourteenth Amendment. After analyzing the history of rules and understandings with respect to the possession and protection of the bodies of the dead, and rejecting the former decisions, the court held that "serving a duty to protect the dignity of the human body in its final disposition that is deeply rooted in our legal history and social traditions, *the parents had exclusive and legitimate claims of entitlement to possess, control, dispose and prevent the violation of the corneas and other parts of the bodies of their deceased children.*"[55] Hence, based on the parents' duties and their responsibilities after the death of their child, the court concluded that the parents had property interests in the corneas of their deceased children protected by the Due Process Clause of the Fourteenth Amendment.

The move the courts take to recognize a property right in the dead reflects how the law not only shapes the field in which it is part of but how it is also developed by the field in which it finds itself. The shift in the legal cases is also an example to the way the law provides a whole language to this field - a language of property rights.

However, I would argue that the language of property in these recent rulings is a basic conceptual error. Property is a set of legal rules and norms that structure power. The rules tell us who has to ask whom for what, and how much power or powerlessness they will

[55] *Ibid.* at 796. (My emphasis – D.S.).

have in their request. As Jennifer Nedelsky explains, the error to use such language of property comes from the thought that whenever the issue at stake is who has control or authority to make decisions with respect to something, that something must be property.[56] In my view, we do not need the concept of property. It adds nothing desirable and it brings with it a whole set of presuppositions (such as those connected to commodification and objectification) which are inappropriate for human beings. Perhaps the notion of stewardship is better.[57] Nevertheless, I think we should reject the use of property language as dominating the relations between the pregnant woman's family members (or next of kin) and the pregnant woman in this complex situation.

Conclusion

As I tried to show we need to look at things differently. This also involves a change in our language, but not before a change in our way of thinking. Autonomy, field, boundary, human body, privacy and property are some of the main concepts that our case evokes. In my view, the relational feminist theory can do a good job in addressing these concepts, especially in cases where a dilemma whether to maintain a brain dead pregnant woman occurs.

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[56] **"Nedelsky, Property"**, *supra* note 31 at 361. Here again the analogy to children is clear: "The law confers a wide range of powers of control and decision-making authority upon parents with respect to their children. Yet we do not mistake children for property" - *Ibid.*, at 362.

[57] Mary Lyndon Shanley suggest that "a person's relationship to his or genetic material is better thought of as a kind of stewardship than as ownership". By this she means a turn away from "those strands of the liberal tradition that emphasize the individual and property in the body, and towards those strands that rest on a deeper understanding of the person rooted in multiple and complex relationships to family and civil society" - **Shanely**, *supra* note 32 at 94-5.

In this chapter I also tried to emphasize the important role of the law in each of these concepts. The law helps define the field, which includes individuals' interactions with it. It defines the scope of the field one wants to focus on.[58] It constructs and creates powers, norms, and boundaries to foster and enhance autonomy.[59] It also provides a whole language to the field.[60]

But the law is also part of the social field. As Cynthia Willett puts it, "the function of law is to protect the social individual from violation, and to cultivate the erotic power of the individual-in-relationship-to-others."[61] The law never acts in a vacuum. It works in a more complicated ways to interact with many forces. It makes assumptions that are not outcomes of a logical or analytical process.[62]

The law's language is that of rights and duties. The language of rights involves mutual relations. X has a right if Y has a duty to fulfill this right. X's right without Y doesn't mean anything. Legal rights structure relationships of power, responsibility, trust, obligation, respect, and care-taking. Thus, it is the connections between people, their relationships to one another, that matter in the sorts of issue for which we invoke legal

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[58] An example for this is the *parens patriae* jurisdiction of the court that grants it the power to step into the shoes of the parents and make orders in the best interests of the child.

[59] Thus, for example, the law usually ignores the fact that individuals exist in families or relational contexts, it shapes the image of dependence as negatively compared with the desirable status of interdependence.

[60] For example see Reva Siegel that analyzes the use of the "privacy language" by the court as reasoning to marital violence - Reva Siegel, "The Rule of Love" (1996) 105 Yale L. Journal 2117.

[61] **Willett**, *supra* note 4 at 163. Willett places an important locus to the notion of Eros. Joining the writings of Lorde and Walker, Willett sees love as a force for the expansion of the human personality in relationship to others. Eros in her view is a primarily source for, and not a primitive threat (as in the Freudian and post-Freudian thinking) to subjectivity.

[62] See for example Judge Major in the *D.F.G* case: "the law will presume that she (the pregnant woman) intends to carry the child to term untill such time as she indicates a desire to receive, makes arrangements for or obtains an abortion" – **D.F.G**, *supra* note 34 in section 116 to the Judge's decision.

rights. One cannot talk about the rights of the pregnant woman, the fetus, or the woman's family without engaging the relational discourse.

All of these factors should be considered. Relations are complex. No absolute answer or directive can be sought from analyzing them. However, their importance to the human condition is so big that not to consider them would be a terrible mistake but more importantly a basic misunderstanding of the human nature itself.

The mother-fetus relation is one set of human relations I described in this chapter. Let us now move to analyze the ethical duties of a pregnant woman to her fetus, formed under this special bond.

CHAPTER 7: ETHICAL DUTIES OF THE PREGNANT MOTHER

In her article on "The Architect and The Bee: Some Reflections on Postmortem Pregnancy",[1] Hilde Nelson raises the question whether physicians have a legal duty to sustain pregnancies of women who die during the first or second trimester. In order to answer this question, Nelson assumes four different grounds on which such a legal duty might rest. The duty might be a matter of respecting the woman's wishes, there may be a duty to the State, a duty might be based on beneficence of the fetus, or one might find a duty of "special relationship" between the mother and the fetus. In regard to the latter, Nelson's conclusion is that it is not clear at all how a relationship between "such shadowy figures could breed special duties".[2] More general, her conclusion is that there is no basis for a legal duty to continue a pregnancy after the woman is dead.

In this chapter, I will the dilemma caused by post-mortem pregnancy from the standpoint of the pregnant woman. I will do so by focusing on the fourth ground Nelson proposed as a base for the duty to sustain pregnancy of a dead woman. In contrast to Nelson, I would claim that the special relations the woman and the fetus have (to which Nelson herself strongly argues) do provide such a moral duty. However, I would argue that this duty should be declined upon the end of the relationship between the mother and her fetus with the mother's death. I will support my argument by analyzing the special relationship between the mother and the fetus from four related ethical theories: ethics of

[1] (1994) 8 (3) Bioethics 247 ["**Nelson**"].
[2] *Ibid.*, at 261.

relationships, responsibilities to society, ethics of families, and ethics of care. In the end, I will also bring a religious perspective that would support my practical conclusion.

The Nature of Maternal-Fetal Relationship

A legal duty to sustain pregnancy implies that there are two separate (legal) entities involved: the brain-dead pregnant woman on the one hand and her fetus on the other hand. The idea of separateness between the mother and the fetus touches upon the delicate problem of maternal-fetal conflict. This conflict is raising the following questions: what is the relation between the mother and the fetus? What does this relation entail on the moral and legal status of the fetus? I will try to answer these questions by looking into the nature of the relationship between the mother and her fetus, and by asking about the moral and (perhaps) legal implications that such a relationship creates.

I will turn now to discuss the nature of the maternal-fetal relationship. A fascinating description about pregnancy is brought by Hilde Nelson in her article. By rejecting Marx's famous distinction between the architect and the bee, according to which the woman's activity of being pregnant is thought to follow its own preordained patterns, she writes:

> "In important ways, the pregnant woman more nearly resembles the architect than the bee. As is typical for her species, she both obeys the laws of nature and improves upon them, ordering and shaping what she finds in the natural world through her own intentional, creative activity. She transforms natural processes by valuing them or by imbuing them with meaning; out of the ordinary phenomenon of hunger, for example, she creates a dinner party. That is, she turns the need for food into an occasion for

> expressing friendship, or possibly furthering social ambition. Like the architect's, her edifices can be and often are purposeful and deliberate...once having conceived the purposiveness continues: the woman creates a relationship with her fetus. It begins as an act of the woman's imagination, as soon as she knows or suspects she is pregnant. At that point she may be at odds with her own body, or she may be in a special harmony with it, as the newly formed fetus both is and is not a part of her own self. If she feels it as an intrusion she may figuratively push it away, distancing herself from it and perhaps aborting it or, after birth, neglecting it or giving it up for adoption. Or she may embrace it lovingly from the beginning, imagining its future and setting it within an existing web of relationships in which it will have a valuable place. Throughout the course of the pregnancy it becomes less and less her self and more and more its own. From the beginning it has a value independent of the meaning-system she weaves around it, but what she weaves also has value – the value of painting or a song, and not just the value of the honeycomb..."[3]

Nelson's strong words go together with the Feminist writings of Cynthia Willett, Mary Shanely and Barbara Johnson, which I discussed in the previous chapter. Following these writings, the mother and the fetus are one entity, or two creatures in a special relationship, that is far beyond the mere biological. This relationship has, in my view, a strong ethical implication. It creates special obligation to the fetus. This moral obligation is not derived from the fetus' separate moral or legal status, specifically from the legal claims of the fetus as right holder. It is also not derived from the mother's traditional right to privacy, autonomy, or alike. It is founded on the unique relationship that these two creatures share in the process of pregnancy. I will turn now to justify my argument by applying four different, though close, ethical theories: ethics of relationships, responsibilities to society, ethics of families, and ethics of care. Beforehand, I will

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[3] **Nelson**, *supra* note 1 at 262-263.

explain why the two major ethical theories, Consequentialism in the form of the Utilitarian theory and the deontological theory of Kant cannot fully apply to my analysis.

In this chapter, I am asking whether the mother owes a duty to the fetus to maintain him or her alive. As this question is not focused on the consequences of the proposed act, it is not a matter of Consequentialism like the Utilitarian theory. Here, I am not dealing with the position that an action is morally right or wrong according to its consequences. Hence, I do not need to take account of what can reasonably be expected to produce the greatest balance of good or least balance of harm, in order to assess the best utilitarian outcome.[4] I am examining the ethical weight of the mother's response (and her physician accordingly) whether to be maintained on life support or not from a deontological perspective.

My standpoint would be Emanuel Kant's belief that an act is morally praiseworthy only if done neither for self-interested reasons nor as a result of a natural disposition, but rather from duty. That is, the person's motive for acting must be recognition of the act as resting on duty. However, this chapter will not focus on Kant's supreme principle on universality.[5] Neither will it touch upon Kant's requirement not to treat persons as

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[4] Tom L. Beauchamp & James F. Childress, *Principles of biomedical ethics* (5th ed.) (New York, Oxford University Press, 2001) at 12 ["**Beauchamp & Childress**"].

[5] According to this principle, an action has moral worth only when performed by an agent who possesses a good will, that is whose moral duty is based (solely) on a universally valid rule – **Beauchamp & Childress**, *ibid* at 13.

means.[6] It will focus on the centrality of the duty in the ethical judgment. More specifically, I will ask for the source of such a duty, while focusing on duties that derive from relations between the mother and the fetus.[7] This is why I will apply more relevant ethical theories to my analysis, which I will now turn to describe.

Ethics of Relationship

The idea that duties that derive from relationships implies that moral responsibilities are neither corollaries of a first moral principle (like the principle of beneficence or autonomy) nor "rules of thumb" for determining sound deliberative conclusions. Under the relational theory, moral responsibilities are a product of the multiplicity of relationships with particular persons that make up our lives. It is through the specific, concrete experience of encountering this person in these circumstances, or of being connected in these ways, and also of recognizing the intrinsic and unique value of this person, that a relationship is formed in which responsibilities are recognized.

Relationships and their accompanying responsibilities are a function of the potentialities in the concrete circumstances of people's lives. In addition, they have a temporal

[6] This requirement means that we can never treat the other (exclusively) as means to our ends. From this requirement Kant derives the demand that persons should be treated with respect and moral dignity - **Beauchamp & Childress,** *ibid* at 14. Applying this requirement to our situation would be a difficult task as we would have to face, *inter alia*, the following questions: Is the brain dead mother "a person", subject to moral benefits; is the fetus "a person" subject to moral duties"; is the requirement of treating the other as a means pre-assumes an intention, and if so, can we attribute this intention to the fetus; is maintaining a dead woman on life support for the delivering of her fetus an action that treats her solely as a means, and are there not any benefits that she might gain as being a dead mother to a fetus who is about to be born, etc'.

[7] My inspiration for this analysis comes from W. D. Ross' theory on prima facie duties. Ross' main argument is that duties like fidelity, reparation, gratitude, beneficence, non-maleficence, justice and self-improvement are based in significant relations.

dimension that is crucial to their proper understanding: they develop over time, sometimes growing, or just altering, sometimes declining, and sometimes ending altogether.

The concept of a duty based on special relationship assumes that some people have a duty to undergo more than minimal risk on behalf of others because they have *willingly* consented to put themselves in a special relationship to those persons. One obvious example to such a duty is the duty of physicians to treat their patients even where there is a risk of life-threatening infection. Another example would be the duty of firefighters and lifeguards to rescue and protect others even with the cost of endangering their own lives. Under this assumption the duty derives from the willingness to undertake it.

Another possibility from which the duty can derive is *causality*. Under this source, a person is responsible for putting someone else at serious risk of harm, even unintentionally. A classic example would be the duty of a person who abandoned an open refrigerator in a vacant lot where the door was jammed shut over a trespasser.[8] Some claim that the parent's duties to care for their children are of this sort.[9] Pregnancy satisfies these two forms of duties: the mother has willingly put herself in this special

[8] An Israeli case declared such a duty and found that the breach of that duty constitutes negligence under the private law. See 196/64 *The Attorney General v. Mordechai Bash* (The Supreme Court of Israel) 18 (4) 568 from 15 December 1964.
[9] **Nelson**, *supra* note 1 at 260.

relationship with the fetus,[10] and she also has put her fetus to be in a causal risk of harm under the process of pregnancy.

All of us suppose that we have, with respect to various particular persons with whom we are so related, a set of more or less well-defined specific moral responsibilities. Reflection on such relationships draws our attention to the importance of responding in ways appropriate to particular human beings.

In non-intimate contexts (business, school, work, etc'.) we can claim the same kind of moral respect that anyone else gets; we can expect that our rights will be honored and our dignity observed. But in intimate contexts, we are owed much more: love and importance, fidelity and solidarity, all grounded in the fine-grained particulars of lives lived in common. The mother-fetus relation is the best example for such intimate relations. In fact, I could easily claim it is the most intimate relation one could have.

Christopher Gowans argues for two kinds of considerations that our responsibilities to intimates are rooted in.[11] The first is the perception that each of these persons has intrinsic and unique value. The second is the recognition that some connection or another obtains between oneself and these intimates. Thus, for example, it is because Jennifer

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[10] *Ibid.,* at 263: "women, unlike other animals, often are pregnant for a reason: they may conceive and carry a fetus because they want a special relationship that will last over time, or because they want an existing child to have a sibling, or because without children they would feel less firmly rooted in the world, or because they hope the baby's bone marrow will be a lifesaving match for a dying family member".

[11] Christopher W. Gowans, *Innocent Lost : An Examination of Inescapable Moral Wrongdoing* (New York: Oxford University Press: 1994) at 122.

regards John as intrinsically and uniquely valuable, and because she knows he is her son and the person she has raised, that she understands herself to have special responsibilities towards him. The idea that individuals are regarded as valuable in themselves means that they are not only valued as a means to some further valued end or that they are valued not only by being a part of some valued whole.

In contrast to Kant who regards respect for persons as ends in themselves as a manifestation of respect for the moral law dictated by pure practical reasoning, on the responsibilities to person account we do not regard intimate as intrinsically valuable by application of an *a priori* moral law, but through the experience of concrete interaction. It is the context of our particular relations with the person that matters. On this view, a person is not only intrinsically valuable, but has an intrinsic value which is different from that of everyone else.

By contrast, for Kant what makes persons ends in themselves is a property *shared equally by all*: rationality and autonomy. Since only this property is morally fundamental, nothing about persons that distinguishes them from one another is of deep moral relevance. Persons are intrinsically valuable, but equally so.

In the Utilitarian tradition, persons are neither intrinsically valuable nor uniquely valuable. In calculating the goodness of the consequences of our actions everybody is to

count for one, and nobody for more than one.[12]

In both Kantian and Utilitarian traditions, whatever may be unique about individual persons cannot be of basic moral significance. Persons cannot be uniquely valuable in a way that makes a difference to morality.

The uniqueness of persons can play different roles in deliberation. In some cases, for example, those of familial or romantic love, the specific ways in which a particular person is unique are vitally important: we attempt to respond to what is uniquely valuable in that person. In other cases, especially as we move away from the paradigm of intimate relations, we are in less of a position to understand or appreciate much of what is uniquely valuable in a person. In the extreme case, we can hardly respond to anything specific about the person at all.

Being intrinsically and uniquely valuable creates the potentiality for responsibility. It establishes that this is a kind of being for whom one can have moral responsibilities. It does not by itself establish that someone, indeed that anyone, has responsibilities. These

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[12] For a different view see Thomas Mappes & David DeGrazia (eds.), *Biomedical Ethics*, 5th ed. (Boston: McGraw-Hill: 2001) at 16. Although not distinguishing between intimate relations and non-intimate relations, Mappes and DeGrazia claim that duties that derive from relations are consistent with Rule-Utilitarianism: "Rule-Utilitarianism also seems to accord reasonably well with our experience of particular morally significant relationships. We commonly perceive ourselves as having special obligations arising out of our various morally significant relationships, and we think of these obligations as incompatible with functioning in the manner of an act-utilitarian. For example, parents have a special obligation to care for their children; physicians have a special obligation to act in the interests of their patients, and so forth. Such special obligations can be understood as having a rule-utilitarian foundation, as deriving from rules that, if generally followed, would maximize utility".

only arise when some connection is established between persons, for example, through family relation, friendship, love, nationality, ethnicity, agreement, proximity, knowledge, common background, commitment, interest, etc`. On the basis of one or more of these various forms of connection, and typically the mutual recognition of the unique and intrinsic value of one another, a relationship between persons may be formed. Constitutive of such relationships is an understanding of some form of responsibility by each person to the well being of the other, though the nature and scope of these responsibilities, as well as the extent of their symmetry and the degree to which they are well defined, varies with the nature of the relationship.[13]

Applying this theory to the relation between the mother and her fetus is highly appealing. Although the fetus is in an early stage of development, it has uniqueness. It was created in special context (time, place, emotional state, etc`.), and it carries with it the special meaning of bringing a child into the world in the unique way of the process of pregnancy, which I described above. As long as the mother is aware of this uniqueness, and as long as she acknowledges the value of her fetus, and of her relationship with the fetus, she is responsible for its well being. Thus, she cannot abort him out of her own discretion, and

[13] It is important to stress here two points: first, there is a great deal of diversity in the ways in which connections among us come about. This diversity results from the fact that our relationships depend upon social institutions that are both complex and variable across history and cultures. The different possibilities of our particular social world determine how we can come to be related to other persons. The implication of such diversity is a considerable variety among the moral responsibilities that arise from these relationships. Second, relationships typically arise through a combination of choice and unchosen circumstances. In some case, for example in responsibilities children have towards their parents, there is no element of choice at all. In most cases, relationships come about through choice in the context of circumstances that are unchosen and contingent, such as the choice of our spouse, the choice of our workplace (where we have relations with other workers), etc`.

to the extent she can do so, she has a duty to refrain from smoking, drinking excessive amounts of alcohol, or taking recreational drugs. The moment she becomes brain-dead, she looses her ability to appreciate and understand that she has such a special relationship (and hence responsibilities) to her fetus. The second and perhaps the most important component of her responsibility for her fetus is gone.

Responsibilities to Society

The duty of the mother to her fetus can also be justified by an ethics of responsibilities to society in general. Human flourishing requires more than individual relationships. It requires participation in collective forms of human activity. Moreover, many relationships with individual persons are possible only within the context of these collectives. Thus, we have responsibilities not only to individual persons, but also to social entities, which consist of persons brought together through some common interest, purpose, origin, need, belief, aspiration, hope, etc`. Hence, there may be responsibilities to one's community, nation, government, ethnic group, race, family[14], clan, tribe, religious institution, university, company, profession, labour union, political party, and so on. These social entities differ radically from persons. There is nothing that constitutes a person as persons constitute social entity.

[14] A family here represents a social entity, regardless of its unique characteristics on which I will further elaborate.

Yet, social entities have life of their own that transcends the persons who make them up. Often, these social entities have as their *raison d`etre* some concern that transcends the needs of any specific individuals, for example a university's commitment to education and research. The existence of these entities typically does not depend upon the membership of any particular persons. This is why our relationships with these groups and our responsibilities to them are not reducible to our relationships with and responsibilities to some list of persons. Our responsibilities to a social entity thus should be thought of to something which consists of persons united in some human interest.

A given relationship implies an understanding of the features of the responsibilities that are constitutive of it. These features depend on a variety of factors: the nature of the persons or social entities involved, the nature of the relationship, various circumstances of people's lives (history, health, finances, talents, opportunities, etc.), other relationships, and a sense of what is realistically possible in human life generally and specifically for the particular person involved.

One such an important social entity is the family. The fetus, although not born, is part of the mother's family (new or existing one). From the mere fact of its existence, the fetus constructs this social entity, shapes it and gives it a new meaning, power-relation, and form. Being part of it, on the one hand, and activating it on the other hand, the fetus' well-being is instrumental to the establishment of this new and developing social entity. The mother, as a moral agent, owes *a societal* duty to enhance this *social entity* and to

provide it by, *inter alia*, being responsible for her fetus. In this view, the duty towards the fetus serves as a means to flourish the new social entity (the family).

However, families have intrinsic values in themselves. They should be ethically respected not only since they are social entities like other entities. They are special. They represent a combination of the ideas I discussed above, that is they are unique social entities which constitute intimate relations within their members. Thus, they create special ethical obligations to which I will turn to consider now.

Ethics for Families

What is so special in families? Family members cannot be replaced by similarly (or better) qualified people. The function of families is to cherish individual members, not for contributions to various ends, but for themselves. Family members are "stuck" with each other. We do not choose familial relations, we do not replace family members with other, better qualified people, and we can not just walk away from these relationship.

As a matter of biology and history, occupying family roles intersects with a variety of considerations we regard as morally important. Families are social entities with strong intimate relations. These relations provide a rich set of expectations, and we are particularly vulnerable to deep disappointment and even damage if those expectations are simply ignored. Finally, families serve as our first and perhaps most fundamental school

for moral formation, and they are also crucial to the formation of a child's conscience and the sense of self. It is within families that children learn how to live within the set of relationships in which they are nested.

Recently, ethics of families have been well incorporated within medical ethics. This process took place due to some important changes in the role of physicians, on the one hand, and in the centrality of families and communal needs, on the other hand.

Indeed, the traditional ethics of medicine shares with the more general tradition of ethics a primary concern with individuals. Thus, many physicians think it is wrong to take broader communal concerns into account when making treatment decisions for their patients.[15] Nevertheless, medicine is not ethically devoted to all individuals. Only those people who have a doctor-patient relationship are the subject of special moral concern. Medical ethics are, therefore, a contractual ethics in which all special duties flow from a relationship freely entered into by willing participants.[16]

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[15] A very strong claim would be that physicians not only consider communal interests, but they have an obligation to save resources for society – an obligation that sometimes can compete with their own obligation to their patient. This makes them "double agents". See the excellent piece of Marcia Angell, "The Doctor As Double Agent" (1993) 3(3) Kennedy Inst Ethics J 279.

[16] A stronger argument which I will not develop here would be that not only is medicine ethics not individualistic and impartial, but it tends to favor those who are powerful enough to enter into the doctor-patient relationship. Thus, it tends to favor those with more rather than less money, education, social standing, etc`.

However, as Nelson and Nelson rightly claim, medical ethics, unlike general ethics, are grounded in a social practice, that is culture-specific traditions of the profession.[17] This view is supported by contemporary calls for physicians to take their patients seriously and to see them as active decision-makers, who can (and should) often determine their medical interests for themselves, and who will not always opt for courses of action the physician approves.[18] The most profound example for such a view is the fact that questions of justice in the allocation of medical resources (like organ transplantation) become very pressing. By dealing with such questions, doctors are expected to make a balance between the interests of their patients and the interests of society at large.

The implications of health care decisions are far beyond the patients themselves. As Eva Kittay beautifully writes when she discusses Communitarianism and its effect on bioethics:

> "We frequently speak as if the obligation to provide care to a particular person belonged to a given individual or, perhaps, to a family. But an individual in need of care is like a stone cast in the water. Those feel the impact most immediately who are in closest proximity, but the effects come in wider and wider ripples. Even though the well-being of an individual may be the immediate duty of those who are closest, it is the obligation of the larger society to assure that care can be and is provided"[19]

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[17] Hilde Lindemann Nelson & James Lindemann Nelson, *The Patient in The Family* (New York; Routledge; 1995) at 57-59.

[18] These calls are along with the huge rise in medical-practice law suits that seems to have made a continuing threat to the professional career of physicians.

[19] Eva F. Kittay, "A Feminist Public Ethic of Care Meets the New Communitarian Family Policy" (2001) 111 Ethics 523 at 535. Some argue that health care decision making is not only a (neutral) matter of the society or the community in general, but that it is also and mainly influenced by our own culture, ideology, discourse and tradition. See for example, Daniel Callahan, "Bioethics: Private Choice and Common Good" (1994) 24(3) Hastings Center Report 28 at 31: "If we think of medical developments as simply putting difficult but discrete moral choices before us – how to best use this or that technology, whether to turn off a respirator, or whether to engage in a fetal therapy – we have already failed to see the presence of a still deeper question. That is really a twofold question: first, to what extent has the culture engendered by medicine already constrained our choice (forcing us, for instance, to consider the use of a respirator

Along with the development of this view are the centrality of the family, and the increased role of the family in shaping the patients' attitude and decision-making. As the focus in the clinical area has extended from the patient to other family members (spouse, partner, parents, step parents, siblings, step siblings, grandparents, uncles, etc'), physicians confront an inherent need to discuss their patient's health problems with people other than the patient herself.[20] The situation of a pregnant brain-dead woman is a classic example for such a complexity, as it always involves other family members as well. Sometimes, the patient's family members' attitudes can vary among themselves.[21]

Ethics of Care

Another theory that can justify my argument on the familial obligation the mother has towards her fetus is ethics of care. The theory of ethics of care focuses on a set of character traits that people all deeply value in close personal relationships: sympathy, compassion, fidelity, love, friendship, etc'.[22] Caring and compassion is also emphasized –

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whether we want such a choice or not)? and second, what kind of culture well we be engendering by the pattern of private decisions that eventually emerges from the need to make decisions? ".

[20] Sometimes, sharing the patient's health problems with other family members can cause ethical dilemma. For example, when the physician discovers a new genetic disease, a question arises whether the physician has a duty to contact other family members that may also be sick where the patient herself objects to tell her family.

[21] The case of Ellen Higgis that Jeffrey Spike brings in his article is an example of a real life situation in which the mother opposed to maintaining Hellen "alive" while her father and his second wife asked for this procedure. See Jeffrey Spike, "Brain Death, Pregnancy, and Posthumous Motherhood" (1999) 10 (1) J. Clin. Ethics 57.

[22] Interesting to note here that the Latin word for cure is cura, which also means care.

though not exclusively - by virtue-ethics approaches.[23] An ethics of care places greater emphasis on health-care providers' communication skills and emotional sensitivity, and on the effects that ethical issues have on relationships. An ethics emphasizing caring for others encourages resolutions of moral problems that give greater authority to family members in health-care decision making.[24]

The Royal Commission on New Reproductive Technologies adopted the guidelines of ethics of care and saw this theory as the most suitable in maternal-fetal conflicts. In its report, the commission concluded that:

> "In line with the ethics of care, we believe that the best approach is to seek ways to ensure that the needs of both the woman and the fetus are met... the ethic of care offers a means of avoiding the conflicts inherent in judicial intervention by promoting two fundamental values: respect for the rights and autonomy of the pregnant woman and concern for the health and well-being of the fetus. The best way to accomplish this is not by compelling pregnant woman to behave in certain ways, but by providing a supportive and caring environment in which they can make informed decisions and choose from among realistic options before and during pregnancy."[25]

Hence, taking family seriously as important social entities or due to their intrinsic special values is also in accordance with ethics of care. As I showed above, ethics of families (as social entities and as special entities with intrinsic values), and ethics of care can support

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[23] Edmund D. Pellegrino, "Toward a Virtue-Based Normative Ethics for The Health Professions" (1995) 5(3) Kennedy Inst Ethics J 253 at 269.

[24] There are five central ideas in ethics of care: moral attention, sympathetic understanding, relationship awareness, accommodation and response. See Ruth C. Manning, "A care Approach" in Helge Kuhse and Peter Singer eds. *A Companion to Bioethics* (Malden, Mass.: Blackwell Publishers: 1998) at 98.

[25] The Royal Commission on New Reproductive Technologies, *Proceed with Care – Final Report* (Ottawa: Ministry of Supply and Services: 1994) Vol. 2 at 962.

the claim for the mother's duty to maintain her fetus alive. However, with the mother's death, the mother is no longer part of the family she has owed to in her life. Her moral agency is over now, and she has no more obligations of care to her fetus. My practical conclusion will be finally supported by religious ethics, especially Catholic ethics.

Religion and Bioethics

Religious ethical discussion is often conducted by reference to moral rules which prohibit or mandate the performance of certain types of actions. Much religious moral thought assesses actions in terms of the *intentions* embedded in them rather than in terms of what is done or what results.[26] The intention embedded in the action can substantially determine the moral permissibility of the action. The idea of intent, for example, can lead to different result when interpreting an act as "letting die" rather than "kill".[27] In our case, letting the mother (and her fetus) die peacefully does not amount to killing the fetus. By using the principle of "double effect" we can argue that the death of the fetus can be regarded as best foreseen but unintended result. Of course, this is different than (actively) performing an abortion on a living pregnant woman. In addition to the act of killing itself, this living woman continues to owe her fetus all the moral duties I discussed above, so

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[26] Baruch Brody, "Religion and Bioethics" in Helge Kuhse and Peter Singer eds. *A Companion to Bioethics* (Malden, Mass.: Blackwell Publishers: 1998) *A Companion to Bioethics* (Blackwell, 1998) 41 at 44 [**"Baruch Brody"**].

[27] One of the objections to Utilitarianism derives from this distinction and from the absence of components such as intention and responsibility. As Arras and Steinbock writes: " For nonconsequentialists, it can be very significant whether an outcome occurs because of something *I did*, whereas for consequentialists all that matters ultimately is *what happens*. This has led some consequentialists to reject a time-honored distinction in medicine between 'killing' and 'letting die' ". See John D. Arras & Bonnie Steinbock eds., *Ethical Issues in Modern Medicine*, 5th ed. (Mountain View, Calif.: Mayfield Publication Co.: 2000) 11.

that performing abortion is also morally wrong from the mother's perspective, that is from her moral obligations toward her fetus.

Respecting the secular principle of "autonomy"[28] can derive in religious ethics from the concept of *fidelity*.[29] Much religious moral thought draws upon theological conceptions to develop an ideal of human relations. One such ideal is covenantal fidelity. According to this ideal, God and his people have entered into a covenant of fidelity, which mandates faithfulness to each other, so individuals entering into special relations with each other should feel bound by the mandates implied by the ideal of covenantal fidelity. It is difficult to speak of the pregnant woman's duty of fidelity to her fetus.

Nevertheless, as derived from this duty, the physician must respect the patient's wishes and be faithful to her, not because she holds the right to autonomy (and hence according to the traditional view, as soon as she dies, she no longer enjoys this "right"). The woman's wishes should be respected and considered mainly because the physician has a duty of faithfulness towards her. This duty does not end while she is still a patient, lying in the intensive care unit, though brain-dead. Acting not in accordance to her prior wishes (including the situation in which she did not positively leave any directives regarding her pregnancy upon her death) violates the ideal of fidelity.

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[28] In this chapter, I did not focus on the principle of autonomy. A major reason for many of the problems identified with the autonomy ideal, especially in regard to dead people is that the notion of autonomy is commonly understood to represent freedom of action for agents who are paradigmatically regarded as independent, self-interested, and self-sufficient. As such, it is easy to categorize dead people as not being autonomous or as people who are not entitled to autonomy (due to their death). The familiar critique by Relational Feminists to this liberal approach to autonomy is that it takes atomistic individuals as the basic units of a political and legal theory, and, thus, fails to recognize the inherently social nature of human beings. See *infra* Chapter 6 to my thesis.

[29] **Baruch Brody**, *supra* note 26 at 45.

There are more specific values that are fundamental to Catholic bioethics from which one can support my practical conclusion not to maintain a brain-dead pregnant on life support. One important value is the belief in the sanctity of life. The value of a human life, as a creation of God and a gift in trust, is beyond human evaluation and authority.[30] God maintains dominion over it. As Markwell and Brown explain, by this we are stewards, not owners of our own bodies and are accountable to God for the life that has been given to us.[31] Prolonging "life" after a person is dead is "playing God" perhaps even in the extremist way. Moreover, according to the Catholic stance, a person is a composite of body and soul, and as long as there is a living body (even with reduced mental capacities or with brain-death), there is still a person at present. Hence, it seems that the Catholic tradition would hesitate to recognize, from the first place, that the brain dead pregnant woman is dead.

Indeed, as Markwell and Brown argue, the process of maintaining a brain-dead pregnant woman on life support for the delivery of her fetus, especially when the fetus is at the very early stage of development constitutes extraordinary means, and therefore, it seems that also from a religious perspective, there is no moral obligation to sustain the woman's body for the sake of her unborn child.

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[30] This is not exclusive to the Catholic tradition. In fact, all of the monotheistic religions (Judaism, Islam and Christianity) maintain that we have a duty to protect the life given to us by God.

[31] Hazel J. Markwell & Barry F. Brown "Bioethics for Clinicians: 27. Catholic bioethics" (2001) 165(2) CMAJ 189.

Conclusion

In this chapter, I examined whether a pregnant mother owes a duty to save the life of her fetus and to provide its well being. I showed that such a moral duty derives from the special and intimate relationship between the mother and the fetus. Such relationship has two considerations that support this duty: the uniqueness of the fetus, and the mother's understanding and acknowledgement of such uniqueness. However, I claimed that when the mother is dead, the nature of the relationship changes, as she is no more aware of her fetus and her relationship with it. I also showed how responsibility to society in general, and to social entities, like families, in particular, constitutes a moral duty towards the fetus.

In addition to being social entities I further showed how the intrinsic values of families play important role in forming such a moral duty. Nevertheless, I argued that such a an instrumental duty that enables the establishment of families, no more exists as the pregnant woman is no more socially and morally part of the family she owed to while alive. I strengthened my argument by applying ethics of care, and by analyzing the practical conclusion I arrived to from a religious perspective.

Thus, a brain-dead pregnant woman has no moral duty to keep her fetus alive after her death, and without any other prior intentions on her behalf, it would be impermissible to maintain her on life support for this purpose.

CHAPTER 8: CONCLUSIONS AND SUGGESTIONS

In this last chapter of the thesis, I will discuss the few reported legal cases which directly deal with maternal brain-death. I will examine in particular how they could apply in the Canadian legal system. In order to establish a proper legal opinion regarding the treatment of brain-dead pregnant women, I will also investigate whether an analogy from other situations of posthumous reproduction could be made. After discussing the proposals that have been made in the context of this dilemma, I will draw some conclusions and formulate some practical suggestions.

Legal Cases

Only three reported legal cases seem to deal directly with maintenance of brain-dead pregnant woman on life-support. Two of them are from Israel, while the third is an American case.

A. The Israeli cases

In Israel, an extraction of organ from the deceased for therapeutic purposes is permitted with the approval of three physicians, and with notification of family members of the deceased within five hours (or other reasonable time if a family member can not be reached) after death.[1] Under usual circumstances, the spouse of the deceased, her children, her parents or her siblings should agree to the surgery. The law specifically

[1] The *Anatomy and Pathology Act* 1953, s. 6.

states that if the deceased objected while alive to the surgery, it will not be done even if the deceased's next-of-kin agreed to do it.[2]

However, the delivery of a fetus from a pregnant dead woman is an exception to this general rule, and physicians are exempted from going through the process of consent, or even notifying the family.[3] In the center of this exclusionary rule, Dr. Ruth Halperin-Kadary explains, is the perception that a delivery of a fetus, even from a dead woman, is not a surgery. Rather it is a natural and usual act, derived from the classical role of women to bring child to the world, which does not require any special procedure.[4]

One of the Israeli cases dealt with this particular issue. The case came to court when the husband of a pregnant woman, who was in a permanent vegetative state, asked for a declaration of the court, that in case of brain death the hospital would be compelled to immediately deliver the fetus.[5] The woman was on her 28th week, and it was estimated that a delivery of the child under such circumstances would have 20% chances that the fetus would die, and 40% chances that the fetus would suffer from developmental complications. The husband's parents supported the view *not to maintain* the woman on life support, while the woman's parents were divided on this question.

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[2] The opposite view applies as well: if the deceased agreed that the surgery would be performed after her death, the physicians are compelled to perform it even if the deceased's next-of-kin disapproves it.

[3] *The Anatomy and Pathology Act* 1953, s. 6C. Interesting to note that the title of this section is "the salvation of the fetus".

[4] Ruth Halperin-Kadary, "'To Leave Life Behind You': The Delivery of A Fetus from the Body of a Deceased – In Any Possible Case?" in Raphael Cohen-Almagor ed. *Dilemmas in Medical Ethics* (Jerusalem: Hakibutz Hameuhad: 2002) 107 at 128.

[5] T.M.A.103/92 (The District Court of Jerusalem) February, 4th 1992 available at http://www.daat.ac.il/daat/kitveyet/assia/bazaq.htm, last visited on 27 April, 2003.

Although the court was not convinced that the deceased's mother was ready to rear the child to be born, and no other family member appropriate for taking care of the child was found, the court issued the order. The court emphasized the importance of saving the fetus' life, and referred to section 6C to the Anatomy and Pathology Act 1953. Relying on the Jewish law, the court also stated that despite the uncertainty whether the fetus has a right to life or not, if the fetus does not endanger the mother's life, there is a moral and perhaps a legal duty to save the fetus' life. Finally, the court referred to *Roe v. Wade*, stating that the fact that the woman was on her third trimester made it easier for the court to intervene in her pregnancy.

However, in another case, when the husband of an eight-month brain-dead pregnant woman sought an order to deliver the fetus, the court refused to issue such an order.[6] In a two pages decision, the court ruled that it was not authorized to accept the husband's petition, as it was formed under the Capacity and Guardianship Law 1967, and even substantially, the court found that such an order would not serve the interests of the pregnant woman.[7] Nevertheless, the court did not discuss the Anatomy and Pathology Act, hence it is not clear what it would have ruled if it had addressed that statute.

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[6] T.M.A. 38/89 (The District Court of Jerusalem), January, 18th 1989, **published in** Ygal Shifran ed., *A Question of Authority: Whether to Deliver a Fetus from the Body of a Deceased* (Jerusalem: Rabanut Harashit Le-Israel: 2001) 17-8.

[7] The husband testified that he cannot rear the child, and it was not clear if there were good chances that the child-to-be-born would not be handicapped.

B. *University Health Services v. Piazzi*[8]

In the *Piazzi* case, a Georgia court granted a hospital's petition to keep a brain-dead pregnant woman on life support until the birth of her fetus, over the objections of her husband and family. Donna Piazzi had not drafted a living will or other health care directive embodying her intentions in such a situation, and the biological father of the fetus (who was not Donna's husband) favored continuing medical care to save the fetus.

After forty-five minutes of hearing, the court determined that Donna Piazzi lacked the power to terminate life-sustaining medical treatment during her pregnancy even if she executed a living will, relying upon the pregnancy restriction in the Georgia Natural Death Act, which invalidated an advance directive at pregnancy.[9]

The court also rejected the argument that Donna possessed a constitutional right to refuse treatment and to terminate pregnancy, concluding that these privacy rights extinguished when she became brain-dead.[10] Finally, the court found that public policy in Georgia requires the maintenance of life support systems for a brain dead mother so long as there exists a reasonable possibility that the fetus can develop and survive.

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[8] No. CV86-RCCV-464 (Ga. Super. Ct. Aug. 4, 1986), **mentioned in** Molly C. Dyke, "A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes" (1990) 70 B.U.L.Rev. 867 at 870-872.

[9] The Georgia Act stated that the directive "shall have no force and effect during the course of pregnancy" - GA. CODE ANN. § 31-32-3 (Supp. 1990).

[10] The court said: "The privacy rights of the mother are not a factor in this case, because the mother is dead as defined by Georgia law...and the United States Supreme Court decisions upholding the rights of women to abort non-viable fetuses are inapplicable because those decisions are based on the mother's right of privacy, which was extinguished upon the brain death of Donna Piazzi". *Ibid.* at 7.

Was there a reasonable possibility that Donna's fetus will develop and survive? The court believed there was. Reality, unfortunately, proved the opposite. The fetus died of multiple organ failure within forty-eight hours after its delivery.[11]

C. Application of Legal Cases

Unfortunately, the reported cases I mentioned above do not really offer us much insight into the legal solution to our dilemma. Not only are the Israeli cases contradictory, but they also stem from a legal system which has specific legislation on the issue of maternal brain-death. As argued earlier, section 6C to the Anatomy and Pathology Act 1953 is an exception to the rules related to the treatment of the body of a deceased. Whether there is a justification for such an exception or not, it reflects an existing legal position. Canada does not have such legislation, and, in my view, it cannot rely on these decisions.

We can also not rely on the *Piazzi* case. Besides the tragic outcome of the *Piazzi* decision, the court's ruling ignores some important issues that relate to the interests of a brain-dead person. Without any justification, it immediately assumes that we should not care for those interests. But more importantly, the *Piazzi* decision rests on Georgia's pregnancy clause in its living will legislation. As I discussed in chapter three to my thesis, out of respect for the women's right to self-determination, Canada chose not to have pregnancy clauses in its wide regulation of living will. Applying *Piazzi* would seem inappropriate for the Canadian system.

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[11] James M. Jordan, "Parents, Children and the Courts, Note" (1988) 22 Ga. L. Rev. 1103 at 1110 (FN25) **[Jordan]**.

An Analogy from Posthumous Reproduction

Posthumous reproduction occurs when a child is born after one or more of the biological parents have died. Posthumous reproduction by women involves the extracting egg from a woman *while she is alive*, fertilizing it with frozen sperm, and subsequently implanting it in a surrogate after the genetic contributor's death.[12] Posthumous reproduction by men involves retrieving sperm from a man *while alive*, freezing it, and using it for fertilization after the man has died.[13] Posthumous reproduction can also occur when one or both of a stored frozen embryo's parents dies.[14]

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[12] In Israel, the *Regulations of the Health Security (In Vitro Fertilization)* 1981 provide that there shall be no use of an ova of a donor that has passed away. Nevertheless, frozen ova retrieved from a married woman, whose husband passed away, can be donated to other woman with the consent of the donating woman.

[13] For examples, see *Parpalaix v. CECOS T.G.I. Creteil*, Aug. 1, 1984, Gaz. Pal. 1984, 2, pan. Jurispr., 560. In this case, Alain Parpalaix, after being diagnosed with testicular cancer, deposited his sperm at a sperm bank for future use after his chemotherapy treatment. When Alain died, his wife wanted to use the sperm and the bank refused, arguing that the deceased did not leave any instructions on what should be done with his sperm after his death. The court found that there was a fundamental right to procreate, and the bank was ordered to return the vials of sperm to the wife of the deceased; see also *Hecht v. Superior Court* 20 Cal. Rptr. 2d 275 (Cal. Ct. App. 1993); *Hart v. Shalala*, No. 94-3944 (E.D. La. Dec. 12, 1993); *R v. Human Fertilisation and Embryology Authority, ex parte Blood* [1997] 2 All E R 687; In Israel, in contrast to the legal view on posthumous reproduction by women (***supra*** note 12), the *Rules Regarding Management of Sperm Banks and Guidelines for Artificial Insemination* 1992 provide in section 28 that a frozen sperm of a donor who died should be destroyed, unless the donor's wife asks, within a year from his death, to keep the sperm for further freezing. Up until now, the use of a frozen sperm after the death of his contributor, has been also approved by Israeli courts in two different cases: 1922/96 (The District Court of Tel-Aviv) September 21, 1997; 10440/99 (The District Court of Tel-Aviv) November 25, 1999.

[14] The embryos then may be used by the surviving partner for reproduction, donated to others for reproduction, discarded, or be used for stem-cell research. The latter, is not legal in Canada. The *Rios* case is the only reported case in which the genetic contributors of an embryo died. A wealthy California couple received *in vitro* fertilisation treatment in Australia. Two embryos were frozen when the Rios couple died in an airplane crash. The couple left no written instructions regarding the fate of their embryos and a weighty debate arose about whether the embryos should be destroyed, made available for anonymous donation, or deliberately gestated in order to permit them to inherit an intestate share of the Rioses' estate. The State of Victoria committee recommended the disinheritance of the embryos and their adoption by other couple.

According to the proposed legislation in Canada, posthumous reproduction is illegal, unless the deceased had specifically consented to it, prior to his or her death.[15] In Israel, there seems to be a different legal view depending on the dead genetic contributor.[16]

The arguments in favor of posthumous reproduction focus on the right to reproduce. No doubt, "reproduction connects individuals with future generations and provides personal experiences of great moments in large part because persons reproducing see and have contact with offspring, or are at least aware that they exist".[17] It is argued that people who lost their spouses should not lose the opportunity to reproduce because of an unexpected death. In fact, posthumous reproduction is the only way of having a child with (or from) the deceased.

Opponents of this approach argue, on the contrary, that only a few features of what is valued about reproductive experiences remain, when the reproduction is posthumous. A

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[15] Bill c- 13, which is the current Canadian draft of the *Assisted Human Reproductive Act* prohibits, at section 6(1), the use of "reproductive material", without written consent for that specific purpose, which presumably include the use of *in vitro* embryos after the death of one or both genetic contributors. See AHRA, available at http://www.hc-sc.gc.ca/english/pdf/reproduction/legislation.pdf, last visited on 13 June, 2003; The Law Reform Commission of Canada: *Medically Assisted Procreation* concluded, in section 5(1) to its recommendations that "Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control....": The Law Reform Commission of Canada: *Medically Assisted Procreation Recommendations* (Ottawa: Ministry of Supply and Services, 1992). See also *Processing and Distribution of Semen for Assisted Conception Regulations*, SOR/96-254.

[16] The *Regulations of Health Security (In Vitro Fertilisation)* 1981 state, in section 8(b)(2), that there shall be no use of a frozen embryo of a married couple if the wife died, whereas if the husband died, the frozen embryo can be implanted in the widow's uteros only one year after the death of her husband, and with a report obtained from a social-worker.

[17] John A. Robertson, "Posthumous Reproduction" (1994) 69 Ind. L. J. 1027 at 1031; See also Kristin Antall, "Who Is My Mother: Why States Should Ban Posthumous Reproduction by Women?" (1999) 9 HTHMTX 203 at 227.

large part of the decision to have a child involves the desire to rear and gestate a child. In posthumous reproduction, a woman will be neither gestating nor rearing the child.[18]

Another argument against posthumous reproduction focuses on the psychological and financial well being of the child. It is argued that as a matter of public policy, children should have two parents *whenever possible*. To support such an argument studies are brought from which one can learn that children of single parents are disadvantaged in general, and children reared without mothers are even more disadvantaged, in particular.[19]

An additional issue related to posthumous reproduction is harvesting gametes from a deceased. The harvesting question is more complicated than the use of gametes after the death of their contributors, as it involves a direct bodily intervention with the dead. Although this process mainly applies to harvesting sperm from the dead,[20] it is only a matter of time until harvesting ova becomes possible.

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[18] As Jeffery Spike asserts: "Most pregnant women look forward to their motherhood, and a loving relationship with their baby, and not simply to giving birth and then giving the baby away, never to be seen again": Jeffery Spike, "Brain Death, Pregnancy, and Posthumous Motherhood" (1999) 10 (1) J. Clin. Ethics 57 at 64 [**Spike**]. In Spike's view, if circumstances do not allow anyone close to the deceased to raise the baby, the presumption should be that she would no longer wish to undergo the indignity of treatment.

[19] While single parents usually have the other parent available to be involved in the child upbringing, both emotionally and financially, in posthumous reproduction, there is one bereaved parent bringing a child into the world without the option of assistance from the other parent. In addition, there are psychological implications to a child who learns he or she was born after the death of his or her parent. See Ruth Landau, "Planned Orphanhood" (1999) 49 Soc. Sci. & Medicine 185.

[20] There are few methods to harvest the sperm. The "easiest" method is by exposing the testicles of the deceased to electric pulses. The invasive procedures include taking samples of sperm by stabbing the testicles, producing sperm cells in the laboratory from a testicle tissue that was taken from the deceased, and the most invasive procedure is the cutting down of testicles and producing sperm cells in the laboratory.

What makes these procedures even more problematic is that the sperm only remains effective after freezing, if it was harvested within 24-36 hours after death. Hence, a decision has to be made quickly, and usually, there is no time to go to the court. In practice, if a family member of the deceased asks for the harvesting procedure, it will usually be performed. No legal regulation is devoted to these procedures and, not surprisingly, only a few of these cases get to court. So far, there are no legal reported cases found in the Canadian, American, or English courts. Two legal reported cases were found in Israel, in which, due to time limits, orders to harvest the sperm were issued, without any legal discussion.[21]

Indeed, as Roxanne Mykitiuk and Albert Wallrap argue, if retrieval of gametes from existing supplies in storage banks is permitted only with the consent of the deceased, harvesting gametes from the deceased should be considered morally unacceptable without prior consent of the deceased.[22]

An analogy from posthumous reproduction cases can be made to the case of a brain-dead pregnant woman. In the latter case, the arguments that oppose posthumous reproduction fully apply, whereas the argument that supports it seems less impressive. In contrast to the life of a child who is born posthumously by using a frozen gamete of a deceased, the

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[21] 1130/01 (The Family Court of Haifa) January 9, 2002; *Re German* (The Supreme Court of Israel) March 13, 2002.

[22] Roxanne Mykitiuk & Albert Wallrap, "Regulating Reproductive Technologies in Canada" in J. Downie, T. Caulfield and C. Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths: 2002) 367 at 410.

physical and mental health of a child who is delivered in a cesarean section from a dead mother after being maintained on life-support, are at a high risk. This poses much weight to the argument of the well being of the child. Not only will the rearing parent face the difficulties of a single parent (that would arguably affect the child's well being), but he will also have to cope with possible severe impairments of his child.

Moreover, as opposed to a deceased who has only deposited (or was harvested) his or her *gamete*, the brain-dead pregnant woman has already fulfilled her right to procreate while alive. She has knowingly gone through the process of pregnancy, directly experiencing some part of being a mother to a potential *child*, who was created by *both* parents. The argument on the right to procreate is weaker than the "regular" cases of posthumous reproduction.

Finally, one can hold that maintaining a brain-dead woman on life-support seems to be a longer and more undignified procedure to the deceased than a *one-time* surgical action of harvesting gamete from the dead. If the latter activity should be banned by law (unless the deceased has given his or her consent to it), then it is also necessary to approach the first, at least with the same carefulness.

Suggestions

Some suggestions were made in the literature regarding the management of pregnancy complicated by maternal brain-death. William Dillon *et al.* have suggested some

guidelines for the medical team.[23] According to these guidelines, in a pregnancy of less than 24 weeks, no extraordinary measures for mother or fetus are needed; in a pregnancy of 24-27 weeks, life support measures for the mother to maintain somatic life and pregnancy are needed, and immediate delivery by cesarean section. The guidelines also provide that if maternal viability could not be maintained or if fetal distress occurred, and in a pregnancy of greater than 28 weeks, delivery of the fetus should be by cesarean section as soon as possible.

Jeffery Spike posed two necessary conditions to maintaining the brain-dead pregnant on life-support.[24] First, strong evidence that the deceased would have wanted to deliver a child posthumously, or, in the absence of such evidence, that the biological father of the fetus would want this. In the latter case, there also should be no evidence that this is contrary to the wishes of the deceased. Second, pregnancy is advanced to the point that the chance for a good fetal outcome, in terms of both fetal morbidity and mortality, is acceptable by a best interest standard.

Nicola Peart and colleagues argue that whatever the legal position may be, ethically the dead woman's prior wishes cannot be irrelevant to any decision made by her family or by the doctors involved. They claim that since the woman has a personal investment in the future of her fetus, her specific request to continue the pregnancy in the event of brain

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[23] William P. Dillon, Richard V. Lee, Michael J. Tronolone, Sharon Buckwald and Ronald J. Foote, "Life Support and Maternal Brain Death During Pregnancy" (1982) 248 (9) JAMA 1089 at 1091.
[24] **Spike**, *supra* note 18.

death ought to be followed, if at all possible. When the woman's wishes are not known, Peart *et al.* argue that there is a *prima facie* obligation on the medical staff to try to ensure the survival of the fetus, if this can be achieved without causing it damage. However, they further argue that if the pregnant woman's prior wishes are known, they must carry considerable weight. In the absence of a clear legal requirement on the medical staff or the family, their obligation is to respect the dead woman's wishes.[25]

Stephen Wear *et al.* suggest a test of "clear and compelling fetal interest". Only under such an interest would it be allowed to maintain a brain-dead pregnant woman, even when her family opposes to such a procedure.[26]

The variety of suggestions reflects the fact that deciding how to deal with a pregnant brain-dead woman is a question of balance. Dilon *et al.* and Stephen Wear *et al.* put more weight to the interest of protecting the potential life, but they ignore the woman's interests. The suggestion of Dilon *et al.* is as arbitrary as the viability criteria, and Wear *et al.*'s test is obscure, as it is not clear if and when there is a compelling fetal interest. Peart *et al.* seem to offer a more reasonable balance, giving proper weight to the woman's interest. In my view, their guidelines can be consisted with the main Canadian legal principals regarding pregnant women.

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[25] Nicola S. Peart, Alastair V. Campbell, Alex R. Manara, Shelley A. Renowden and Gordon M. Stirrat, "Maintaining A Pregnancy Following Loss of Capacity" (2000) 8 Med. L. Rev 275 at 297.

[26] Stephen Wear, William P. Dillon and Richard V. Lee, "Maternal Brain Death During Pregnancy – Letter to the Editor" (1989) 261 (12) JAMA 1728-9.

However, as I showed in my thesis, the physicians have no *prima facie* obligation to save the fetus. The fetus is not their patient. Their fiduciary duties to their patient (the pregnant mother) also *affect* the fetus, but not initiate a separate and autonomous set of duties to the fetus. These special duties, like any other physician-patient duties, are conditioned in the patient's health. When the patient dies, extinguishes all of the effect from such duties. Even if Peart *et al.* would be right in arguing for such a *prima facie* duty, it seems strange that such a duty is dependant upon the question whether the mother's prior wishes are known or not.

Conclusions

In my thesis, I have used James Nelson's model of "casuistry of pregnancy",[27] that is the making of moral judgments by noting similarities and differences between clear cases of admirable and defective maternal behavior in other women's experiences. Thus, I looked into situations of abortions and bodily interventions that affect pregnant women's life style and physical condition. In addition, I analyzed the legal framework of pregnancy clauses in advance directive legislation, and I also probed the pregnant woman's ethical obligation toward her fetus under several ethical and religious theories.

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[27] James Lindemann Nelson, "Making Peace in Gestational Conflicts" (1992) 13 Theoretical Medicine 319 at 326.

As my research topic also deals with a dead woman, I examined the tissue gift laws and looked into the main moral, legal, psychological, religious, spiritual, and physical aspects of the question on the interests of dead people.

The moral and legal status of the fetus, as well as the jurisprudential question of the fetus' interest were also raised. Along with other issues, such as gestational age of the fetus, pragmatic obstacles to the medical intervention, legal requirement for consent, rights of next-of-kin and friends of the deceased, and the physician-patient relationship, I made an analogy from posthumous reproduction, and discussed the major suggestions to my research question.

Throughout my research, I compared the Canadian legal system to the American, English and Israeli legal systems, and I analyzed my research question from a relational feminist approach.

At the end of my inquiry, I want to draw the following conclusions:

1) Maintaining a brain-dead pregnant woman on her first or second trimester is not what the court in *Roe v. Wade* meant to create. It is separating between the act of intervention in the woman's pregnancy and the state's interest that justify it. Moreover, the trimester approach in *Roe v. Wade* cannot apply to the case of a dead pregnant woman, as it addresses only the abortion context where the state must consider *both* an interest in maternal health and an interest in potential life

2) As it appears from my analysis of the Canadian abortion-law and the law that governs bodily interventions in pregnant women, a pregnant woman has a protected right to fully control her body. This right is explicit that even the biological father of the fetus can not interfere with such a right. Thus, seeking for the father's view can be only relevant, if the biological father sheds light *on the woman's view*, but not otherwise.

3) Pregnancy clauses, which exist under the American law, should not be a model for the Canadian law, which gives more emphasis on the woman's wishes and less weight to the consideration on the fetus' potential life than the American approach.

4) Canadian courts refused to interpret the existing law in a way that would confer the fetus a legal substantial status prior to birth. The fetus has a moral stance from a biological perspective, but not a psychological one. The common view is that a fetus is not a "person", and does not have independent rights. In addition, from a normative perspective, recognizing fetal rights is wrong for women, for the maternal-fetal relationship, and for the physician-patient relationship. Lastly, the term "potential life" does not exist in a void; the state's interest in potential life is dependent on the mother's willingness to have *within her body* such a potential.

5) The organ-donor model, which is reflected in the tissue gift laws, should not be applied to the case of a dead pregnant woman. However, this model teaches us that if a deceased did not ask that his or her body be used for any of the purposes mentioned in law, no other person is entitled to ask for it.

6) The gestational age of the fetus is an important factor, which has to be balanced with the pragmatic difficulties of maintaining a dead woman on life support that include physical, financial, emotional and personal barricades.

7) Ascribing interests to brain-dead people is possible by subsuming the immediate aftermath of each dead person's life within the *overall* course of his or her existence through highlighting the ways in which the dead person still exists after his death. There are moral, psychological, religious, and metaphysical reasons for doing so, along with the profound value of the human body and the obligation to treat it humanly.

8) Obtaining the pregnant woman's consent is a precondition to any possible intervention with her body, including maintenance on life-support. In the case of a brain-dead pregnant woman, an explicit consent is needed.

9) Maintaining a dead pregnant woman on life-support undermines the traditional physician-patient relationship, obliging physicians to withdraw their commitment to act in the best interest of their (one and only) patient and, and instead become the fetus's practitioners.

From Principles to Actions

Should physicians maintain a brain-dead pregnant woman on life-support for the delivery of her fetus? Applying the principles above leads to the following practical solution:

The first question is whether the woman had given explicit directions about what should be done in case of maternal brain death. If she had, physicians are obligated to follow her instructions, regardless the gestational age of the fetus.

The second question is whether the woman had given explicit directions about what should be done in case of loss of competency (in general). If she had, physicians are obligated to follow her instructions if the fetus in its first or second trimester. No state interest in protecting potential life should apply before.

If there is no advance directive or durable power of attorney for health care decisions (specific for maternal death or general when the fetus is in its third trimester), directions must be sought from previously expressed statements of the deceased. 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.

If the woman's wishes cannot be obtained by a surrogate, maintaining the dead patient on life-support should be permitted only if the following three conditions are met:

1) The fetus is in its third trimester.
2) The medical treatment proposed guarantees in more than 75% proof a successful outcome for the fetus (at least 75% chances of survival). This proof should be obtained by at least two physicians. Every degree of proof below that would undermine Canada's unique approach to pregnant women and the protection of potential life.
3) The medical treatment will last 14 days or till a proof of 75% that the fetus' chances to survive are above 85% is reached – at the least.

In order to avoid this difficult situation I would also recommend taking precaution measures.

First, along with increasing the public awareness to advance directives in general, I would recommend inserting a question into the model of living will form that inquires how the person wishes to be treated during pregnancy. This inquiry will 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.

Second, medical and nursing schools should be dedicated to teaching students about advance directives and pregnancy provisions. 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 province in which they are practicing.

Third, the state should also play a role in educating attorneys and the public about the advance directives and their legal effect in a multitude of circumstances, including pregnancy.

Fourth, as caring for the brain-dead pregnant woman creates a series of crises for the nurses,[28] it is important to train nurses how to create meaning in the situation as a way to

[28] Carol Diehl, JoAnn Haas and Karen Moore Schaefer, "The Brain-Dead Pregnant Woman: Finding Meaning to Help Cope" (1994) 13(3) Dimens Crit Care 133; Esther Santons reveals that when she and her colleagues asked, if they would carry again for a brain-dead woman, they all replied they would, but "pray we'll never have to" - Esther Santons, "Sheila's Death Created Many Rings of Life" 93 Nursing 44 at 48.

facilitate the special grieving process that is attached to the medical, legal and ethical dilemmas that raise here.

Finally, because all cases reported have resulted in premature delivery, families need to be counseled about possible short and long-term complications of pre-term delivery.

If a human being has any just, prior claim to anything at all, it is a just, prior claim to his or her own body. The adoption of the brain death standard was originally intended to avoid the prolongation of somatic life by facilitating the discontinuance or resuscitative apparatus.[29] A brain-dead body needs to be respected in a humane way. A woman's right to make decisions about her own body and reproductive choices[30] should be substantially protected. The tool of life-sustaining treatment threatens these elementary concepts.

As Judith Jarvis Thomson claims:

> "The mother and the unborn child are not like two tenants in a small house which has, by an unfortunate mistake, been rented to both: the mother owns the house".[31]

Let us all remember that it all starts (and ends) with (and in) the mother.

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[29] **Jordan**, *supra* note 11 at 1163.

[30] See Nancy Gertner, "Interference With Reproductive Choice" in Sherrill Cohen & Nadine Taub eds., *Reproductive Laws for the 1990s* (Clifton, NJ: Humana Press: 1989) 307.

[31] Judith Jarvis Thomson, "A Defense of Abortion" in Tom L. Beauchamp & LeRoy Walters eds., *Contemporary Issues in Bioethics*, 5th ed. (Belmont, C.A: Wadsworth Publishing Company: 1999) 202 at 205. Gertner proposes a mechanism of tort claims in cases of breach of the mother's reproductive choices.

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