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"Natural Incubators": Somatic Support as Reproductive Technology, and the Comparative Constitutional Implications on Cases of Maternal Brain Death in the U.S., Canada, and Ireland

Sonya Laddon Rahders*

INTRODUCTION

"Using a dead woman's body as an incubator against her wishes ... should be of grave concern to everyone who cares for and about both women and our nation's moral health." 1

Heart-wrenching stories pepper the media at an increasingly alarming rate: young mothers, beloved wives and daughters, rendered incapacitated by sad accidents or unexpected illness. Any time a person enters a coma or is diagnosed as brain dead, their family faces a limited array of painful options for treatment. But one condition adds even further complexities to those choices. What happens when a pregnant person is diagnosed as brain dead? This issue has arisen in a handful of recent high-profile cases,

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garnering a variety of responses and outcomes. People who are brain dead are in fact considered dead by medical professionals, but despite uniform medical standards there is a significant amount of grey-area in terms of whether doctors believe them to be truly dead, or instead severely comatose. Courts have even murkier guidelines, and cases of maternal brain death are treated differently internationally.

Two contrasting cases that occurred in the U.S., for example, are those of Marlise Muñoz and Karla Perez. In Texas in late 2013, Marlise Muñoz was rendered brain dead after suffering a brain embolism when she was just fourteen weeks pregnant. Against the wishes of her husband and family, the hospital kept her on somatic support, citing a state law that requires pregnant people to be kept on “life” support. Her husband sued to have her removed from support and allowed to die. While the court ultimately ruled that she should be removed from support, the hospital acquiesced prior to the decision because the fetus was no longer viable. Karla Perez, by contrast, collapsed in Nebraska in early 2015 while twenty-two weeks pregnant. Ms. Perez was kept “alive” on support for fifty-four days and a healthy baby was delivered via cesarean section in May 2015.

This is a subject of limited medical study, with only thirty cases reported worldwide between 1982 and 2010. As such, it is also a subject of very limited legal inquiry. A 2013 grand rounds study from the United Arab Emirates concluded that medical technology has reached such an advanced stage that gestational age is no longer a barrier to whether or not a pregnant person may be kept on somatic support until the fetus is delivered. After a healthy birth resulted from somatic support of one individual who was declared brain dead at just sixteen weeks’ gestation, the study concluded that a brain dead pregnant person might serve as a “natural incubator.”

This comment examines the subject of brain death in pregnancy through the lenses of both reproductive technologies and constitutional rights. Drawing comparisons between three very different countries, this comment seeks to contribute to the legal dialogue about what rights an individual has against the state in cases of maternal brain death, and what the implications may be for assisted reproductive technologies and reproductive rights in the future. In part one, to explore the meaning of

2. “Life support” generally refers to the medical interventions used to provide a body with nutrients and oxygen when it cannot do so on its own. Throughout this paper, however, I will use the more technical term “somatic support,” or simply “support,” since a brain dead body is medically dead, and thus cannot have sustained life.


5. Said, et al., supra note 1, at 220.
brain death, I examine three cases of brain death that each incited controversy when they arose concurrently in late 2013 in the United States and Canada. I compare treatment of Marlise Muñoz in Texas with treatment of Jahi McMath in California, a young girl who was declared brain dead in late 2013 but whose parents fought to keep her on somatic support; and Robyn Benson, declared brain dead in Canada at twenty-two weeks pregnant but whose husband and family wished to keep her on somatic support. In Ms. Benson’s case, a healthy baby was ultimately delivered via cesarean section. Barely a year later, in late 2014, a third case arose in Ireland where a woman referred to as N.P. was forcibly kept on life support after brain death, based on Ireland’s laws that confer the same rights to a fetus as they do to a woman. Each of these countries has at least one additional recorded case of maternal brain death within the past twenty years (Maria Lopez, California, U.S., 1999; Sophia Park, Toronto, Canada, 1999; Unnamed, Ireland, 2001).

In part two, this comment compares the constitutional law and rights that govern each of these cases in the U.S., Canada, and Ireland. For each country, I outline recent cases of maternal brain death. I then explain their context through the respective courts’ historic treatment of brain death, and the sometimes-conflicting Constitutional provisions that govern the subject. Each country has differing views on—and differing Constitutional protections for—a series of more common issues that arise when considering maternal brain death. In trying to make sense of the laws and morals that inform debates about maternal brain death, this comment outlines each country’s treatment of abortion, the right to refuse health care, death with dignity laws, and organ donation.

I. BRAIN DEATH IN THE MODERN CONTEXT

A. MARLISE MUÑOZ, ROBYN BENSON, AND JAHI MCMATH: PREGNANT, INCAPACITATED, BRAIN DEAD, AND AT THE MERCY OF THE STATE.

1. Marlise Muñoz (Tarrant County, Texas)

In late November 2013, a young woman collapsed in her Texas home. Marlise Muñoz was rushed to the hospital, where she was declared brain dead from lack of oxygen caused by a possible blood clot in her lung. At the time of her collapse Muñoz was thirty-three years old and fourteen weeks pregnant. Her body, which had been kept on ventilators while physicians tried to save her life, immediately became the subject of a


terrifying controversy: what would happen to the fetus she carried? Erick Muñoz, Marlise’s husband, asked physicians to remove her from ventilators. Both Erick and Marlise worked as paramedics, and they had discussed Marlise’s firm wishes not to be kept alive by machines should the situation arise. But the hospital refused the husband’s wishes, citing a provision of the Texas Advance Directives Act that says pregnant persons shall not be removed from life support.\(^8\) Despite the early gestational age of the Muñoz fetus, and the clear indicators that the fetus was likely no longer viable, the hospital maintained that it must keep Marlise on ventilators for at least several more weeks until a firm judgment could be made about the viability of the fetus.\(^9\)

In January 2014, when the Texas hospital continued to keep Marlise Muñoz “alive” on life support, Erick Muñoz filed a petition in Tarrant County District Court requesting that the court compel John Peter Smith Hospital to remove his wife’s body from the medical technology so that his family could dispose of her remains in peace. The emergency motion, filed January 14, 2014, alleged that the Texas statute could not apply to Marlise: “Marlise cannot possibly be a ‘pregnant patient’ – Marlise is dead.”\(^10\) Should the court disagree that her status as dead mooted the statutory issue, the motion raised two alternative Constitutional bases for Marlise to be removed from treatment. First, the hospital had violated Marlise’s Fourteenth Amendment privacy rights under *Cruzan v. Director, Mo. Dep’t of Health* by not allowing her to refuse medical treatment.\(^11\) Second, the hospital violated Marlise’s equal protection rights under the Fourteenth Amendment by treating her, as a member of a class of pregnant women, different from other persons.\(^12\) The court ultimately agreed that Muñoz was being unlawfully maintained on somatic support, and she was removed in mid-January after nearly eight weeks. The fetus did not reach a state of viability during that time.

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\(^8\) *TEX. HEALTH & SAFETY CODE ANN.* § 166.049 (West 1999).


\(^11\) Emergency Motion, *supra* note 11, at 6 (citing Cruzan v. Mo. Dep’t of Health, 497 U.S. 261, 278 (1990)).

\(^12\) Emergency Motion, *supra* note 11, at 7.
2. Robyn Benson (Victoria, B.C., Canada)

In December 2013, Robyn Benson collapsed from a brain hemorrhage, and was declared brain dead a short while later. She was thirty-two years old and twenty-two weeks pregnant. At her husband’s request, Benson was kept on a ventilator for six weeks, and a baby boy was delivered at twenty-eight weeks through caesarean section. Although premature the baby was otherwise healthy, and Robyn was removed from life support the next day.13

There are several differences between the Benson and Muñoz cases, most notably the gestational age of the fetus and the family’s wishes. There are jurisdictional similarities and differences, as well, which are addressed in further detail below. Posthumous reproduction14 is illegal in Canada and restricted in the U.S. In addition, Canada enforces different abortion standards that give more decision-making power to the pregnant person. These legal standards undoubtedly contributed to the relative lack of controversy surrounding Benson’s pregnancy and death, but she is nevertheless an important counterpart to the Muñoz legal battle.

3. Jahi McMath (Alameda County, California)

Only weeks after Marlise Muñoz collapsed in November 2013, a family in California was also struggling with brain death. Jahi McMath was a thirteen-year-old girl who suffered complications from surgeries to remove her tonsils and alleviate sleep apnea. She never recovered from the surgery and was declared brain dead at Oakland Children’s Hospital in early December 2013. Jahi’s parents, however, refused to accept this diagnosis. Citing their faith that God would restore Jahi’s health, and their “belief” that she was still alive, the family filed a temporary restraining order in Alameda County to bar the hospital from removing Jahi’s ventilators. While the case was pending, the hospital reached an agreement with the family that they would allow Jahi’s body to be transferred to a private facility, if the family could find transport and a location that would


14. Daniel Sperling, *Maternal Brain Death, 30 AM. J.L. & MED. 453, 495-96 (2004)* (“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. Posthumous reproduction by men involves retrieving sperm from a man while alive, freezing it, and using it for fertilization after the man has died. Posthumous reproduction can also occur when one or both of a stored frozen embryo’s parents dies.”).
accept the body to maintain the “life-sustaining” treatment. However, the restraining order ruling set a potentially dangerous precedent, acknowledging for the first time that there may be posthumous parental rights to a brain dead child.

Although the forgoing individual accounts arose under distinct circumstances and involved varying relationships with families, hospitals, and expression of the brain dead individual’s interests, there are several common themes that form the basis for the following discussion. What is the medical rationale for brain death, and where the line is drawn between people who are in a coma or people who are dead? There are questions about who should be making decisions for people who are left in such a state: should their advance directives be honored, should their families be empowered to decide about their care, or can the state intervene? Drawing comparison between three very different countries, this comment seeks to open a legal dialogue about what rights an individual has against the state in cases of maternal brain death, and what the implications may be for assisted reproductive technologies and reproductive rights in the future.

B. WHEN CAN A STATE KEEP A PREGNANT PERSON ON LIFE SUPPORT?

Several scholars have begun to examine these recent cases, which arise with increasing frequency as medical technology advances. Lawrence O. Gostin drew similar parallels from the McMath and Muñoz cases, outlining the ethical and legal dilemmas raised by a party attempting to fight for treatment when it is being refused, or to fight for refusal of treatment when it is being imposed. Gostin drew few conclusions, however, beyond the likelihood of persisting legal, emotional, and ethical issues surrounding brain death. Dr. David C. Magnus, et al. also compared the McMath and Muñoz cases to raise a frightening conclusion about the determination of death and the rights of families, warning that, “allowing family members to determine death threaten[s] to undermine decades of law, medicine, and ethics.” But where do we draw the line? Should a family, such as the Muñoz family, be able to assert the decedent’s wishes to die with dignity? And if so, should a family like the McMaths be able to assert their own religious beliefs to contravene medical advice?

Reproductive health and rights commentator Andrea Grimes refers to the conundrum as one that should be dealt with on a case-by-case basis, with respect for each individual circumstance, and the belief that “we, as average citizens, can trust ourselves to make these tough decisions without heavy-handed direction of black-and-white laws written for very, very gray
Indeed, the occurrence of maternal brain death is rare enough that such specific situations could perhaps be decided on a case-by-case basis. When these “gray situations” enter the courts, however, there must be some standard to apply. The historic constitutional bases for terminating a pregnancy or refusing medical treatment may no longer be enough, and these rare cases could also have potentially dangerous precedential effects on such existing rights.

Only thirty cases of maternal brain death were reported between 1982 and 2010, but a 2013 case study from Dr. Said, et al. in the United Arab Emirates pointed out that instances in medical literature are increasing. Said reported the case of a thirty-five year old woman who was declared brain dead while pregnant with a fetus at sixteen weeks gestation, and was kept on support technology for another sixteen weeks until the fetus was viable and a successful delivery was made through caesarean section. The 110-day somatic support was one of the longest occurrences to date worldwide, and led Said, et al. to conclude that the gestational age of the fetus at brain death “is no longer an important issue . . . with the important advances in life-support technology and critical care that enables the maintenance of vital functions.”

It is this medical determination, particularly in light of recent handling of brain dead patients, which raises significant concerns for future of reproductive technology and the corresponding whittling of women’s reproductive autonomy. If medical providers believe that the technology exists to make a dead body a beneficial “natural incubator,” regardless of gestational age of the fetus or the family’s wishes, we risk losing the ability to draw the line between active reproduction and passive incubation in the female body.

C. VEGETATIVE STATE VERSUS BRAIN DEATH, AND DEATH: MEDICAL STANDARDS AND DEFINITIONS

Brain death is sometimes considered to be one of several disorders of consciousness, though the spectrum generally includes disorders of those individuals who are still medically and legally alive. Disorders of consciousness, in decreasing order of severity and inactivity, include coma, vegetative state, minimally conscious state, and the false-positive “locked-in syndrome.” Closest to brain death on the spectrum is a coma. “Coma

18. Esmaeilzadeh, et al., supra note 5.
22. Maxine H. Harrington, Advances in Neuroimaging and the Vegetative State: Implications for End-of-Life Care, 36 Hamline L. Rev. 213, 214 (2013) (suggesting that technological innovations in neuroimaging may allow a patient in a vegetative state to communicate their wishes for treatment by asking them to think of specific images in response to yes/no questions, and then monitoring brain activity).
is a state of unwakefulness (eyes-closed) and unawareness. It is usually a temporary, acute state that can last days to weeks. Patients may devolve from coma to brain death, which is defined as the irreversible cessation of all functions of the brain," or may recover to a vegetative state and then to full consciousness. There is confusion and controversy about differentiation of brain death and vegetative state even in the medical community, but it is nevertheless generally well settled that a nonreactive vegetative state is a state of living, while brain death is a diagnosis that occurs when there is no remaining brain function and is equivalent to death. In either diagnosis, patients may be kept on somatic support methods until termination of support is deemed appropriate. These support methods provide the patient with nutritional and ventilator support, temperature regulation, antibiotics, and other medical interventions to maintain the body's physicality without the direction of the brain.

One very relevant legal difference between the two diagnoses is who makes the decision to terminate support. In the case of a brain dead patient, "[e]ven many of the most vocal critics of brain death agree that there is no obligation to continue providing mechanical support after brain death." A hospital may elect to leave the patient on support for a matter of days so that the family can say goodbye, though in some cases any further treatment of the patient may constitute interference with a dead body, as was the case with Oakland Children's Hospital and Jahi McMath. For a patient in a vegetative state, on the other hand, doctors must follow an advance directive as instructed. In the absence of directive, a medical surrogate, usually a family member or a close friend, is appointed to make decisions about whether or not to sustain treatment. With this understanding, a hospital's default recommendation for a brain dead patient might be to remove them from support, while the recommendation for a vegetative patient might be to leave them on support. The conceptual line between brain death and coma is slim, and physicians may feel in either case that they must focus on survival of the fetus.

In the U.S., the Uniform Determination of Death Act ("UDDA"), approved in 1980, sets a standard for physicians to determine death. "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. A determination of death must be made in accordance with accepted medical standards." Brain death falls squarely within the second criterion for determination of death, even if machines may artificially perpetuate the first criterion. The UDDA was adopted to solidify the concept that loss of integrated physical and mental function is the earmark of death—beyond, for example, loss only of respiratory or reactive processes. The UDDA is accepted in its model form by all fifty U.S. states, though two retain religious exceptions to the determination of death at the request of the deceased's family.

While medical and legal scholars report that this standard is well established and well understood in the medical community, quantitative evidence paints a different, more concerning picture. Ari Joffe, et al. conducted a 2012 survey of how American neurologists understand brain death. All doctors should ostensibly have an understanding of brain death as informed by the UDDA—particularly neurologists, as the specialists usually declaring brain death in a patient. However, the report concluded that "most neurologists do not understand . . . the standard concept that [brain death] is death . . ." In fact, many doctors believed that there was high potential for false diagnosis of brain death, and there was confusion about whether brain death actually marks the irreversible cessation of brain function. Thus, a person’s bodily autonomy and exercise of right may rest on a doctor’s personal understanding of brain dead despite clear, uniform statutory standards for determining death. Even more alarming, however, were the survey results regarding a hypothetical brain dead pregnant patient. When offered to select from different stages at which the neurologists might declare death in the patient, six percent reported that they would not consider the patient to be dead until after delivery of the fetus. A similar survey of Canadian neurosurgeons indicated that sixteen percent would not diagnose brain death before delivery or demise of the fetus. Thus even when legal and medical standards may indicate that a brain dead pregnant person should be removed from support, some physicians may allow personal convictions to distort their actions. This conflation of maternal life or death with fetal "life" may be one conceptual obstacle to remodeling existing laws and medical standards.

33. Id. at *3.
Several authors draw parallels between brain dead organ donors and pregnant persons, as one body is being used in part for the survival of another. For example, Said, et al. draw a very clear conclusion that the "ethical justification for prolonging the vital functions of the mother can be supported better if she is a prospective organ donor as the fetus would be the first to benefit from receiving the organs of the mother." However, the inconsistency of medical understanding of brain death, coupled with the relative rarity of maternal brain death, means that there is no standard protocol for dealing with pregnant brain dead patients.

Medical recommendations regarding treatment of a brain dead pregnant patient vary widely and include evaluations based on gestational age of the fetus, evidence of the desires of the mother, ethical obligations of medical staff, and potential interests of the fetus. Despite these variations, the issue remains that the fetus should not in most cases be considered the primary patient of the medical provider. A doctor has certain responsibilities to a pregnant patient, but these duties are extinguished upon death of the patient, leaving the fetus in medical and legal limbo. There could be serious implications to abortion rights and the rights of pregnant people if it is determined that fetuses, even in these limited situations, have protectable medical interests as patients.

D. IS "NATURAL" INCUBATION THE FUTURE OF ASSISTED REPRODUCTIVE TECHNOLOGY?

The advancement of technology in the past ten years has changed the landscape of reproductive technologies considerably. Medical literature indicates that gestational age is no longer a concern in determining whether a pregnant woman should be kept on somatic support until delivery, which may impact concepts of fetal viability. Many states in the U.S. are currently pushing to ban abortions as early as twenty weeks, and taking

35. Said, et al., supra note 1, at 222.
36. Anne Drapkin Lyerly, Margaret Olivia Little, and Ruth R. Faden, A Critique of the 'Fetus as Patient', 8(7) AM. J. BIOETH. 42 (2008), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2553002/pdf/nihms68449.pdf ("'Patienthood' . . . is a normative status that connotes concrete expectations for professional engagement: physicians are duty-bound to be fiduciaries of their patients. More specifically, physicians are typically understood as having a strong, primary, and equal fiduciary duty to their individual patients. This raises the concern that, insofar as clinicians regard themselves as having two patients—even two intertwined patients—they may regard their obligations to and the value of each of their patients as equal. Yet tragically, we face circumstances in the context of pregnancy that reflect how important it is to recognize the primacy of the clinician's duties to the pregnant woman.").
other measures to restrict people from terminating pregnancy as early as possible. If maternal death is considered similar to abortion as a cause of fetal "death," then the new technology coupled with the increasing insistence that a human life exists before fetal viability will create major obstacles for people seeking to terminate life support of a pregnant brain dead patient. Indeed, it is this combination that sets the stage for a new method of reproduction by human incubation.

One area of reproductive technology that has not yet received attention in comparison to maternal brain death is the concept of surrogate pregnancy. Some scholars address surrogate motherhood in relation to in vitro fertilization to effect posthumous parenthood (and certainly all scholars writing on the topic at hand discuss surrogate decision-makers). But in the language of reproductive technology, could it be argued that a brain dead pregnant woman begins to serve the role of a gestational surrogate mother? If this is the case, what precedent exits to bar the practice of using brain dead organ donors as gestational surrogates? Since medical scholars have remarked that the ethical implications of maternal brain death are seriously lessened when a woman is an identified organ donor, it is not inconceivable that female-bodied organ donors would be used to gestate the offspring of others as an acceptable technological advance in the not too distant future.

There are no clear solutions to the issue yet, but as technological capacity increases it is likely that more such cases will arrive. Esmaeilzadeh, et al. recommend that an international registry of brain dead pregnant patients be established so that physicians can access a more comprehensive database of case studies and practical treatment recommendations. Said, et al. recommend discussing the possibility of brain death in prenatal counseling, and executing a written document with mothers to express their wishes for treatment. While the medical


39. See, e.g., Esmaeilzadeh et al., supra note 5, at *9; Said, et al., supra note 1, at *4; but, c.f. Sperling, Maternal Brain Death, supra note 16, at 470 ("The organ donor model is inapplicable to the case of a brain-dead pregnant woman.").


41. Said, et al., supra note 1, at 223 (citing Anita J. Catlin & Deborah Volat, When the Fetus is Alive but the Mother is Not: Critical Care Somatic Support as an Accepted Model
recommendations address practical tools, there is little agreement regarding the application of legal standards in these cases. Considering a brain dead pregnant woman to be dead and refusing to maintain somatic support can run afoul of state interests in potential life, as well as the wishes of the family. Keeping such patients on support also illuminates serious issues of personal and reproductive autonomy, medical decision-making, and state interest interference. The occurrence of brain death in pregnant women remains rare enough that perhaps cases are best decided on an individual basis with deference to the wishes of the family. Nevertheless, increased technological capacity will likely continue to raise more pressing issues of posthumous reproduction and "natural" incubation. With that in mind, the next section of this comment examines some of the legal standards used in recent cases of maternal brain death, and what existing Constitutional rules may be applied.

II. CONSTITUTIONAL COMPARISONS

A. LEGAL STANDARDS, CONSTITUTIONAL ISSUES, AND THE LACK OF COHESIVE REGULATION IN THE U.S.

Defining when death occurs sets "a highly significant social boundary. It determines who is recognized as a person with constitutional rights, who deserves legal entitlements and benefits, and when last wills and testaments become effective." Although an individual generally ceases to have any protectable interests at the determination of death, there are some interests that a person retains posthumously. These include protection from defamation, continuation of attorney-client privilege, and the execution of property rights through a last will and testament. Analyses of property rights and fetal interests can be applied to brain death cases, and analogized to both abortion and reproductive technologies that allow such phenomena as posthumous reproduction. In the Muñoz case, "the state appear[ed] to be violating two interests: the individual’s interest in a dignified death and burial and the physician’s interest in acting ethically by not treating a dead patient."

Fourteen U.S. states currently have laws compelling hospitals to keep a pregnant person on somatic support, regardless of advance directives or the families’ wishes. Louisiana proposed a bill in April 2014 to be come the...
fourteenth such state, just weeks after Texas’ ruling in the Muñoz case. Louisiana H.B. 1274 changed an existing statute defining end-of-life procedures, to “add more explicit language saying that if a patient is pregnant and an obstetrician determines the woman’s life ‘can reasonably be maintained in such a way as to permit the continuing development and live birth of the unborn child,’ the doctor must use life-sustaining procedures.” The law was passed in June 2014 and included the caveat that the law “would not interfere with the rights of children, parents, or siblings of the woman to make end of life decisions.”

Nearly half of U.S. states also have Natural Death Statutes that include a pregnancy clause that invalidates advance directives in the case of a pregnant patient. In the wake of the Muñoz case, there have been popular media calls to repeal such “discriminatory” laws. There have also been scathing medical opinions: Dr. Jeffrey L. Ecker, for example, calls such laws “wrongful usurpation of the rights of individuals – in this case, one particular class of individuals: women.” Dr. Ecker suggests that physicians refuse to uphold such laws and support their patients as conscientious objectors.


47. Id.
49. Louisiana Law Regarding End of Life Procedures (HB 1274), RH REALITY CHECK, http://data.rhrealitycheck.org/law/louisiana-law-regarding-end-of-life-procedures-hb-1274/ (last updated July 8, 2015); LA. REV. STAT. ANN. § 40:1299.64.6(D) (“It is the policy of the state of Louisiana that human life is of the highest and inestimable value through natural death. When interpreting this Part, any ambiguity shall be interpreted to preserve human life, including the life of an unborn child if the qualified patient is pregnant and an obstetrician who examines the woman determines that the probable postfertilization age of the unborn child is twenty or more weeks and the pregnant woman’s life can reasonably be maintained in such a way as to permit the continuing development and live birth of the unborn child, and such determination is communicated to the relevant classes of family members . . . .”).
50. See ALA. CODE § 22-8A-4(E); ARK. CODE ANN. § 20-17-206(C); COLO. REV. STAT. ANN. § 15-18-104(2); CONN. GEN. STAT. ANN. § 19A-574; GA. CODE ANN. § 31-32-4; IDAHO CODE ANN. § 39-4510; 755 ILL. COMP. STAT. ANN. 35/3(3); IND. CODE ANN. § 16-36-4-8(D); IOWA CODE ANN. § 144A.6(2); KY. REV. STAT. ANN. §§ 311.625, 311.629(4); MINN. STAT. ANN. § 145B.13(3); MO. ANN. STAT. § 459.025; OHIO REV. CODE ANN. § 2133.06; OKLA. STAT. ANN. TIT. 63, § 3101.8(C); S.D. CODIFIED LAWS § 34-12D-10; TEX. HEALTH & SAFETY CODE ANN. § 166.049; WASH. REV. CODE ANN. § 70.122.030; WIS. STAT. ANN. § 154.07(2). See also Gregorian, supra note 44, at 412 (citing Bretton J. Horttor, A Survey of Living Will and Advanced Health Care Directives, 74 N.D.L. REV. 233, 233-34 (1998)).
52. Ecker, supra note 2, at 890.
Few court cases have addressed the Natural Death Statutes, and even fewer have addressed the specific issue of maternal brain death. Despite the lack of judicial inquiry, it is well established in the U.S. that individuals have the constitutional right to dictate their own reproductive choices and to refuse medical treatment.53 In a 2009 proposed legal methodology for cases of maternal brain death, University of Virginia Law School J.D. candidate Alexis Gregorian also drew parallels to cases regarding forced caesarian section of incapacitated patients, where courts have “explicitly rejected a balancing test between the mother’s interests and the fetus’ interests and heavily emphasized the mother’s right to forego medical treatment.”54 Gregorian argued, however, that in cases of maternal brain death it is a “legal fiction” to claim that the dead person has persisting interests. This “fiction” then perpetuates the idea that the dead person has a continuing right to refuse medical treatment; thus, a court must necessarily weigh the competing interests of the fetus and of the state against the fictitious interests of the dead.55

Gregorian also used fetal viability as a line of demarcation, much like those established in Roe v. Wade and Planned Parenthood v. Casey.56 In her proposed methodology, Gregorian argued that there should be three different standards for determining what to do in the case of maternal brain death. First, if the woman dies pre-viability and has an advanced directive or living will, those choices about life support should be honored.57 Second, if the mother suffers brain death without having clear preferences outlined, the decision should be made through substituted judgment, where a surrogate decision-maker is appointed.58 This should be done with the consensus of the family; or if consensus cannot be reached, the decision should be made with the assistance of the court, weighing the interests of the mother, her family, and the biological father. Finally, if the mother becomes brain dead post-fetal-viability, or at about twenty-nine weeks, the state’s interest in potentiality of life becomes compelling, and should take more weight than the tenuous interest of the brain dead woman to refuse treatment.59 Gregorian acknowledged that this would mean changing state advance directive laws, and that the post-viability line, while in line with some abortion jurisprudence, does not comport with the cases regarding forced caesarean section. Nevertheless, the final word in U.S. abortion law comes from the Casey court, holding that the state’s compelling interest in potential life is controlling.60

54. Gregorian, supra note 44, at 418 (citing In re A.C., 573 A.2d 1235, 1247 (D.C. 1990)).
55. Id. at 419.
57. Gregorian, supra note 51, at 419.
58. Id. at 420.
59. Id. at 423.
60. Id.
James M. Jordan in 1988, Radhika Rao in 2000, and Daniel Sperling in 2004 also produced scholarship examining the legal issues that arise with maternal brain death.\textsuperscript{61} Jordan predicted that there would be an increasing number of such cases as technological advancements increased and courts decided more cases about the right to refuse medical treatment.\textsuperscript{62} A 1977 Georgia case, \textit{University Health Services, Inc. v. Piazza}, is an oft-cited cases of maternal brain death in which a woman was declared brain dead at sixteen weeks' gestation. While her family and husband wanted her removed from life support, the biological father of the fetus (not the husband) challenged the decision.\textsuperscript{63} The court held that “the privacy rights of the mother are not a factor in this case because the mother is dead . . . .”\textsuperscript{64} Analyzing this decision against abortion and right-to-death cases that controlled at the time, Jordan concluded that this holding is incorrect. “Brain death does not extinguish the rights of a woman over her body, because a statutory standard of death cannot arbitrarily limit a fundamental constitutional right, and because her bodily control also derives from a posthumous property right in her own cadaver.”\textsuperscript{65}

Professor Radhika Rao also framed the issue as one of both property and privacy, and concluded that the differences between the theories rather than the intersections define when one governs. Constitutional privacy rights and property rights share many similarities, where “[b]oth property and privacy revolve around . . . images of bounded space, of protected sanctuaries or spheres of decentralized decision-making.”\textsuperscript{66} Property law implies ownership of the body (external or internal), while privacy law requires that the body and its ownership are indivisible.\textsuperscript{67} Rao set out a three-part inquiry for determining which should apply.

[W]hether the body should be identified as the subject of a privacy interest or the object of property ownership depends essentially upon (1) whether it is living or dead; (2) whether it is integrated with the whole person or a separate part; and (3) whether it is involved in a personal relationship or an object relationship.\textsuperscript{68}

\begin{itemize}
\item \textsuperscript{62} See, e.g., In re Quinlan, 355 A.2d 647 (1976).
\item \textsuperscript{64} Order in the Piazza Case, \textit{supra note} 64, at 417.
\item \textsuperscript{65} Jordan, \textit{supra note} 62, at 1165.
\item \textsuperscript{66} Rao, \textit{supra note} 1, at 423.
\item \textsuperscript{67} Rao, \textit{supra note} 1, at 444.
\item \textsuperscript{68} \textit{Id.} at 445.
\end{itemize}
Applying this framework to a brain dead pregnant person under the first part of the test, Rao suggested that any autonomy retained after death "must derive from property rather than privacy. Consequently, the state may conscript her [pregnant] body for public use as a fetal incubator just as it may conscript any other form of property."\textsuperscript{69}

Sperling addressed the issue within the frameworks of abortion law, human tissue law, and posthumous gifts. He declined to extrapolate abortion law under \textit{Roe} to cases of maternal brain death, and instead argued that the alternative "undue burden" test from \textit{Casey} should be applied. He also analyzed the issue using Canadian law, explaining that Canadian courts are reluctant to restrict abortion, and generally confer to a person full freedom of choice in the early stages of pregnancy. Sperling concluded that, similar to Gregorian's proposal, early in the pregnancy the woman's wishes should be respected if known, and determined through a surrogate process if unknown. Sperling continues to write extensively on the topic, and remarked in 2008 that, contrary to the frameworks suggested by Jordan and Rao, there is no property interest in the posthumous body because the basic tenets of property law require elements of ownership, possession, and exclusion that are lacking in a deceased body.\textsuperscript{70}

With this background in mind, the following comparison assesses differing approaches to the rights that underlie maternal brain death cases in the United States, Canada, and Ireland. While none of these countries have cohesive regulations that apply to the relatively rare incidences of maternal brain death, each has availed itself of the legal and constitutional frameworks they have previously applied to similar issues. They have varied conclusions—surprisingly restrictive in the United States’ currently constricting abortion landscape, relatively uncontroversial in Canada’s accommodating reproductive rights arena, and surprisingly respectful of the mother’s bodily autonomy under Ireland’s vehemently anti-abortion laws.

1. United States

   a. Marlise Muñoz, 33 Years Old, 14 Weeks Pregnant, November 2013 (Texas)

   Marlise Muñoz collapsed at home on November 26, 2013. At the time, she was thirty-three years old and fourteen weeks pregnant. Her husband Erick Muñoz rushed her to the hospital, but lifesaving efforts were unsuccessful and Mrs. Muñoz was declared brain dead on November 28, 2013.\textsuperscript{71} Both of the Muñozes were trained paramedics, and Mr. Muñoz

\textsuperscript{69}. Rao, \textit{supra} note 1,452-53.

\textsuperscript{70}. DANIEL SPERLING, POSTHUMOUS INTERESTS: LEGAL AND ETHICAL PERSPECTIVES 142 (2008).

\textsuperscript{71}. Defendant's Brief in Response to Plaintiff's Motion to Compel at 1, Muñoz v. John Peter Smith Hospital, No. 096-270080-14 (Tex.Dist. Jan. 24, 2014), 2014 WL 285056 [hereinafter Defendant's Brief].
was sure from their personal conversations that his wife would not want to be left connected to artificial “life support.” However, the hospital refused to remove Mrs. Muñoz from somatic support, citing a section of Texas Health and Safety Code that prohibits life-sustaining treatment from being removed when a patient is pregnant. Mr. Muñoz filed a motion to compel the hospital to remove Mrs. Muñoz from somatic support on January 14, 2014. The motion argued first that the hospital misinterpreted Health and Safety Code because Mrs. Muñoz was not a “pregnant patient” – she was dead and the hospital was in fact desecrating her body; or alternatively that the hospital was acting in blatant violation of her Fourteenth Amendment rights to privacy and equal protection under the laws.

Citing Texas “state’s expressed commitment to the life and health of unborn children[,]” the hospital responded that legislation was intended to protect a fetus regardless of whether Mrs. Muñoz remained alive. Furthermore, given the state’s interest in protecting life, “it is reasonable to distinguish between a pregnant patient and a patient who is not pregnant. The Equal Protection Clause is not violated by the treating two different classes of terminally ill patients differently.” Judge R.H. Wallace of the District Court of Texas, 96th Judicial District, disagreed and entered a judgment on January 24, 2014 ordering the hospital to remove Mrs. Muñoz from “life-sustaining treatment.” Judge Wallace concluded succinctly that “[t]he provisions of § 166.049 of the Texas Health and Safety Code do not apply to Marlise Muñoz because . . . Mrs. Muñoz is dead.” Judge Wallace declined to rule on its constitutionality because the law did not apply to Mrs. Muñoz. By the time the order was granted and Mrs. Muñoz was removed from somatic support, all parties agreed that the fetus was not viable.

b. Maria Lopez, 1999 (California)

Author Daniel Sperling, who has researched maternal brain death extensively, reported Mrs. Maria Lopez as an additional U.S. case of maternal brain death. According to Sperling, Mrs. Lopez was declared

72. TEX. HEALTH & SAFETY CODE ANN. § 166.049 (“A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient.”).
74. Id.
75. Defendant’s Brief, supra note 82, at 3-4.
76. Defendant’s Brief, supra note 82, at 8.
78. Id.
brain dead on April 24, 1999, while pregnant with twins. The family decided not to withdraw “life-support measures” and the twins were later delivered prematurely via cesarean section.\footnote{SPERLING, MANAGEMENT OF POST-MORTEM PREGNANCY, supra note 8, at viii.} There is little other information available about Mrs. Lopez, though according to reports from several anti-abortion or “right to life” news sources, it appears that Mrs. Lopez was not actually brain dead.\footnote{See Liz Townsend, Twins Born Healthy after Mother Wakes from “Irreversible” Coma, NAT’L RIGHT TO LIFE NEWS (Oct. 21, 2013), http://www.nationalrighttolifenews.org/news/2013/10/twins-born-healthy-after-mother-wakes-from-irreversiblecoma/#.VVINxJNV iko; Dave Andrusko, Woman Awakens From Coma to See Newborn Daughter, NAT’L RIGHT TO LIFE COMM. (2001), http://www.nrlc.org/archive/news/2001/NRL04/coma.html.} She instead awoke from a coma, and the babies were delivered while she was conscious. According to a story in the Los Angeles Times, Mrs. Lopez entered a coma after ruptured brain vessels resulted in severe hemorrhage; her family was advised to withdraw life support and agreed to do so, but Mrs. Lopez awoke just as a priest was performing her last rites.\footnote{Mike Downey, A Recovery That Is Best Explained as a Miracle, L.A. TIMES, Jul. 30, 1999, available at http://articles.latimes.com/1999/jul/30/news/mn-61025.} The story of Mrs. Lopez does not actually involve \textit{brain death}, but nonetheless highlights the difficulties that medical and legal practitioners face in determining brain death. She also remains an example of the agonizing choices that families are faced with, and potential legal obstacles that arise in determining death.\footnote{For similar discussion of comatose women who have been kept on support until their children are delivered, see the case of Barbara Blodgett in 1989. Michelle Green, Joni H. Blackman, & Victoria Balfour, Awakening from a Coma, a Washington Woman Meets Her Miraculous Baby Boy, PEOPLE MAG., Feb. 27, 1989, available at http://www.people.com/people /archive/article/0,,20119654,00.html. Another case arose recently in 2015, when Sharista Giles’ baby was delivered prematurely while she was in a coma. Sydney Lupkin, Sharista Giles: Mom Wakes Up From Coma to Find She’s Had Her Baby, ABC NEWS, Apr. 9, 2015, http://abcnews.go.com/Health/mom-wakes-coma-finds-baby/story?id=30193953.}

c. Courts on Brain Death

There is only one U.S. case that has explicitly addressed the matter of maternal brain death, in 1986. In \textit{University Health Services, Inc. v. Piazzi}, a Georgia court examined the case of Donna Piazzi, who was declared brain dead at approximately twenty weeks gestation.\footnote{Order in the Piazzi Case, supra note 64.} The hospital and court admitted that it was likely they could keep Mrs. Piazzi on somatic support until the fetus reached viability. Mrs. Piazzi’s husband Robert Piazzi wished to have her removed from somatic support. A different man named David Hadden, who claimed to be the father of the child, wished to keep Mrs. Piazzi on somatic support in the interest of preserving the fetus, allegedly his child. The court looked at the issue of whether it was proper to order continued life support to preserve a fetus. Taking it as a question of first impression, the court declined to analogize well-settled abortion law.
The law is settled that prior to viability the mother may decide to abort a fetus... and that after viability the state can both prohibit abortions and require that the mother undergo necessary treatment to protect the life of the fetus. These well-settled principles of law do not apply here because the mother is brain dead and the fetus is not yet viable.

Citing Georgia's feticide law, court determinations of the state's interest in fetal life, and laws that negate advance directives of a pregnant woman, the court concluded "that so long as there exists a reasonable possibility that a non-viable fetus can develop and survive with the maintenance life support systems for its brain dead mother, then those life support systems must be maintained."

Courts have not yet established a common understanding of brain death generally, and the U.S. Supreme Court has never addressed the matter of a brain dead patient. In the influential Cruzan case, discussed in further detail below, the dissent highlighted the difference between a persistent vegetative state and brain death, noting that in a comatose patient "[a]n erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem, and result in complete brain death." This lack of uniform understanding unfortunately mirrors conventional medical understanding. According to Joffe's 2012 survey of American neurologists, although "[a]lmost half accept [brain death] because it is a state of permanent unconsciousness... more than half do not consider it equivalent to circulatory death." There is a broad disparity among neurologists' understanding of brain death and the subsequent treatment of a brain dead patient, despite the UDDA.

d. Constitutional Provisions

There is no explicit constitutional right in the U.S. to abortion, health care, or death with dignity. These rights, however, are interpreted to exist primarily under the Fourteenth Amendment to the U.S. Constitution. In the seminal abortion case Roe v. Wade, the Supreme Court held that the "right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action... or in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her

85. Order in the Piazzi Case, supra note 44, at 417 (citing Roe v. Wade, 410 U.S. 113 (1973); Jefferson v. Griffin Spalding County Hospital Authority, 274 S.E.2d 457 (1981)).
86. Id. at 418.
89. See discussion and accompanying text, supra note 37.
pregnancy.”\textsuperscript{90} As discussed below, the right of privacy has also been extended to include the right to refuse lifesaving healthcare. It is suggested that these matters exist in established property rights.\textsuperscript{91}

e. Abortion Laws

\textit{Roe v. Wade} established a constitutional right to abortion in 1972. The U.S. Supreme Court “conclude[d] that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation.”\textsuperscript{92} To assess the interplay of state interests, \textit{Roe} established a trimester framework. The framework can be broken down as follows: in the first trimester of pregnancy the pregnant woman’s interests take precedence and no restrictions may be imposed; in the second trimester the decision to have an abortion may be regulated by the state using measures reasonably related to maternal health; and in the third trimester, the state’s interest takes precedence and abortion may be regulated or prevented “except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”\textsuperscript{93}

This framework was amended in 1992, when the Court in \textit{Planned Parenthood v. Casey} affirmed \textit{Roe}’s central holding but imposed an “undue burden” test to replace the trimester framework.\textsuperscript{94} After rejecting the trimester framework, the Court reasoned that “[t]o protect the central right recognized by \textit{Roe v. Wade} while at the same time accommodating the State’s profound interest in potential life, we will employ the \textit{undue burden} analysis . . . .”\textsuperscript{95} The undue burden standard, however, remains open to broad interpretation. The Court explained only that “[a]n undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a \textit{substantial obstacle} in the path of a woman seeking an abortion before the fetus attains viability.”\textsuperscript{96} Courts continue to examine the question of what constitutes a “\textit{substantial obstacle}” to abortion care that is sufficient to impose an undue burden.\textsuperscript{97} States remain able to implement

\textsuperscript{91} See discussion and accompanying text, supra note 72.
\textsuperscript{92} Roe, 410 U.S. at 154.
\textsuperscript{93} Roe, 410 U.S. at 164-165.
\textsuperscript{94} Planned Parenthood v. Casey, 505 U.S. 833, 872-73 (1992) (“The trimester framework no doubt was erected to ensure that the woman’s right to choose not become so subordinate to the State’s interest in promoting fetal life that her choice exists in theory but not in fact. We do not agree, however, that the trimester approach is necessary to accomplish this objective. A framework of this rigidity was unnecessary and in its later interpretation sometimes contradicted the State’s permissible exercise of its powers. . . . We reject the trimester framework, which we do not consider to be part of the essential holding of Roe.”).
\textsuperscript{95} Casey, 505 U.S. at 878 (emphasis added).
\textsuperscript{96} Id. (emphasis added).
\textsuperscript{97} At the time this article went to print, the case Whole Woman’s Health v. Cole was pending review before the U.S. Supreme Court. The case, if accepted, is poised to “produce the most important abortion ruling since 1992 . . . .” Adam Liptak, \textit{Supreme Court Prepares to Take On Politically Charged Cases}, N.Y. TIMES, Oct. 4, 2015, at A13, available at
their own regulations on abortion under the auspices of ensuring maternal health. While there is a constitutional right to abortion, it is increasingly controversial in the United States. These restrictive attitudes are rooted in conservative beliefs that a fetus is a full human life at the moment of conception—the same attitudes that inform opposition to removing a brain dead pregnant person from somatic support.

f. Right to Refuse Health Care

There is a Constitutional right to refuse health care in the U.S. While it is not explicit, the Supreme Court has interpreted that it is included in Fourteenth Amendment privacy rights. "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." The Supreme Court has upheld this right relative to an individual's wishes, but has declined to extend it to the wishes of immediate family. In Cruzan v. Missouri Department of Health, the Supreme Court entertained arguments about whether a hospital must be forced to comply with the family's wishes to remove a woman from life support. Nancy Cruzan was in a persistent vegetative state after a car accident, but the hospital refused to remove her from life support without a court order, absent clear evidence of Ms. Cruzan's own wishes. The Court concluded that the hospital could consider the family's wishes, but did not have to absent compelling evidence of Ms. Cruzan's own wishes. It is thus established that a person has a right to refuse medical treatment and end of life care.

http://www.nytimes.com/2015/10/05/us/politics/supreme-court-prepares-to-take-on-politically-charged-cases.html?r=0. See Whole Woman's Health v. Cole, 790 F.3d 563 (5th Cir.) modified, 790 F.3d 598 (5th Cir. 2015) (addressing whether or not Texas created undue burdens on abortion access by requiring that abortion clinics have admitting privileges at local hospitals, and that clinics meet the same standards as ambulatory surgical centers).

98. State initiatives referred to as TRAP laws are the primary method of restriction, occurring with increasing frequency across the country. In the wake of unsuccessful attempts to explicitly limit abortion access, targeted regulation of abortion providers ("TRAP" laws) attack the procedure through secondary methods including restricted funding, and clinic operating and facilities requirements. See GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: TARGETED REGULATION OF ABORTION PROVIDERS (Oct. 1, 2015), http://www.guttmacher.org/statecenter/spibs/spib_TRAP.pdf.


100. Cruzan, 497 U.S. at 286-87 (1990) ("we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling—a feeling not at all ignoble or unworthy, but not entirely disinterested, either—that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may choose to defer only to those wishes, rather than confide the decision to close family members.").
We can also draw comparison from cases of forced caesarean section. In the case of *In re A.C.*, a Washington, D.C. appeals court held that a pregnant patient should nearly always have the final say in whether or not a caesarean section is performed, and that incompetent patients "have just as much right as competent patients to have their decisions made while competent respected." Belgien Professor Christophe Lemmens asserts that generally no state interest outweighs the treatment refusal of a competent adult, even in the case of a pregnant patient. However, in the case of advance directives, Lemmens points out that while it may be binding for a woman to refuse treatment if pregnant and incapacitated, it is not enforceable for a woman to request to be maintained on life support. Regardless of a patient’s wishes, a physician is never obligated to engage in treatment that is not medically indicated. This standard again raises the comparison between the Muñoz and McMath cases, where one family was asserting the right to refuse treatment, and the other attempting to assert a right to enforce treatment. The latter case is not legally supported, no matter how compelling the family story may be.

Determination of a brain dead (or comatose) patient’s wishes remains a point of strong contention. Laws like the Texas provision at issue in Mrs. Munoz’s case are surprisingly more common than one might expect. More than thirty states have laws on the books that invalidate a living will or the wishes of a guardian decision-maker if a woman is pregnant but rendered intellectually incapacitated. These statutes either indirectly remove decision-making power by declaring advance directives invalid in case of pregnancy (California is an example), or explicitly mandate that treatment of the pregnant woman be continued (like in Texas). Professor Rao argues that because these laws treat women’s bodies as property, it is more appropriate to invoke property laws in the case of maternal brain death than the traditional privacy rights usually associated with choice in pregnancy. Other scholars have similarly evoked property analyses in hypothetical circumstances of maternal brain death, but they have never

103. *Id. at 500.
104. See discussion and accompanying text, *supra* note 16.
106. *Id. at 411-12.
107. *Id. at 452 ("[T]he brain-dead pregnant woman . . . has crossed the legal boundary separating life from death, and thus receives precisely the same treatment under law as a corpse. If she continues to possess some degree of autonomy over her body after death, that autonomy must derive from property rather than privacy.").
been tested in courts. Property rights are in fact some of the few rights that unambiguously remain attached to a person: people may indicate what is done with their remains and property, and these declarations remain valid after death.

g. Death With Dignity Laws

The right to die was entertained by the Supreme Court in *Cruzan*, though there is no definitively established constitutional right to death with dignity. States regulate end of life care and assisted death on an individual basis. In Washington state, for example, there are laws that allow assisted suicide. The Washington Death With Dignity Act, effective in 2009, “allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have less than six months to live.” In California, the End-of-Life Option Act passed in October 2015, amending the California Health and Safety Code to allow that “[a]n individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all [four enumerated] conditions are satisfied.”

End-of-life decisions have long been intertwined with “choice” politics and anti-abortion initiatives. The famous case of Terri Schiavo brought these issues to public attention in the late 1990s, when a New Jersey woman was in an irreversible persistent vegetative state, and her parents sought to keep her on somatic support while her husband wished to have her removed. The parents of Schiavo challenged a court order to remove the feeding tubes, going so far as to incite state legislation, and eventually Congressional action.

h. Organ Donation

Another comparator in cases of maternal brain death is the treatment of organ donation. Medical professionals recently drew an explicit parallel between maternal brain death and organ donation, commenting that in


110. WASH. REV. CODE ANN. § 70.245.010 et seq.

111. CAL. HEALTH & SAFETY CODE § 443.2 (as amended by S.B. 128, 2015 Cal. Leg., Reg. Sess. (Cal. 2015)).

112. See George J. Annas, “*Culture of Life*” Politics at the Bedside—The Case of Terri Schiavo, 352 NEW ENGL. J. MED. 1710, 1711-13 (2005); Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1289, (11th Cir. 2005) (“Parents of incapacitated patient whose artificial life support had been removed pursuant to Florida court order brought action for alleged violation of patient’s rights with respect to withholding of food, fluids, or medical treatment.”).
cases of maternal brain death "ethical justification for prolonging the vital functions of the mother can be supported better if she is a prospective organ donor as the fetus would be the first to benefit from receiving the organs of the mother." In the U.S., organ donation is governed by the Uniform Anatomical Gift Act ("UAGA"). If a pregnant woman is declared brain dead and the use of her uterus is to be evaluated as an organ donation, specific provisions of the UAGA apply regarding such a donation. Importantly, and in direct contrast to the legal disputes that we have seen over maternal brain death, the UAGA outlines ways that a person may agree to or refuse organ donation, and "in the absence of an express, contrary indication by the individual set forth in the refusal, an individual’s unrevoked refusal to make an anatomical gift of the individual’s body or part bars all other persons from making an anatomical gift of the individual’s body or part." If the UAGA applied to cases of maternal brain death, hospitals would be required to acknowledge a woman’s advance directive indicating that she does not want to be kept on life support or make organ donations, even if she were pregnant.

Adopted in 1968 and promulgated by all fifty states, the Uniform Anatomical Gift Act governs what type of anatomical donations may be made posthumously, and thus grants some individuals agency over what is to be done with their remains. A person may make a gift of their entire body, ostensibly implying that a woman’s body could be donated for use as an incubator. Additionally, the Federal Drug Administration oversees regulation of the National Organ Transplant Act ("NOTA"), a law that prohibits exchange of money for donated body parts. If NOTA and the UAGA applied to the use of a donated uterus, it begins to sound like a gestational surrogacy arranged with living woman, where the process must be contracted for and funds may not be exchanged.

Each U.S. state also has laws that prohibit interference with a cadaver. Texas makes it a criminal misdemeanor to dissect or damage any whole or part of a corpse. In California, it is a felony to mutilate a dead body, and a misdemeanor to fail to release remains. In the McMath case, the physicians at Oakland Children’s Hospital refused to insert the feeding

113. Said et al., supra note 1, at *4.
114. UNIF. ANATOMICAL GIFT ACT § 7 (UNIF. LAW COMM’N 2006).
117. TEX. PENAL CODE § 42.08(a)(1) (2005).
118. CAL. HEALTH & SAFETY CODE § 7052(a) (2007) (Unlawful mutilation, disinterment, or act of sexual penetration or sexual contact with human remains; felony; definitions); CAL. HEALTH & SAFETY CODE § 7053 (2007) (Detention or attachment of human remains for debt; failure to release human remains, personal effects, or certificate required under Division 102; misdemeanor).
tubes that would have been required to transport the body to a private facility, maintaining that the hospital was legally and ethically prohibited from operating on a dead body.\textsuperscript{119} While California statute clearly defines a brain dead person as dead, McMath’s family attorney argued that she deserved Constitutional protection as a disabled person, as well as asserted the family’s Constitutional privacy right to make medical decisions for their own child.\textsuperscript{120} The case highlights the difficulties posed in accepting brain death as true death, especially when faced with a body that appears to exhibit signs of life when supported by medical technology.

Texas statutes further complicate the issue when considering the relatively recent “futility” provision of the Texas Advance Directives Act. Under an uncommon provision of the Act—the same Act that kept physicians from removing Marlise Muñoz from life support due to her pregnancy—physicians are empowered to refuse life saving medical treatments even to those who request them. “This law applies to everyone who finds themselves in need of medical assistance to maintain one’s life, even outpatients in need of such things as dialysis or portable respirators, and regardless of whether one’s condition is expected to improve.”\textsuperscript{121} Texas physicians would have been well within their explicit statutory rights to refuse treatment to Jahi McMath, or even to Robyn Benson. Would they have done the same for Marlise Muñoz had she not been pregnant? Or perhaps if the family had wished to keep her body on “life support” after delivery of the baby, physicians could have refused to take such futile measures? Comparison of provisions of this Texas statute alone makes it clear that to the state, Muñoz’s value was related only to the fetus that she carried, regardless of its viability, and not related to the life choices that she and her husband had hoped to make.

2. Canada

a. Robyn Benson, 32 Years Old, 22 Weeks Pregnant, December 2013 (Victoria, B.C.)

Robyn Benson was thirty-two years old and twenty-two weeks pregnant when she collapsed from an apparent brain hemorrhage in December 2013, and was declared brain dead at a Victoria hospital shortly thereafter.\textsuperscript{122} Mrs. Benson’s case falls in stark contrast to the case of


\textsuperscript{121} Nora O’Callaghan, Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act, 60 BAYLOR L. REV. 527, 529 (2008).

\textsuperscript{122} Grimes, In Texas and Canada, supra note 14.
Marlise Muñoz, playing out simultaneously in the neighboring United States. Importantly, Mrs. Benson’s fetus was on the cusp of viability. Additionally, her family did not contest any laws or treatment: her husband Dylan Benson asked that she be kept on somatic support until the baby was delivered. Baby Iver Benson was successfully delivered by cesarean section at twenty-eight weeks gestation, and Mrs. Benson was subsequently removed from somatic support. While the case drew little controversy in comparison to Mrs. Muñoz, it nevertheless raised questions of how such cases should be treated. It also illustrates the persistent, common misunderstanding of brain death: shortly after Mrs. Benson was removed from somatic support, a reputable news outlet reported that the dead woman had “died.”

The perspective of the husband, and the treatment by media, closely mirror another Canadian case from more than a decade earlier.

b. Sophia Park, 25 Years Old, 10 Weeks Pregnant, 1999 (Toronto)

Sophia Park was declared brain dead in Toronto Western Hospital on November 27, 1999. After several misdiagnoses of tuberculosis, she slipped into a coma resulting from tuberculous meningitis. At the time of the diagnosis, Ms. Park was twenty-five years old and ten weeks pregnant with her first child. Doctors recommended removing somatic support. Ms. Park’s husband Paul Shin vehemently disagreed, and took to popular media in the hopes of compelling the hospital to keep his wife on somatic support until the baby could be delivered. The media obliged, and several articles ran calling for the continued support of Ms. Park. The media, however, frequently conflated brain death with coma, even going so far as to refer to a “‘brain death’ coma” as a medical state. As discussed previously, brain death and coma are very distinct. Ms. Park’s family was devoutly religious, and believed that keeping the baby alive was in

126. Crean, supra note 125.
127. Jonathon Gatehouse, Don’t Give Up, Says Woman Who Gave Birth While in Coma: Hope for Toronto Family, NAT’L POST (Toronto), Dec. 3, 1999, at A2 (comparing a U.S. case, where Washington state resident “Mrs. [Barbara] Blodgett was thrown from a Jeep in a June, 1988, accident and suffered severe head injuries. Three months pregnant at the time, the then 24-year-old slipped into a deep coma, and doctors told her family that she was in a state of ‘cerebral death.’ That December, while still in a coma, she gave birth to a healthy baby boy. After the birth she regained consciousness.”).
128. See discussion and accompanying text, supra note 25.
God's plan; the media reflected this belief by reporting on the fact that Ms. Park's fetus was still "alive," even though she was not. While the hospital provided Ms. Park with the "best care possible," the fetus was determined to be non-viable on December 3, 1999. A medical ethicist noted at the time that "[a]lthough the hospital has no legal obligation towards the foetus, which may or may not be medically viable, many people will believe that it has a moral one . . .".

c. Courts on Brain Death

Canadian courts have applied inconsistent measures for brain death. This is unsurprising, given that there is also inconsistent understanding in the medical community. A 2007 study of Canadian neurosurgeons' understandings of brain death concluded that, "a stand-alone concept of [brain death] may not exist." Relevant to the current discussion and perhaps quite tellingly,

When faced with a pregnant brain dead patient, 16% of respondents did not feel comfortable diagnosing death before the neonate was delivered. When faced with a family that insists on continued support of a brain dead patient, 31% would continue this life support to honor the family's wishes. If similar support would not be continued on a patient after circulatory death, this suggests that BD is thought to be different from death.

Canadian court decisions highlight a line of reasoning that similarly applies different standards of brain death in different contexts. The British Columbia Supreme Court reasoned that the standard should apply differently in civil court and criminal court, since civil court is more concerned with the people's morality.

The suggestion that brain death or the irreversible cessation of brain function be the legal standard for determining when death occurs may be suitable in the medical context and even in the civil law context, but it is a completely impractical standard to apply in the criminal law.

In an Ontario case, the court referred to brain death as a temporary state, citing "evidence that [a witness] had suffered memory problems after a medical incident in the eighties which left her brain dead for a number of

129. Gatehouse, supra note 126.
131. Gatehouse, supra note 126 (quoting Dr. Margaret Somerville, founding director of McGill University's Centre for Ethics and Law).
133. Id.
134. R. v. Green, 1988 CarswellBC 927, ¶ 8 (Can. S.C.B.C.) (WL) (rejecting a murder defense that the victim was brain dead and thus already dead when the defendant shot him twice).
In an Ontario arbitration for wrongful employment termination, the court referenced the cavalier manner in which the term “brain dead” is often used, allowing that in some contexts “[t]he use of the phrase ‘brain dead’ is a schoolyard term and certainly does not link the grievor to any comments made by a member of the hospital staff.” Finally, illustrating a perception of a distinct difference between brain death and death, a Saskatchewan court detailed how a woman suffered from a dramatic hemorrhage after childbirth and the expulsion of her uterus, resulting first in brain death and then death some minutes later. These decisions highlight the lack of cohesive guidance on brain death, in both the legal and medical communities.

d. Constitutional Provisions

Canadian cases of maternal brain death appear to have been less contentious than U.S. cases, which may have to do with attitudes about abortion and end of life care generally. Most of rights to abortion or health care in Canada are grounded in Section 7 of the Canadian Charter, which specifies that “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” Fundamental freedoms are enumerated in Section 2, declaring that “Everyone has the following fundamental freedoms: (a) freedom of conscience and religion; (b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication; (c) freedom of peaceful assembly; and (d) freedom of association.” Finally, Canada also has a clause similar to the U.S. Equal Protection clause: Section 15 of the Charter reads, “Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.”

136. York University and York University and United Plant Guard Workers of America, Local 1962, Re, 1989 CarswellOnt 4253, ¶ 66 (Can. O.A.) (WL) (a university security officer was terminated for misrepresenting himself to the family of an ailing colleague, and among other offenses told university administrators that the ailing man in question was “brain dead”).
139. Canadian Charter § 2.
140. Canadian Charter § 15.
e. Abortion Laws

At the time of Ms. Park’s death, one author noted concisely that “[I]legally, in Canada, there is no obligation to save the life of a fetus. Laws protecting fetal life were erased when the laws limiting abortion were struck down 10 years ago, and the law remains mute regarding the first nine months of human life.” Canada affords no explicit constitutional right to abortion but implements few obstacles to people who seek abortion. Abortion was decriminalized in Canada through a case brought before the Canadian Supreme Court by Dr. Henry Morgentaler in 1988. The Morgentaler case removed prior criminal penalties against abortion providers, and established that under Morgentaler and the Canada Health Act, a person should have unrestricted access to abortion care. The Court also allowed that indigent women should have equal access to abortion, so state-funded medical programs would cover the cost. The Canada Health Act requires insurance coverage of medically necessary procedures, defined only in that “medically necessary is that which is physician performed,” and interpreted in many forums to mean that abortion is indeed medically necessary and covered. The effect is that while there is no “right” to abortion in Canada, there is nevertheless ostensibly unencumbered access.

f. Right to Refuse Health Care

The Canadian Supreme Court has yet to rule on whether or not there is a right to refuse health care, but at least one scholar confidently concludes an analysis that “[S]ection 7 of the Charter of Rights and Freedoms guarantees a right to refuse non-consensual care . . . ” While courts have also not explicitly said that there is a right to receive health care, over the past decade they have appeared to become more open to the idea.

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141. Crean, supra note 125.
145. Though while Morgentaler decriminalized abortion and authorized state funding, the reality remains that access differs wildly across Canadian provinces. See Radhika Rao, Abortion Rights, in GLOBAL PERSPECTIVES ON CONSTITUTIONAL LAW 73, 85 (Vikram David Amar & Mark V. Tushnet eds., 2009).
147. Id.
g. Death With Dignity Laws

As of February 2015, Canada has legalized physician-assisted suicide, stemming from a court case that explicitly ruled on the right to death with dignity.\textsuperscript{148} In \textit{Carter v. Canada}, the Canadian Supreme Court held that sections of the criminal code prohibiting physician-assisted suicide were unconstitutional.\textsuperscript{149}

Section 241 (b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.\textsuperscript{150}

h. Organ Donation

Organ donation is common in Canada, though it is regulated differently in each province.\textsuperscript{151} According to the Public Health Agency of Canada,
[b]ecause most organ donors in Canada are patients who have been declared brain dead, the process and procedure for determining death of the individual based on neurological or brain-based criteria has key implications for organ donations. Work of the CCDT and CBS has contributed to developing and supporting the implementation of leading practice guidelines on the neurological determination of death.\textsuperscript{152}

In most Canadian provinces there is a Human Tissue Gift Act that governs organ donation.\textsuperscript{153} It is relatively easy for a person to consent, and certain provisions are made for how consent or lack thereof is treated in case of mental incapacity. If a person hasn’t consented, “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, for example, authorizes the patient’s next-of-kin to consent on his or her behalf for the same purposes.”\textsuperscript{154} In Canada, permissible donor tissue is classified more


\textsuperscript{150} \textit{Id.}


\textsuperscript{154} Sperling, \textit{Maternal Brain Death}, \textit{supra} note 152, at 466.
narrowly than in the U.S. In many provinces, "tissue" includes organs but does not include blood or skin or any other regenerable material. In at least three provinces, tissue is explicitly defined not to include reproductive cells including "spermatozoa, an ovum, an embryo, a foetus, blood or blood constituents."

However, after examining several means to classify maternal brain death, including organ donation regulations in the U.S., Canada, and the U.K., author Daniel Sperling concludes unequivocally that organ donation models cannot be appropriately employed in cases of maternal brain death. Organ donations are intended "to promote the welfare of an existing human being . . . . Its first and foremost aim is to save the life of the sick. In our situation, the fetus is not 'sick' nor does it enjoy any moral status similar to an existing human being."

3. Ireland

a. N.P., 26 Years Old, 15 Weeks Pregnant, December 2014 (Dublin)

In late 2014, a twenty-six year old Irish woman, N.P., was declared brain dead. She was a mother of two and fifteen weeks pregnant. Despite the wishes of her family, she was kept on somatic support until the fetus was deemed non-viable. In P.P. v. Health Service Executive, N.P.'s father sued to have her and her family's wishes honored, by removing her from somatic support. By November 29, 2014, hospital staff informed P.P. that his daughter had died. "All had agreed that the life-support machine should be turned off, because his daughter was dead and the chances of the unborn child surviving were minimal. He wanted her to have a dignified death and be put to rest." The court heard from several experts, including medical professionals who had conducted studies on maternal brain death illustrating very low survival rates of the fetuses, and health care-givers who described the distressing and demeaning conditions in which N.P.'s body was being kept. Distress caused to the mother (or in this case the mother's body) is often imputable to the fetus, as well, and no one testified that they believed the fetus would survive. N.P. had no advance directive, and the court believed that she would not have sought an abortion and would indeed have "fought long and hard to bring her unborn

155. Id. at 467 (citing Trillium Gift of Life Network Act, R.S.O., ch. H-20, § 1 (1990) (Can.) (defining "tissue")).
156. Id. at 470.
158. Id.
159. Id. ("in addition to the ongoing trauma and suffering experienced by the family and partner of N.P. through the continuance of somatic support, such continuing support will cause distress to the unborn child in circumstances where it has no genuine prospect of being born alive.").
child to term.". Nevertheless, the court was satisfied with the evidence that there was no chance the fetus could become a live baby, and concluded that an order to remove N.P. from somatic support was not inconsistent with the country's interests in preserving unborn life. "Given that the unborn in this jurisdiction enjoys and has the constitutional guarantee of a right to life, the court is satisfied that a necessary part of vindicating that right is to enquire as to the practicality and utility of continuing life support measures."161

b. Unnamed Woman, 14 weeks, May 2001

The N.P. case also resurrects discussion of a woman in 2001 who faced a similar fate, though few details of her specific case are available. A British citizen in Ireland collapsed from a brain hemorrhage at fourteen weeks pregnant. Given the strict Irish rules about preservation of a fetus, the hospital was unsure of what life-preserving measures should be taken. The woman was only removed from somatic support after the fetus was determined non-viable, two weeks after her collapse.162 Medico-legal ethicists concluded in its wake that even in cases of brain death if there was a chance of fetal viability then the hospital has an obligation to continue support. They reasoned that, "once a medical practitioner in Ireland treats a pregnant patient, he/she is in fact treating two separate entities. If one of those entities dies, the doctor's duty to the other remains. What must then be judged is whether the treatment is in the best interests of that other entity."163 However, the Attorney General refused to take a case on the matter since there was no realistic chance that the fetus would have become a live baby, and "withdrawal of ventilation, nutrition and fluids would not require legal sanction given that the likelihood of successful foetal outcome was considered to be remote."164

c. Courts on Brain Death

In 1995 one Irish case, In the Matter of a Ward of Court, examined the removal of life support for a woman in an "almost persistent vegetative state."165 The High Court concluded that they should "approach such cases from the standpoint of 'a prudent, good and loving parent in deciding what course should be adopted.'"166 On appeal, the Supreme Court agreed with the parens patriae role of the courts, and though they did not use the same "prudent parent" standard they nonetheless reached the conclusion that the
court could compel life support to be removed from the 45-year-old woman. Other cases have examined similar issues, but none have explicitly addressed brain death until the recent P.P. case.\footnote{167}

d. Constitutional Provisions

In Ireland, the state must protect "the personal rights of the citizen," and defend "the life, person, good name, and property rights of every citizen" under Article 40.3 of the Irish Constitution.\footnote{168} Article 40.3.3, discussed in further detail below, explicitly places the life of a woman and the life of her fetus on equal footing.\footnote{169} There are also interpretations of Article 40.3.1 that imply unenumerated rights to marital privacy and maternal care of a child.\footnote{170}

e. Abortion Laws

The Irish constitution places the life of a mother and the life of a fetus on equal footing, affording the same rights and protections to both entities.\footnote{171} In this devoutly Catholic country, the "pro-life" amendment was added to the Constitution in 1983 to expressly prohibit abortion in the wake of the U.S. Supreme Court's \textit{Roe v. Wade} decision. Article 40.3.3 of the Irish Constitution reads, "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right."\footnote{172} Enacted as an absolute ban on abortion, the amendment remained infallible for over two decades, until it was finally challenged in the European Court of Human Rights in August 2005. In the case \textit{A, B, C v. Ireland}, three women (A, B, and C) alleged violations of their basic rights under three Articles of the European Convention on Human Rights.\footnote{173} The Court's final ruling, issued in 2010 by a three-judge


\footnote{172. See ABC v Ireland, \textit{IRISH FAMILY PLANNING ASSOCIATION} (IFPA), http://www.ifpa.ie/Hot-Topics/Abortion/ABC-v-Ireland (last visited May 1, 2015); Mairéad Enright, \textit{A, B & C v. Ireland: The Basics, Human Rights in Ireland} (Dec. 16, 2010),
panel, held unanimously that Ireland’s law violated the Convention. The Irish government responded to the ruling with the Protection of Life During Pregnancy Act of 2013,\(^{174}\) creating exceptions to the ban in cases where “there is a real and substantial risk of loss of the woman’s life . . .” resulting from physical illness\(^ {175}\) or suicide,\(^ {176}\) or an “immediate risk” in emergency.\(^ {177}\) In any case, the decision must be approved and certified by at least two physicians. If a pregnant person cannot receive physician certification, she may appeal to a review committee comprised of physicians and psychiatrists, who will render a decision within seven days.\(^ {178}\) Unfortunately, the vagueness of the new risk threshold and the cumbersome bureaucratic appeal process mean the exception makes little difference in practice.\(^ {179}\)

f. Right to Refuse Health Care

In Ireland a competent person has the right to refuse health care, after a 1965 Supreme Court case established the right to bodily integrity.\(^ {180}\) In Ryan v. Attorney General, a woman objected to required fluoridation of public water supply because of its potential health impacts on her family.\(^ {181}\) While the court found that the plaintiff could show no actual harmful effects of fluoride, they nonetheless affirmed an interpretation of Constitutional Article 40.3 conferring an un-enumerated right to bodily integrity.\(^ {182}\) In 1996, the Supreme Court reaffirmed this idea as it relates to health care, holding that no person may be compelled to accept medical treatment, even if such refusal results in death.\(^ {183}\)

g. Death With Dignity Laws

There is no death with dignity law in Ireland – assisted suicide is illegal. There have been repeated unsuccessful attempts to introduce a bill to repeal that prohibition.\(^ {184}\) In the aforementioned case In re a Ward of

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\(^{175}\) Id. at § 7(1)(a)(i).

\(^{176}\) Id. at § 9(1)(a)(i).

\(^{177}\) Id. at § 8(1)(a).

\(^{178}\) Id. at § 10-13.


\(^{181}\) DEIRDRE MADDEN, MEDICINE, ETHICS AND THE LAW IN IRELAND 547 (2d ed. 2011) (citing Ryan v. Attorney General [1965] IR 345 (Supreme Court)).

\(^{182}\) Id.

\(^{183}\) Id. (citing In re a Ward of Court (No. 2) [1996] 2 IR 79).

\(^{184}\) See Michelle Hennessy, The three landmark cases that shaped assisted suicide law in Ireland, THEJOURNAL.IE, (Nov. 21, 2013, 7:30 AM), http://www.thejournal.ie/assisted-
Court, the majority concurring judges pointed out that the "right to life" that the court considered necessarily included a right to die a natural death.\[185\]

"[T]his does not give a right to terminate one's own life or to have death accelerated. It is confined to the natural process of dying. Loss of mental capacity does not result in the diminution of that person's Constitutional rights and in this case the ward's right to life necessarily implies a right to die a natural death. The cause of death would not be the withdrawal of food and nutrition, but the original injuries she sustained . . .\[186\]

That is, then, in Ireland a person has the right to refuse medical interventions, or be removed from artificial life support; nothing in their mental deterioration prior to death removes that right.

h. Organ Donation

Ireland is referred to as an “informed consent country” for organ donation.\[187\] There is no specific law in Ireland regarding organ donation, but they follow guidelines from the United Kingdom. The U.K. Human Tissue Act of 2004 established an agency called the Human Tissue Authority to oversee organ donation, and reaffirmed that “[c]onsent is the fundamental principle of the legislation and underpins the lawful removal, storage and use of body parts, organs and tissue. Different consent requirements apply when dealing with tissue from the deceased and the living.”\[188\] One analysis pointed out that the population of brain dead or “beating-heart” donors was decreasing significantly, and the Act’s emphasis on consent was an effort to expand the donor pool.\[189\] There was significant backlash to the Act’s provisions in the U.K., as people found the idea of an opt-in donor system distasteful and an abuse of misappropriated “right” to other people’s organs.\[190\]
Faced with this disparity and the recent rise in questions of maternal brain death, a medical ethicist recently proposed that all hospitals should have specific protocols in place to deal with such matters. Similar concerns have been raised worldwide, and will likely only increase as medical technology makes prolongation of somatic support increasingly possible. Each of the three countries surveyed above have very different constitutions, legal landscapes, and public perceptions of the issue. Indeed, it is clear that the lack of cohesive regulation or standard practice for cases of maternal brain death leads to confusion and heartache. Lawmakers should be prepared to address these matters explicitly within the evolving landscapes of reproductive rights, organ donation, and consent to medical care.


192. A more in-depth proposal for specific measures is beyond the scope of the constitutional survey undertaken in this comment, but will likely be the subject of a subsequent paper.