PREGNANCY EXCLUSIONS IN ADVANCE DIRECTIVES: A POST-*DOBBS* EQUAL PROTECTION ARGUMENT

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I. INTRODUCTION

Advance directives—legal instruments that allow individuals to document their medical decision preferences in the event of later incapacitation—are a tool for safeguarding patient autonomy.[1] Every state in the United States recognizes the validity of some form of advance directive.[2] Yet more than half of states have laws that potentially invalidate a person's

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1. *See* AM. MED. ASS'N, CODE OF MED. ETHICS: OPINION 5.2 ADVANCE DIRECTIVES (2025), https://perma.cc/3QBF-JYBB.

2. *See Advance Health Care Directives and POLST*, FAM. CAREGIVER ALL., https://perma.cc/LK4B-TXFG.

advance directive solely because a patient is pregnant.[3] These "pregnancy exclusions"[4] are embedded in state statutory schemes and can serve to automatically revoke or suspend a pregnant woman's previously documented end-of-life decisions, including decisions about whether and when life-sustaining care should cease. Such exclusions may lead medical providers to administer life-sustaining treatment against the patient's stated wishes for the sole purpose of preserving the pregnancy. Plainly stated: these exclusions may potentially compel providers to use an incapacitated pregnant patient's body as an incubator.

It is difficult to imagine a more devastating situation than that of an incapacitated patient's family who has lost a loved one and still faces decisions about whether to continue life support for the purpose of sustaining the pregnancy. In February 2025, Adriana Smith, a 30-year-old Georgia resident, sought medical attention at Northside Hospital after experiencing a series of headaches. Clinicians administered medication to Ms. Smith and she was released. The following day, Ms. Smith was found unresponsive and was subsequently declared brain dead. At the time of Ms. Smith's death, she was approximately nine weeks pregnant.[5] Medical personnel kept Ms. Smith on life support for 16 weeks to sustain her pregnancy. In June 2025, clinicians terminated Ms. Smith's life support after delivering Ms. Smith's baby via caesarean section, at approximately 25 weeks gestation.[6]

There are conflicting and unclear reports about Ms. Smith's family's wishes regarding her medical care, as well as the basis for the hospital's decision to continue life support. It was initially reported that the hospital told Ms. Smith's family that Georgia's anti-abortion laws demanded that life-sustaining care for Ms. Smith continue.[7] A later statement from the Georgia Attorney General indicated, however, that the Georgia law did not require sustaining care because "removing life support is not an action with the purpose to terminate a pregnancy."[8]

In Ms. Smith's situation, there is no publicly-available information that she had executed an advance directive.[9] Even if one had existed, however, it remains

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3. *See* Jessica Waters & Madelyn Adams, *Fetal personhood rulings could nullify a pregnant patient's wishes for end-of-life care*, THE CONVERSATION (Apr. 8, 2024), https://perma.cc/8XRC-WARS (citing Joan H. Krause, *Pregnancy Advance Directives*, 44 CARDOZO L. REV. 805, 807 (2023)).

4. *See* Shea Flanagan, *Decisions in the Dark: Why "Pregnancy Exclusion" Statutes are Unconstitutional and Unethical*, 114 NW. U. L. REV. 969, 988 (2020).

5. *See, e.g.*, Jeff Amy, Geoff Mulvihill & Sudhin Thanawala, *Hospital tells family brain-dead Georgia woman must carry fetus to birth because of abortion ban*, AP NEWS (May 16, 2025), https://perma.cc/9DQR-S4NN; Lindsey Breitwieser, *Expert says Adriana Smith's case goes beyond abortion politics,* THE INDEPENDENT (July 1, 2025), https://perma.cc/F3CZ-VB7T.

6. *See* Breitwieser, *supra* note 5.

7. *See* Amy et al., *supra* note 5; *see also* GA. CODE ANN. § 16-12-141(b) (West 2025) (establishing that "[n]o abortion is authorized or shall be performed if an unborn child has [. . .] a detectable human heartbeat," including limited provisions for exceptions).

8. Itoro N. Umontuen, *Adriana Smith's pregnancy ordeal raises ethical questions regarding Georgia's abortion bans*, THE ATLANTA VOICE (May 28, 2025), https://perma.cc/7MV2-U5NV (quoting Georgia Attorney General Chris Carr).

9. *See, e.g.*, *Legal Spotlight: Ongoing Case Raises Urgent Questions About Pregnancy and Georgia Advance Directives*, BRANDENBURG EST. PLAN. L. FIRM: BLOG (May 21, 2025), https://perma.cc/PY78-LX7R.

uncertain whether Georgia's advance directive law—which includes a pregnancy exclusion—would have honored Ms. Smith's autonomous medical decisions in the context of pregnancy.[10]

Ms. Smith's case is not an isolated one. The widely-publicized story of Marlise Muñoz in Texas is illustrative. In 2013, Ms. Muñoz suffered a pulmonary embolism and was declared brain dead at approximately 14 weeks of pregnancy.[11] Ms. Muñoz's family asserted that she had verbally expressed her desire to be withdrawn from life-sustaining treatment under circumstances similar to those she ultimately faced.[12] Despite these assertions, Ms. Muñoz lacked a formal advance directive. Texas law also contained a pregnancy exclusion that places statutory restrictions on withdrawing life support from pregnant patients, which, in any event, would have ostensibly superseded any formal directive.[13] Ms. Muñoz remained on support for nearly three months while a legal battle unfolded over the withdrawal of such treatment.[14]

In 2025, Ms. Smith's case reignited discourse surrounding end-of-life care for pregnant individuals. While there are significant questions about protecting the bodily autonomy and privacy of all pregnant patients, we focus here on the specific situation where a patient has previously executed a legally valid advance directive and a state law pregnancy exclusion could force invalidation of that directive. This paper builds on the existing scholarship[15] regarding pregnancy exclusions in two ways: (1) by situating these exclusions within the post-*Dobbs*[16] legal landscape and (2) by exploring potential equal protection challenges to pregnancy exclusions. Part II briefly explains the history and legal foundation for

10. GA. CODE ANN. § 31-32-9(a)(1) (West 2025) ("Prior to effecting a withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration from a declarant pursuant to a declarant's directions in an advance directive for health care, the attending physician: Shall determine that, to the best of that attending physician's knowledge, the declarant is not pregnant, or if she is, that the fetus is not viable and that the declarant has specifically indicated in the advance directive for health care that the declarant's directions regarding the withholding or withdrawal of life-sustaining procedures or the withholding or withdrawal of the provision of nourishment or hydration are to be carried out[.]").

11. Waters & Adams, *supra* note 3.

12. *See, e.g.,* Waters & Adams, *supra* note 3; Krause, *supra* note 3, at 853.

13. *See* TEX. HEALTH & SAFETY CODE § 166.049 (West 2025) ("A person may not withdraw or withhold life-sustaining treatment under this subchapter from a pregnant patient."); TEX. HEALTH & SAFETY CODE § 166.098 (West 2025) ("A person may not withhold cardiopulmonary resuscitation or certain other life-sustaining treatment designated by department rule under this subchapter from a person known by the responding health care professionals to be pregnant.").

14. Manny Fernandez & Erik Eckholm, *Pregnant, and Forced to Stay on Life Support*, N.Y. TIMES (Jan. 7, 2014), https://perma.cc/QEM9-VNCW.

15. *See, e.g.*, Flanagan, *supra* note 4 at 988; Krause, *supra* note 3, at 840; Nikolas Youngsmith, *The Muddled Milieu of Pregnancy Exceptions and Abortion Restrictions*, 49 COLUM. HUM. RTS. L. REV. 415, 421–49 (2018); Elizabeth A. Marcuccio & Joseph P. McCollum, *Advance Directives Containing Pregnancy Exclusions: Are They Constitutional?*, 34 N. E. J. LEGAL STUD. 21, 22–35 (2015), https://perma.cc/RR8B-Q5EY; Gianna Strand, *Pregnancy Clauses: The Ethically Unfounded Exemption to Advance Care Directives*, 7 VOICE BIOETHICS (2021), https://perma.cc/B75V-UDT8; Katherine Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. GENDER L. 86, 87–164 (1997).

16. *See generally* Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

advance directives. Drawing on the existing scholarship, Part III details current state law pregnancy exclusions. Part IV situates these laws and exclusions within the post-*Dobbs* landscape, exploring the tensions between state abortion laws and advance directive laws. In Part V we briefly explore substantive due process challenges to pregnancy exclusions. In Part V we then argue that pregnancy exclusions not only infringe upon liberty and privacy in personal medical decisionmaking but also constitute a form of sex discrimination, disproportionately impacting women.[17] By reframing the pregnancy-based nullification of advance directives as an equal protection violation, we contribute to the growing body of legal scholarship seeking to preserve constitutional protections for reproductive decision-making in a post-*Dobbs* landscape.

II. DEFINING ADVANCE DIRECTIVES AND HISTORICAL CONTEXT

Advance directives constitute a broad category of legally recognized instruments[18] through which individuals may document their medical preferences in the event they become incapacitated and are no longer able to communicate those wishes independently. As defined by the American Medical Association's (AMA) Code of Medical Ethics, advance directives are

> tools that give patients of all ages and health status the opportunity to express their values, goals for care, and treatment preferences to guide future decisions about healthcare. Advance directives also allow patients to identify whom they want to make decisions on their behalf when they cannot do so themselves. They enable physicians and surrogates to make good-faith efforts to respect the patient's goals and

17. Our use of the term "women" should not be misunderstood to exclude the experiences of people of all gender identities who can become pregnant, but rather to highlight that pregnancy regulation is grounded in reinforcement of traditional sex roles. *See* Reva B. Siegel, Serena Mayeri & Melissa Murray, *Equal Protection in Dobbs and Beyond: How States Protect Life Inside and Outside of the Abortion Context,* 43 COLUM. J. GENDER & L. 67, n. 13 (2023) ("[p]eople of all gender identities may become pregnant, seek abortions, or bear children. Yet, as our brief showed, today and in the past state actors enacting abortion restrictions are concerned with controlling the conduct of women. In justifying the restrictions, they expressly or implicitly reason from sex-role stereotypes about women. State actors can act on the basis of sex-role stereotypes of various kinds, reflecting ideas about who may, or should, or should not become pregnant."). *See id.* at 78 (applying intersectional equal protection analysis); Krause, *supra* note 3, at 809 (noting similar motivation for choice of language).

18. Advance directives take various forms, each containing different provisions for medical wishes requiring different levels of documentation and serving distinct purposes. A living will applies only when a patient is terminally ill or in a "permanently unconscious" state. *See Living will*, NAT'L CANCER INST. DICTIONARY OF CANCER TERMS (Feb. 2, 2011), https://perma.cc/MR7C-XCTC. A durable power of attorney for healthcare allows individuals to designate someone to make healthcare decisions on their behalf, ensuring that their preferences are followed. This is commonly referred to as appointing a "healthcare proxy", "agent", or "surrogate." *See Living wills and advance directives for medical decisions,* MAYO CLINIC (2022), https://perma.cc/RF6N-MGWF. Do-Not-Resuscitate (DNR) and Do-Not-Intubate (DNIs), Physician Orders for Life-Sustaining Treatment (POLST) and Medical Orders for Life-Sustaining Treatment (MOLST) are other form types designed to guide healthcare providers in making immediate medical decisions during emergencies, particularly when a patient is critically ill or nearing the end of life.

> implement the patient's preferences when the patient does not have decision-making capacity.[19]

Advance directives first emerged as a legal tool in the late 1960s when the Euthanasia Society of America (renamed the Society for the Right-To-Die in 1974) endorsed a model living will in 1967, followed closely by the introduction of the first state "right to die" proposal in the Florida legislature in 1968.[20] Subsequent court decisions and state laws further affirmed living wills as an increasingly utilized instrument for documenting patients' wishes.[21] By the close of the 1980s, forty-one states had adopted living will statutes.[22] Notably, the U.S. Supreme Court's first "right to die" decision came in 1990, holding that "the logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment" and that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[23]

Today, every U.S. state and the District of Columbia recognizes and permits the use of advance directives in some form,[24] and about one-third of all U.S. adults have an advance directive in place.[25] The American Medical Association explicitly endorses advance directives, noting that "[r]espect for autonomy and fidelity to the patient are widely acknowledged as core values in the professional ethics of medicine."[26]

As this brief history illustrates, advance directives are strongly anchored in the principle of informed consent–that is, an individual's right to receive information about, and voluntarily make decisions regarding, their own medical care. Advance directives extend this principle into future scenarios; by documenting care preferences in advance, individuals exercise their right to make medical decisions in alignment with their informed choices, even in the absence of their own ability to convey such decisions in real time.

III. ROLE OF PREGNANCY & PREGNANCY EXCLUSIONS IN ADVANCE DIRECTIVES

The process of establishing an advance directive can be procedurally complex and emotionally taxing, requiring individuals to navigate nuanced legal processes

19. AM. MED. ASS'N, *supra* note 1.

20. *See* Henry R. Glick, *The right-to-die: State policymaking and the elderly,* 5 J. AGING STUD. 283, 285 (1991).

21. *Id.*

22. Charles Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211, 211–39 (2010).

23. Cruzan v. Dir., Mo. Dept. of Health, 497 U.S. 261, 270, 278 (1990)

24. *Advance Health Care Directives and POLST*, FAM. CAREGIVER ALL., https://perma.cc/LK4B-TXFG.

25. Kuldeep N. Yadav, Nicole B. Gabler, Elizabeth Cooney, Saida Kent, Jennifer Kim, Nicole Herbst & Adjoa Mante, *Approximately One in Three U.S. Adults Completes Any Type of Advance Directive for End-of-Life Care*, 36 HEALTH AFF. 1244, 1244 (2017).

26. AM. MED. ASS'N, CODE OF MED. ETHICS: OPINION 5.2 ADVANCE DIRECTIVES (2025), https://perma.cc/3QBF-JYBB.

while contemplating hypothetical yet potentially life-threatening medical situations.[27] These decisions often involve anticipating circumstances that would pose significant medical, emotional, and ethical challenges for both the individual and their loved ones.[28] As a lifestage and temporary condition, pregnancy presents additional unique medical considerations; these considerations are particularly acute in the context of high-risk pregnancies, maternal morbidity, or fetal complications.[29] Moreover, the influence of pregnancy in decision-making in end-of-life scenarios—and the legitimacy of those decisions—remains not only under-researched but also entangled in a complex and often ambiguous legal framework.[30]

A. HISTORY OF PREGNANCY EXCLUSIONS

Despite advance directives being recognized by every state, there remains a category of people whose legally documented end-of-life wishes—even if otherwise recognized under state law—may not be executed in nearly half of US states: pregnant women.[31] These "pregnancy exclusions" are those statutes that "require physicians to void the advance directives of pregnant [patients] receiving life-sustaining treatment."[32] In practice, these exclusions may require medical providers to keep pregnant patients on life-sustaining care for the sole purpose of sustaining a pregnancy, even when the patient has explicitly denoted conflicting medical wishes.[33]

Pregnancy exclusions "were largely adopted in the 1980s, with the spread of laws authorizing patients to make advance directives about end-of-life care like living wills and health care proxies."[34] Historically, state legislators' justifications for pregnancy exclusions have echoed the following rationales: (1) "a patient who creates a directive when not pregnant might not fully contemplate how their wishes might change in the case of pregnancy," or (2) a pregnant patient's health

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27. *See Living wills and advance directives for medical decisions*, MAYO CLINIC (Mar. 25, 2025), https://perma.cc/YP4Z-5B6M.

28. *See id.*

29. *See What are some common complications of pregnancy?*, NAT'L INST. OF HEALTH (May 29, 2024), https://perma.cc/DY9G-JZAR.

30. Incisive anchoring points for this paper's discussion include Shea Flanagan's 2020 article, *Decisions in the Dark: Why "Pregnancy Exclusion" Statutes Are Unconstitutional and Unethical* and Joan Krause's 2023 article, *Pregnancy Advance Directives*. *See generally* Flanagan, *supra* note 4 (describing a new five-category typology of advance directive pregnancy exclusions), and Krause, *supra* note 3 (characterizing advance directive statutes according to several categories).

31. *See infra* Part III.B.

32. Flanagan, *supra* note 4, at 969.

33. *See, e.g.*, Flanagan, *supra* note 4, at 974; Krause, *supra* note 3, at 807.

34. Manny Fernandez & Erik Eckholm, *Pregnant, and Forced to Stay on Life Support*, N.Y. TIMES (Jan 7, 2014), https://perma.cc/33A7-F4TK. In fact, such pregnancy restrictions on advance directives "reportedly were included in state advance directive statutes as a concession to the right to life lobby and the Catholic Church, beginning with the first living will law adopted in California in 1976." Katherine Taylor, *Compelling Pregnancy at Death's Door*, 7 COLUM. J. OF GENDER & L. 86, 88 n.10 (1997) (citing HENRY R. GLICK, THE RIGHT TO DIE: POLICY INNOVATIONS AND ITS CONSEQUENCES, 96, 184 (1992)).

care decisions during pregnancy "should be guided by the goal of saving the life of the fetus if at all possible."[35]

The first legislative justification is based on the assumption that "pregnancy is a condition that might not have been contemplated at the time the patient set forth earlier wishes regarding life-sustaining care" and that pregnancy exclusions thus protect patient autonomy by "mak[ing] sure that this is really what the patient would have wanted in these circumstances, given the high stakes."[36] As explained by Elizabeth Villarreal:

> One possible justification for excluding pregnant women from using living wills, therefore, may be that the state believes women are unlikely to think about how their preferences might change during pregnancy. These statutes are protective of incapacitated pregnant women, so this argument goes, who might be devastated to find out that a doctor was required to "carry out her wishes" to end life-sustaining treatment as directed by a document drafted before she came pregnant, even though she would have preferred to continue treatment and give the fetus a chance to develop.[37]

The fetal protection rationale for pregnancy exclusions is more straightforward: extending life-sustaining care for the pregnant woman could, in theory, protect fetal health until the point of live birth. Anti-abortion groups were a lobbying force behind these exclusions, and the codification of these exclusions were "a victory for pro-life advocates, who understood requiring a doctor to give medical treatment to an incapacitated pregnant woman to protect her fetus as a logical next step in protecting human life."[38]

B. CURRENT PREGNANCY EXCLUSIONS

The rapidly changing landscape of pregnancy exclusion laws makes cataloguing these laws a challenge.[39] As of November 2025, our analysis suggests that over half of U.S. states currently include some form of pregnancy exclusion

35. *See* Krause, *supra* note 3, at 807.

36. Krause, *supra* note 3, at 834–35. We extend Krause's autonomy and liberty arguments to an equal protection analysis. *See id*.

37. Elizabeth Villarreal, *Pregnancy and Living Wills: A Behavioral Economic Analysis*, 128 YALE L. J.1052, 1053–54 (2019), https://perma.cc/G7HC-VDKF.

38. *Id*. at 1054.

39. As of May 2025, Pregnancy Justice, a non-profit reproductive justice advocacy and legal assistance organization, maintains a living resource for tracking pregnancy exclusions across the states. *See Legal Landscape*, PREGNANCY JUSTICE, https://perma.cc/B9KG-XV7T. Other scholars have previously developed frameworks for tracking pregnancy exclusions. Flanagan identified and classified advance directive pregnancy exclusions published prior to the 2022 Dobbs decision, see Flanagan, *supra* note 4, at 981. For a taxonomy of advance directive laws, see Krause *supra* note 3, at 823-24. We borrow from and build upon both frameworks in our analysis.

within statutes governing health care directives or end-of-life care.[40] In our analysis, we have categorized state laws broadly into four categories: (1) an advance directive is automatically invalid in the event of pregnancy; (2) an advance directive is invalid if it is "probable" or "possible" that the pregnancy can result in a live birth and/or the pregnancy is "viable;" (3) an advance directive is valid even in the event of pregnancy in some circumstances; and (4) the state code does not mention pregnancy. As of this writing, there are nine states in the first category[41] and sixteen in the second.[42] In contrast, eight

40. *See infra* notes 42–43.

41. These states are: Alabama (ALA. CODE § 22-8A-4) (West, Westlaw through Reg. Sess. 2025), Indiana (IND. CODE ANN. § 16-36-4-8) (West, Westlaw through the 2025 First Reg. Sess. of the 124th Gen. Assemb.), Kansas (KAN. STAT. ANN. § 65-28,103) (West, Westlaw through 2025 Reg. Sess.), Michigan (MICH. COMP. LAWS ANN. § 700.5512) (West, Westlaw through P.A.2025, No. 13, of the 2025 Reg. Sess. of the 103rd Leg.), Missouri (MO. ANN. STAT. § 459.025) (West, Westlaw through 2025 First Reg., First Extraordinary and Second Extraordinary Sess. of the 103rd Gen. Assemb.), South Carolina (S.C. CODE ANN. § 62-5-507) (West, Westlaw through 2025), Texas (TEX. HEALTH & SAFETY CODE § 166.049) (West, Westlaw through 2025 Reg. and Second Called Sess. of the 89th Leg.), Utah (UTAH CODE ANN. § 75A-3-306) (West, Westlaw through 2025 Gen. Sess.), and Wisconsin (WIS. STAT. ANN. § 154.03) (West, Westlaw through 2025). The relevant statutory language varies from state to state. For example, Kansas' law states that "[t]he declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient's pregnancy." KAN. STAT. ANN. § 65-28,103 (West, Westlaw through July 1, 2025 of 2025 Reg. Sess.). Meanwhile, Michigan law provides that "[a] patient advocate cannot make a medical treatment decision [. . .] to withhold or withdraw treatment from a pregnant patient that would result in the pregnant patient's death." MICH. COMP. LAWS ANN. § 700.5512 (West, Westlaw through P.A.2025, No. 13, of the 2025 Reg. Sess., 103rd Leg.).

42. These states are: Alaska (ALASKA STAT. ANN. § 13.52.055) (West, Westlaw through 2025 First Reg. Sess.), Arkansas (ARK. CODE ANN. § 20-17-206) (West, Westlaw through 2025 Reg. Sess. of the 95th Ark. Gen. Assemb.), Georgia (GA. CODE ANN. e § 31-32-9) (West, Westlaw through 2025 Reg. Sess, of the Ga. Gen. Assemb.), Illinois (755 ILL. COMP. STAT. ANN. 35/3) (West, Westlaw through P.A. 104-130 of the 2025 Reg. Sess.), Iowa (IOWA CODE § 144A.6) (West, Westlaw through 2025 Reg. Sess.), Kentucky (KY. REV. STAT. ANN. § 311.629) (West, Westlaw through 2025 Reg. Legis. Sess.), Louisiana (LA. REV. STAT. ANN. § 1151.9) (West, Westlaw through 2025 Reg. Sess.), (West, Westlaw through 2025 Reg. and First Special Sess.), Montana (MONT. CODE ANN. § 50-9-106) (West, Westlaw through 2025 Reg. Sess.), Nebraska (NEB. REV. STAT. ANN. § 20-408) (West, Westlaw through Reg. Sess. of the 109th Leg.), Nevada (NEV. REV. STAT. ANN. § 449A.451) (West, Westlaw through 2025 Reg. Sess.), New Hampshire (N.H. REV. STAT. ANN. § 137-J:10) (West, Westlaw through 2025 Reg. Sess.), North Dakota (N.D. CENT. CODE ANN. § 23-06.5-09) (West, Westlaw through 2025 Reg. Sess.), Ohio (OHIO REV. CODE ANN. § 2133.06) (West, Westlaw through 136th Gen. Assemb. 2025-26), Pennsylvania (20 PA. STAT. AND CONS. STAT. ANN. § 5471) (West, Westlaw through 2025 Reg. Sess.), Rhode Island (23 R.I. GEN. LAWS ANN. § 23-4.11-6(c)) (West, Westlaw through 2025 Reg. Sess. of the R.I. Leg.), and South Dakota (S.D. CODIFIED LAWS § 34-12D-10) (West, Westlaw through 2025 First Special Sess.). Statutory language varies from state to state. For example, Arkansas law provides that "The declaration of a qualified patient known to the attending physician to be pregnant 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." ARK. CODE ANN. § 20-17-206. Meanwhile, Alaska law states: "Notwithstanding any other provision of this chapter to the contrary, an advance health care directive by a patient or a decision by the person then authorized to make health care decisions for a patient may not be given effect if [. . .] it is probable that the fetus could develop to the point of live birth if the life-sustaining procedures were provided." ALASKA STAT. ANN. § 13.52.055 (West, Westlaw through ch. 25 of the 2025 First Reg. Sess. and ch. 1 of the First Special Sess. of the 34th Leg.).

states fall under the third category[43], and eighteen jurisdictions, including the District of Columbia, fall under the fourth.[44]

While there are few reported legal cases assessing pregnancy exclusions, multiple medical studies document the clinical treatment of incapacitated pregnant

43. These states are: Arizona (ARIZ. REV. STAT. § 36-3262) (West, Westlaw through 2025 First Reg. Sess. of the Ariz. 57th Leg.), Connecticut (CONN. GEN. STAT. ANN. § 19a-575) (West, Westlaw through 2025 Reg. Sess.), Florida (FLA. STAT. ANN. § 765.113) (West, Westlaw through July 1, 2025, of the 2025 First Reg. Sess.), Minnesota (MINN. STAT. ANN. § 145C.10) (West, Westlaw through 2025 Reg. and First Special Sess.); (MINN. STAT. ANN. § 145B.13(3)) (West, Westlaw through 2025 Reg. and First Special Sess.), New Jersey (N.J. STAT. ANN. § 26:2H-56) (West, Westlaw through L.2025, c. 146 and J.R. No. 10.), Oklahoma (OKLA. STAT. ANN. tit. 63, § 3101.8) (West, Westlaw through 2025 First Reg. Sess. of the Okla. 60th Leg.), Vermont (VT. STAT. ANN. tit. 18, § 9702) (West, Westlaw through 2025 Reg. Sess. of the Vt. Gen. Assemb.), and Maryland (MD. CODE, HEALTH-GEN., § 5-603) (West, Westlaw through 2025 Reg. Sess. of the Gen. Assemb.). Although Maryland's statutory code does not directly address pregnancy in the context of advance directives, the Maryland Attorney General's office provides a state-sanctioned form that includes provisions for documenting such preferences. *I Need To. . .*, ATTORNEY GENERAL OF MD., https://perma.cc/U6JC-GJRB. While this may present a somewhat ambiguous case for classification, we contend that it most appropriately aligns with Category Three. It should also be noted that Connecticut, Maryland, New Jersey and Vermont proactively affirm the right of a pregnant individual to provide end-of-life wishes, while the Arizona, Florida, Minnesota, and Oklahoma provide more ambiguous language that lends their interpretation to this category. Minnesota serves as an apt example, as the state code appears to contradict itself. Minnesota law under section 145C.10 provides, "When a patient lacks decision-making capacity and is pregnant, and in reasonable medical judgment there is a real possibility that if health care to sustain her life and the life of the fetus is provided the fetus could survive to the point of live birth, the health care provider shall presume that the patient would have wanted such health care to be provided, even if the withholding or withdrawal of such health care would be authorized were she not pregnant. This presumption is negated by health care directive provisions described in section 145C.05, subdivision 2, paragraph (a), clause (10), that are to the contrary, or, in the absence of such provisions, by clear and convincing evidence that the patient's wishes, while competent, were to the contrary." MINN. STAT. ANN. § 145C.10 (West, Westlaw through 2025 Reg. and First Special Sess.). This provision suggests that an existing health care directive by a pregnant individual directing the removal of life-sustaining support would be valid. However, section 145B.13(3) suggests otherwise, mirroring language of much of those states with viability standards for pregnancy exclusions to take precedence, providing that, "in the case of a living will of a patient that the attending physician, advanced practice registered nurse, or physician assistant 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." MINN. STAT. ANN. § 145B.13(3) (West, Westlaw through 2025 Reg. and First Special Sess.). Such discrepancies between statutes within a singular state code calls into question how any given medical provider or legal counsel may proceed under such weighted circumstances.

44. These jurisdictions include: California, Colorado, Delaware, District of Columbia, Hawaii, Idaho, Maine, Massachusetts, Mississippi, New Mexico, New York, North Carolina, Oregon, Tennessee, Virginia, Washington, West Virginia, and Wyoming. *See* Jessica Waters & Madelyn Adams, *Pregnancy Exclusions in Advance Directives: A Post-Dobbs Equal Protection Argument*, AM. UNIV. SCH. OF PUB. AFF. (Oct. 24, 2025), https://perma.cc/9RYP-NAKQ. Notably, Washington state signed House Bill No. 1215 into law as this article was being written and it has taken effect as of July 2025, amending Section 70.122.030 of the state code to remove references to pregnancy. WASH. REV. CODE. ANN. § 70.122.030 (West, Westlaw through 2025 Reg. Sess. of the Wash. Leg.). State lawmakers made clear their motivation in this law to "uphold the fundamental right of adults to determine the end-of-life care they wish to receive," and that "pregnancy should not be a condition that invalidates that right," as stated by Representative Jamila Taylor. *See Governor Signs Taylor Bill Bringing Parity to End-of-life Care for All Washingtonians*, WASH. STATE HOUSE DEMOCRATS (Apr. 16, 2025), https://perma.cc/3XD6-9UXU. However, the absence of an affirmative right in the law's text places Washington in Category Four.

women.[45] It is likely that legal conflicts are underreported, in part under the assumption that families facing such situations are often enduring immense emotional and medical trauma and may have little capacity or willingness to initiate public scrutiny or legal action. After *Dobbs,* such cases are likely to become more common as questions around reproductive autonomy and fetal personhood gain legal and political traction, and, as discussed below, medical providers attempt to reconcile advance directive statutes with state fetal personhood and/or abortion laws.[46] Adriana Smith's case provides a clear example of these emerging conflicts.[47]

We are also seeing a new crop of challenges to state pregnancy exclusion provisions. In May 2025, a group of three Kansas women and two Kansas physicians initiated a legal challenge to a state pregnancy exclusion statute, arguing that Kansas's pregnancy exclusion runs afoul of fundamental rights guaranteed by the Kansas state constitution.[48] A similar challenge to Michigan's pregnancy exclusion was filed in October 2025.[49]

IV. POST-DOBBS REALITIES

A. DOBBS V. JACKSON

The import of the 2022 *Dobbs* decision for abortion access is clear: post-*Dobbs*, states have broad license to regulate, restrict, or ban abortion for any "legitimate" reason, including for the protection of fetal life at any point of pregnancy.[50] States have, unsurprisingly, exercised that license, resulting in a patchwork of state laws. Twelve states now completely ban abortion care, four states ban abortion at six weeks, and additional states place heavy regulations on access to abortion care generally.[51] Some states have also chosen, most often through ballot initiatives put before their voters, to protect access to abortion care.[52]

In a post-*Dobbs* world, medical providers and patients must navigate this patchwork of state abortion laws (old and new) in ways that have a profound

45. *See infra* Part IV.

46. *See id.*

47. *See supra* Introduction.

48. Petition at 2,Vernon v. Kobach, DG-2025-CV-000252 (Dist. Ct. of Douglas Cnty. Kan. May 29, 2025), https://perma.cc/URU9-7WW9. *See, e.g.*, *Groups File Lawsuit Challenging Constitutionality of Pregnancy Exclusion in Kansas's Living Will Law*, IF/WHEN/HOW (May 29, 2025) https://perma.cc/M9SE-5224.

49. *Michigan's Pregnancy Exclusion denies fundamental rights to pregnant people*, IF/WHEN/HOW (Oct. 23, 2025), https://perma.cc/QQ2W-VBNW.

50. *See generally* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 300-01 (2022); Michael J. DeBoer, *State Constitutions and State Abortion Laws After Dobbs*, 64 SANTA CLARA L. REV. 217, 220 (2024).

51. *See, e.g.*, *US Abortion Policies and Access After Roe,* GUTTMACHER INST. (Sept. 5, 2025), https://perma.cc/5NZC-M5HR (delineating examples of states' abortion care restrictions, such as waiting periods, funding restrictions, informed consent and ultrasound requirements, telehealth restrictions, and parental involvement laws).

52. *See id*; Elissa Nadworny & Ryland Barton, *Most states that considered abortion rights amendments approved them*, NPR (Nov. 06, 2024), https://perma.cc/5FEZ-SUSS.

impact on medical practice. A January 2024 study of fifty-four OB-GYNS across thirteen states found that following the *Dobbs* decision, OB-GYNs delayed providing clinical care to pregnant patients—even in emergency situations—for fear of liability under newly-ambiguous state laws. Most of the OB-GYNs surveyed (forty-seven [87%]) "reported worries about practicing in an uncertain legal climate. Fears centered on potential for criminal prosecution, loss of medical license, loss of income, or incarceration."[53]

Importantly, this legal uncertainty also impacts OB-GYNs outside of the abortion context, given the "increased documentation burdens, ethical challenges, and heightened stress when treating cases in legal gray areas."[54] End-of-life care for pregnant people will likely be one of these "legal gray areas" for multiple reasons: (1) pregnancy exclusion statutes vary tremendously in format and content across states, (2) many state-based pregnancy exclusions have ill-defined terms that result in interpretation and compliance challenges, and (3) state-based pregnancy exclusions may not be easily reconcilable with other state laws, such as abortion regulations.

1. Labyrinth of State Advance Directive Laws

First, the process of tracking and deciphering state advance directive and pregnancy exclusion laws is a complex exercise for even the most seasoned lawyers. It requires a careful analysis of state statutes related to healthcare directives, living wills, and end-of-life care, each of which may contain conflicting or incomplete references to pregnancy. It is a basic point but an important one: even U.S. adults who have an advance directive are likely not steeped in the legal complexities of their state laws, and very few are aware that their state laws contain pregnancy exclusions.

For example, ARK. CODE ANN. § 20-6-103 (West 2025) provides conditions under which advance directives are legally valid.[55] However, this portion of the state code does not reference how pregnancy may impact the legitimacy of a directive. This latter information can instead only be found in the portion of Arkansas code detailing the rights of terminally ill or permanently unconscious patients, and states that "the declaration of a qualified patient known to the attending physician to be pregnant 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."[56] This nuance is easily overlooked, and

53. Erika L. Sabbath, Samantha M. McKetchnie, Kavita S. Arora & Mara Buchbinder, *US Obstetrician–Gynecologists' Perceived Impacts of Post–Dobbs v Jackson State Abortion Bans,*7 JAMA NETWORK OPEN 1, 5 (2024), https://perma.cc/K46Q-BR7L.

54. *Id.*; *see Dobbs*, 597 U.S. at 385-86 (Breyer, Sotomayor, Kagan, JJ., dissenting) (explaining that the majority's decision may be used to restrict other privacy-based rights).

55. ARK. CODE ANN. § 20-6-103 (West 2025, Westlaw through 2025 Reg. Sess. of the 95th Ark. Gen. Assemb.).

56. ARK. CODE ANN. § 20-17-206 (West 2025, Westlaw through 2025 Reg. Sess. of the 95th Ark. Gen. Assemb.).

those unfamiliar with the structure of their state laws risk missing critically important provisions if they fail to navigate to the appropriate section.

2. Ambiguous Viability Standards

Second, state advance directives laws suffer from many of the same infirmities as current abortion restrictions: ill-defined terms that are not grounded in medicine or science.[57] As discussed above, some state statutes bar execution of a pregnant person's advance directive at any point in pregnancy; others condition execution of a pregnant patient's end of life wishes on a doctor's determination of whether a fetus is "viable" or, even more ambiguously, whether it is "likely" or "probable" that the fetus will progress to a live birth.[58]

As in the abortion context, the term "viability" lacks a universally-accepted medical or legal definition; furthermore, in practice, determining fetal viability will vary based on the circumstances of each patient.[59] The definition provided by the American College of Obstetricians and Gynecologists illustrates how "viability" is impossible to statutorily define.[60] Rather, the question of viability

> depends on many complex factors, of which gestational age is only one. While gestational age may be helpful in predicting the possible chance that the fetus would survive at time of delivery, many other factors also influence viability, such as sex, genetics, weight, circumstances around delivery, and availability of a neonatal intensivist health care professional. Even with all available factors considered, it still isn't possible to definitively predict survival. While some fetuses delivered during the periviable period can survive, they may also experience significant morbidity and impairment.[61]

The *Dobbs* court itself questioned the concept of viability, making plain that fetal "viability" varies based a number of factors:

> viability is not really a hard-and-fast line. A physician determining a particular fetus's odds of surviving outside the womb must consider "a number of variables," including "gestational age," "fetal weight," a woman's "general health and nutrition," the "quality of the available medical facilities," and other factors. It is thus "only with difficulty" that a physician can estimate the "probability" of a particular fetus's survival. And even if each fetus's probability of survival could be

57. *See, e.g.*, Tanya Albert Henry, *Ambiguous anti-abortion laws are putting patients at risk,* AM. MED. ASS'N (Sept. 16, 2022), https://perma.cc/Q432-DJLU. (compiling examples of medical providers changing care based on ambiguities in state law).

58. *See supra* Part III.B.

59. *See, e.g.*, *Facts Are Important: Understanding and Navigating Fetal Viability*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (2025), https://perma.cc/LT8K-HYHM.

60. *See id.*

61. *Id.*

> ascertained with certainty, settling on a "probabilit[y] of survival" that should count as "viability" is another matter. Is a fetus viable with a 10 percent chance of survival? 25 percent? 50 percent? Can such a judgment be made by a State? And can a State specify a gestational age limit that applies in all cases? Or must these difficult questions be left entirely to the individual "attending physician on the particular facts of the case before him"?[62]

The unworkability of the "viability" standard in the abortion context applies with equal force in the advance directive context. Indeed, the ambiguities are only more acute given the additional medical uncertainties discussed below about whether an incapacitated body at any point of pregnancy—let alone early pregnancy—can actually sustain a fetus to the point of live birth.

Even more unworkable are terms that appear in some pregnancy exclusion statutes—such as a "likely" or a "probable" or a "possible" live birth. For example, Illinois's advance directive guidance states: "[t]he declaration of a qualified patient diagnosed as pregnant by the attending physician shall be given no force and effect as long as in the opinion of the attending physician it is possible that the fetus could develop to the point of live birth with the continued application of death delaying procedures."[63] The Nebraska code includes similar language but opts to prohibit the removal of life-sustaining treatment if it is "probable" that the fetus could develop to a live birth.[64] In contrast, New Hampshire prohibits the removal of life-sustaining treatment for a pregnant individual unless "such treatment or procedures will not maintain the principal in such a way as to permit the continuing development and live birth of the fetus or will be physically harmful to the principal or prolong severe pain which cannot be alleviated by medication."[65]

While advance directives are designed to mitigate some of the trauma of end of life decisions by providing certainty about the patient's desired course of treatment ambiguous pregnancy exclusions undermine this aim by inserting complexity and confusion. In states with pregnancy exclusions, it is easy to imagine how a complex patchwork of state laws might fuel clinicians' fear of liability and generate legal and medical uncertainty—making it more difficult for clinicians to treat patients and counsel grieving families.

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62. Dobbs v. Jackson Women's Health Org. 597 U.S. 215, 277 (2022) (citations omitted) (citing Colautti v. Franklin, 439 U. S. 379 (1979)). The Court also noted that "viability" distinctions may vary state to state based on available medical care in the region, questioning "if viability is meant to mark a line having universal moral significance, can it be that a fetus that is viable in a big city in the United States has a privileged moral status not enjoyed by an identical fetus in a remote area of a poor country?" *Id*.

63. 755 ILL. COMP. STAT. 35/3 (West 2025, Westlaw through P.A. 104-433 of the 2025 Reg. Sess.).

64. NEB. REV. STAT. Code § 20-408 (West 2025, Westlaw through 1st Reg. Sess. of the 109th. Leg.).

65. N.H. REV. STAT. ANN. § 137-J:10 (West 2025, Westlaw through Ch. 304 of the 2025 Reg. Sess.).

3. Abortion Statutes

Finally, there is another emerging layer of complexity: medical professionals (and their lawyers) may face questions about whether states' abortion regulations and/or fetal personhood measures must be squared with regulations governing advance directives during pregnancy. As states' abortion laws have changed in the wake of *Dobbs*, we can imagine several scenarios: a state may ban abortion (completely or after a certain point in pregnancy), but not explicitly restrict (or may even protect) end of life decisions for a pregnant person; a state may protect access to abortion care but have codified advance directive pregnancy exclusions; or a state abortion law may restrict access to abortion care at a point in pregnancy (e.g., six weeks) that differs from, for example, the viability standards found in some pregnancy exclusions.

This complexity has already heartbreakingly played out in Adriana Smith's case. While her family was initially told that the Georgia abortion ban required the hospital to continue life support in order to preserve fetal life,[66] Georgia Attorney General Chris Carr subsequently issued a statement that the abortion statute did *not* apply to Ms. Smith's case, stating: "[t]here is nothing in the LIFE Act that requires medical professionals to keep a woman on life support after brain death . . . Removing life support is not an action 'with the purpose to terminate a pregnancy.'"[67] Democratic lawmakers insisted that this statement was not sufficient to shield hospitals from liability and that additional legally binding clarity regarding whether a hospital was "legally required to maintain a brain dead pregnant woman on life support and [how Georgia's abortion ban] affects legal standing of advanced directives and end-of-life planning for pregnant Georgians"[68] was needed.[69]

These ambiguities and potential perceived conflicts are not unique to Georgia. In another example, Arkansas bans abortion at any point in pregnancy.[70] In contrast, Arkansas advance directive laws are tied to a "possible live birth" standard: Arkansas recognizes that physicians "shall" act in accordance with a qualified patient's health care directives but, if the patient is pregnant, the directive should not be followed "as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment."[71]

To be clear: abortion statutes should not govern end of life care statutes regardless of whether the patient is pregnant. The decision to cease end-of-life care, in

66. Ross Williams, *Critics of Georgia's abortion ban push for clarity after another case makes international news*, GEORGIA RECORDER (May 31, 2025), https://perma.cc/A7HL-BQ9X.

67. *Id.*

68. *Id.*

69. These tensions presumably would have been subject to additional dispute if Smith had an advance directive detailing wishes to be removed from life support. *See* GA. CODE ANN. § 31-32-9 (West 2025) (West, Westlaw through 2025 Reg. Sess. of the Ga. Gen. Assemb.).

70. *US Abortion Policies and Access After Roe*, *supra* note 51.

71. *See* Waters &Adams, *supra* note 3; ARK. CODE ANN. § 20-17-206 (West 2025, Westlaw through 2025 Reg. Sess. of the 95th Ark. Gen. Assemb.).

accordance with a patient's wishes, is not synonymous with abortion. Forcibly continuing life-sustaining care for a clinically dead pregnant person is radically different from restricting an alive individual's access to abortion care. One of the few federal cases to look at this issue, *Almerico v. Denney,*[72] decisively noted the difference. In striking down an Idaho pregnancy exclusion in 2021, the district court noted that the question of the constitutionality of pregnancy exclusions is distinguishable from the abortion question because

> those who seek to invalidate a pregnant woman's advance directive are not seeking an abortion of the fetus, but rather are seeking the proper administration of that woman's choice of her own end-of-life care. [. . .] [A]bortion restrictions stop women from getting the health care that they want or need, pregnancy exceptions forcibly subject women to health care that they neither desire or require.[73]

That said, we recognize two things. First, proponents of fetal personhood measures and abortion bans will likely argue that state abortion bans and/or fetal protection laws preempt end of life directives if the patient is pregnant, and that abortion bans would prohibit any attempts to remove a pregnant woman from life support. Doctors will undoubtedly face the political and legal pressures evident in Smith's case. Second, *Almerico* was a pre-*Dobbs* case. While the *Dobbs* court took pains to state that its decision was limited to the question of abortion and did not extend to other Constitutional rights, the Court was also explicit that its rationale hinged on the state's interest in protecting "potential life," writing: "[w]hat sharply distinguishes the abortion right from the rights recognized in the cases on which *Roe* and *Casey* rely is something that both decisions acknowledged: abortion destroys what those decisions call 'potential life' and what the law at issue in this case regards as the life of an 'unborn human being.'"[74] Post-*Dobbs, Almerico'*s distinction may not stand: courts may reason that abortion and ending life-sustaining care of a pregnant person are more "alike" than not if a state has asserted its interest in protecting fetal life.[75]

The complexity of understanding and implementing state pregnancy exclusions already places medical professionals making decisions about discontinuation of life-sustaining care in a medically and legally precarious decision-making matrix.[76] If doctors are faced with trying to also decipher and reconcile state

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72. *See* Almerico v. Denney, 532 F.Supp. 3d 993, 1003 (D. Idaho 2021).

73. *Id*. (internal quotations omitted) (quoting Shea Flanagan, Note, *Decisions in the Dark: Why "Pregnancy Exclusion" Statutes are Unconstitutional and Unethical*, 114 NW. U. L. REV. 969, 988 (2020); Nikolas Youngsmith, *The Muddled Milieu of Pregnancy Exceptions and Abortion Restrictions*, 49 COLUM. HUM. RTS. L. REV. 415, 419 (2018)).

74. Dobbs v. Jackson Women's Health Org. 597 U.S. 215, 218 (2022).

75. Shea Flanagan, *Decisions in the Dark: Why"Pregnancy Exclusion" Statutes Are Unconstitutional and Unethical*, 114 NW. U. L. REV. 969, 988–89 (2020).

76. *Pregnancy Exclusion Laws Deny Pregnant People End-of-Life Decision-Making,* IF/WHEN/HOW (2025), https://perma.cc/YT23-GNYX.

abortion statutes with advance directive pregnancy exclusion statutes, provider uncertainty and fear of legal exposure may lead to concomitant delays in patient care.

V. CHALLENGES TO PREGNANCY EXCLUSIONS

The traumatic realities of deciphering and implementing pregnancy exclusions for patients, families, and doctors demand reform and repeal of pregnancy exclusions. To date, most of the scholarly arguments questioning the constitutionality of pregnancy exclusions have relied on privacy and medical autonomy arguments grounded in substantive due process protections.[77] The most significant reported decision striking down a pregnancy exclusion, *Almerico v. Denney,*[78] relied on a 14th Amendment substantive due process "liberty" analysis and rested heavily on medical autonomy substantive due process cases.[79] In *Almerico*, the court found that invalidating a pregnant woman's advance directive amounted to constitutionally impermissible "forced" life support as it would "violate[] the constitutional right of a competent person to refuse unwanted lifesaving medical treatment."[80]

We agree strongly with the prior scholarship and judicial opinions finding that fundamental liberty and medical autonomy rights should doom pregnancy exclusions. Simply put, as the *Almerico* court stated, "Women do not lose [medical decision-making] rights because they are pregnant when they fall into a coma."[81] We also posit that the *Dobbs* abortion-specific decision should not extend to protecting pregnancy exclusions—because, as the *Almerico* decision made clear, abortion care and halting end of life care for a pregnant patient are not the same thing.[82] Coupled with the Supreme Court's explicit holding in *Dobbs* that "[n]othing in [this] opinion should be understood to cast doubt on precedents that do not concern abortion,"[83] *Almerico*'s solid substantive due process analysis should stand with regard to pregnancy exclusions.

That said, one cannot ignore the reality that *any* substantive due process analysis protecting medical decision making—particularly during pregnancy—is

77. *See, e.g.*, *id.*; Joan H. Krause, *Pregnancy Advance Directives*, 44 CARDOZO L. REV. 805, 843 (2023); Nikolas Youngsmith, *The Muddled Milieu of Pregnancy Exceptions and Abortion Restrictions*, 49 COLUM. HUM. RTS. L. REV. 415, 434 (2018).

78. *See* Almerico v Denney, 532 F. Supp. 3d 993 (D. Idaho 2021). *Almerico* was a federal lawsuit on behalf of four women filed in 2018 challenging Idaho's pregnancy exclusion law that voided the living wills of pregnant people. The court noted how the exclusion would operate, explaining that "[u]nder the pregnancy exclusion, a pregnant woman about to die, whose advance directive dictated the withdrawal of all life support, would nevertheless have life support forced upon her until her baby could be delivered." *Id.* at 1002.

79. The court in *Almerico* reasoned that "the Supreme Court decided that a competent person has a constitutionally protected liberty interest in making their own health care decisions,including refusing unwanted lifesaving medical treatment." 532 F. Supp. 3d at 1002 (citing *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990)).

80. *Id.*

81. *Id.*

82. *See supra* Part IV (distinguishing abortion from the halting of end of life care).

83. Dobbs v. Jackson Women's Health Org., 597 U.S. 215, 290 (2022).

potentially endangered by the *Dobbs* decision. There, the Court explicitly rejected any 14th Amendment substantive due process protections for abortion access on the basis that abortion is not a right "deeply rooted in this Nation's history and tradition' and 'implicit in the concept of ordered liberty.'"[84] As the dissent warns, however, it is "impossible to understand (as a matter of logic and principle) how the majority can say that its opinion today does not threaten [. . .] any number of other constitutional rights" that were similarly grounded in concepts of substantive due process, privacy, and liberty.[85] Specifically, the Court's other substantive due process decisions regarding same-sex intimacy and marriage, interracial marriage, contraceptive use, and forced sterilization are, the *Dobbs* dissent noted, equally in jeopardy if *Ro*e and *Casey* could be so easily overturned.[86] Indeed, Justice Thomas made plain in his concurrence that he would in fact reexamine each of these prior substantive due process cases based on the *Dobbs* holding.[87]

The dangers for the promise of the pre-*Dobbs Almerico* holding are thus twofold: First, there are serious questions about the threat to all of the Court's substantive due process cases. Second, as discussed above, some courts may well extend *Dobbs*' denial of substantive due process protections to any issue related to questions of "potential life."[88]

Given these threats, it is necessary to explore additional ways to buttress the liberty-based arguments against pregnancy exclusions.[89] One avenue, drawing from the work of Reva Siegel, Serena Mayeri, and Melissa Murray, is an equal protection argument.[90]

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84. *Dobbs*, 597 U.S. at 231.

85. 597 U.S. at 385 (Breyer, J., dissenting). Justice Breyer expressed skepticism about the majority's assertion that it would not disturb its other substantive due process precedents: "[n]or does it even help just to take the majority at its word. Assume the majority is sincere in saying, for whatever reason, that it will go so far and no further. Scout's honor. Still, the future significance of today's opinion will be decided in the future. And law often has a way of evolving without regard to original intentions—a way of actually following where logic leads, rather than tolerating hard-to-explain lines. Rights can expand in that way." *Id*.

86. *See id*. at 385 (citations omitted) (discussing the Supreme Court's substantive due process precedents).

87. *See id*. at 332 (Thomas, J., concurring) ("[I]n future cases, we should reconsider all of this Court's substantive due process precedents, including *Griswold, Lawrence,* and *Obergefell*.").

88. *See id*. at 257 (citations omitted) (explaining that what "distinguishes the abortion right from the rights recognized in the cases on which *Roe* and *Casey* rely is [. . .] that [a]bortion destroys what those decisions call 'potential life' and what the law at issue in this case regards as the life of an 'unborn human being.').

89. Priscilla Smith, *Give Justice Ginsburg What She Wants: Using Sex Equality Arguments to Demand Examination of the Legitimacy of State Interests in Abortion Regulation*, 34 HARVARD J. L. & GENDER 377, 377–412 (2011) (arguing, pre-*Dobbs*, that substantive due process claims need to be bolstered by equality arguments).

90. Reva B. Siegel, Serena Mayeri & Melissa Murray, *Equal Protection in Dobbs and Beyond: How States Protect Life Inside and Outside of the Abortion Context*. 43 COLUM. J. GENDER & L. 67, 67–97 (2023), https://perma.cc/CHM6-ZJF8 [hereinafter *How States Protect Life*]. After *Dobbs*, states are extending arguments about their interest in protection of fetal life *outside* of the abortion context; for example, an Alabama court found that an embryo in a petri dish was a child under the state's wrongful

A. LIMITING THE DOBBS EQUAL PROTECTION DICTA

The *Dobbs* decision reveals that at least some justices on the Supreme Court are not receptive to arguments that abortion regulations should be subject to heightened scrutiny under a 14th Amendment Equal Protection analysis—and that reluctance may extend to other forms of pregnancy-related regulations. In a terse *Dobbs* paragraph, Justice Alito rejected the argument that abortion restrictions discriminate against women, stating:

> A State's regulation of abortion is not a sex-based classification and is thus not subject to the 'heightened scrutiny' that applies to such classifications. The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere pretex[t] designed to effect an invidious discrimination against members of one sex or the other.' And as the Court has stated, the 'goal of preventing abortion' does not constitute 'invidiously discriminatory animus' against women. Accordingly, laws regulating or prohibiting abortion are not subject to heightened scrutiny.[91]

Justice Alito relied on an expansive reading of *Geduldig v. Aiello*. *Geduldig* held that California's disability insurance program, which excluded coverage for pregnancy-related disabilities, did not violate the Equal Protection Clause.[92] The *Geduldig* Court reasoned that the program distinguished between pregnant and non-pregnant persons, not between men and women; consequently, the program's distinction did not constitute sex-based discrimination.[93] Justice Alito opined that abortion restrictions are likewise not sex-based restrictions.[94]

Importantly, however, we posit that Justice Alito's rejection of equal protection arguments regarding abortion restrictions is limited and can be distinguished from constitutional questions regarding pregnancy exclusions. First, it can fairly be read as dicta.[95] The equal protection issue raised by Alito was not squarely briefed or argued[96] by the parties before the Court, but rather raised by amici.[97]

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death statute. *See* LePage v. Ctr. for Reprod. Med., 408 So.3d 678 (Ala. 2023); Kim Chandler & Geoff Mulvihill, *What's next after the Alabama ruling that counts IVF embryos as children?*, AP NEWS (Feb. 22, 2024), https://perma.cc/YNN2-KLQ2. In the year after *Dobbs*, there were at least 210 pregnancy-related prosecutions, "the highest number of pregnancy-related prosecutions documented in a single year." *See* Wendy A. Bach & Madalyn K. Wasilczuk, *Pregnancy as a Crime: A Preliminary Report on the First Year After Dobbs*, PREGNANCY JUST. (Sep. 2024), https://perma.cc/4NBS-QUFF.

91. *Dobbs*, 597 U.S. at 236–37 (citing Geduldig v. Aiello, 417 U. S. 484, 496, n. 20 (1974)).

92. *Geduldig*, 417 U.S. at 485.

93. *Id.*

94. *Dobbs*, 597 U.S. at 236–37.

95. *See, e.g.*, *How States Protect Life*, *supra* note 90, at 68.

96. *See generally* Transcript of Oral Argument, Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022) (No. 19-1392).

97. *See Dobbs*, 597 U.S. at 236–37 (citing Brief for United States as Amicus Curiae Supporting Respondents, *Dobbs*, 597 U.S. 215 (2022) (No. 19-1392), https://perma.cc/HRK7-GM75); *see also*

Second, as discussed *infra*, Justice Alito's terse dismissal of an equal protection argument did not actually engage with amici's arguments and ignored subsequent controlling equal protection cases.[98] And finally, as discussed *supra,* the *Dobbs* court took pains to stress that the decision was one limited to abortion regulation. Indeed, Alito (and *Geduldig*) focus on the question of a medical procedure "only one sex can undergo." With pregnancy exclusions, either sex can undergo the medical procedure of removing life sustaining care, but it is only denied to women. The *Dobbs* dicta should not bind future courts that may consider equal protection based challenges to advance directive pregnancy exclusions.

Accordingly, building on Reva B. Siegel, Serena Mayeri, and Melissa Murray's *Dobbs* amicus brief [hereinafter Siegel, Mayeri, and Murray brief] and their subsequent seminal article *Equal Protection in Dobbs and Beyond: How States Protect Life Inside and Outside of the Abortion Context*, [hereinafter "*How States Protect Life*"] we argue that an equal protection rationale remains a viable path to challenge restrictions based on sex roles, and that it could be used to challenge pregnancy exclusions.

B. THE EQUAL PROTECTION CASE

In sharp contrast to Justice Alito's reliance on *Geduldig*, the Siegel, Mayeri, and Murray brief argued that *Geduldig* has been supplanted by the later (and controlling) sex-based discrimination Equal Protection cases: *Nevada Department of Human Resources v. Hibbs* and *U.S. v. Virginia*.[99] In contrast to the "reasoning from the body seen in earlier cases such as *Geduldig*,"[100] they argue that "*Virginia* and *Hibbs* establish that laws regulating pregnancy are sex-based classifications that violate the Equal Protection Clause when they are rooted in sex-role stereotypes that injure or subordinate."[101] This focus on sex-role stereotypes, rather than mere biology, provides a "historically informed anti-subordination standard to determine whether laws that classify on the basis of sex—including laws regulating pregnancy—violate equal protection" and "examines how a law regulating pregnancy structures social relationships in order to determine whether state action classifying on the basis of pregnancy contravenes equal protection."[102]

Brief for Equal Protection Constitutional Law Scholars Serena Mayeri, Melissa Murray, and Reva Siegel as Amici Curiae in Support of Respondents, *Dobbs*, 597 U.S. 215 (2022) (No. 19-1392) [hereinafter "Siegel, Mayeri, & Murray Brief"], https://perma.cc/V2S9-MNAE.

98. *How States Protect Life*, *supra* note 90, at 68–69.

99. Siegel, Mayeri, & Murray Brief, *supra* note 97, at 10–11.

100. *How States Protect Life*, *supra* note 90, at 77.

101. Siegel, Mayeri, & Murray Brief, *supra* note 97, at 10–11.

102. *How States Protect Life*, *supra* note 90, at 77; *see also* Siegel, Mayeri, and Murray Brief, *supra* note 97, at 7 n.7. ("Even before *Casey*, prominent legal scholars recognized that the abortion right is also protected by the Constitution's equality guarantees. *See Casey*, 505 U.S. at 928 & n.4 (Blackmun, J., concurring in part) (observing that the "assumption—that women can simply be forced to accept the 'natural' status and incidents of motherhood—appears to rest upon a conception of women's role that has triggered the protection of the Equal Protection Clause" and citing scholarship); *see also* Serena Mayeri, *Undue-ing Roe: Constitutional Conflict and Political Polarization in Planned Parenthood v. Casey*, in REPRODUCTIVE RTS. & JUSTICE STORIES 150–52 (Melissa Murray, Katherine Shaw & Reva

The Court's reliance in *Dobbs* on *Geduldig* ignores this evolution of the law, and ignores *Virginia*'s central tenet that a court's analysis of sex-related distinctions must go beyond justifications of physical or biological difference and instead focus on whether such restrictions are in fact sex-based "not simply because they single out women, but because they single out women in order to impose traditional sex roles on them."[103] Siegel, Murray, and Mayeri explain that *Virginia* makes clear that "such classifications may not be used, as they once were, to create or perpetuate the legal, social, and economic inferiority of women."[104] This "anti-subordination standard" insists that laws regulating pregnancy are subject to heightened scrutiny when they are rooted in sex-role stereotypes that injure or subordinate—that is, when they are in fact pretext for invidious discrimination. With the *Virginia* heightened scrutiny lens, we can recognize that pregnancy exclusions amount to "forced motherhood" grounded in constitutionally infirm ideas about women's "essential" nature[105] and that pregnancy regulations operate to subordinate women.[106]

C. BEYOND ABORTION: PREGNANCY EXCLUSIONS

As a threshold matter, pregnancy exclusions are sex-based distinctions: they ban medical procedures—such as discontinuation of life support—for women and not men. In simple terms: no matter which state he resided in, a male brain dead patient's valid advance directive to remove life support—even if he had a pregnant partner—would likely be honored. In contrast, a female brain dead

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B. Siegel, eds. 2019) (describing role of sex equality principles in academic and judicial discourse leading up to *Casey*).").

103. *How States Protect Life*, *supra* note 90, at 80.

104. United States v. Virginia, 518 U.S. 515, 516, 534 (1996) (internal citations omitted).

105. *How States Protect Life, supra* note 90, at 77, 80.

106. Siegel, Mayeri, and Murray Brief, *supra* note 97, at 11 ("Because Mississippi has chosen 'discriminatory means' to protect health and life, the State must satisfy heightened scrutiny by offering an 'exceedingly persuasive' justification for its choice of means that does not rely on 'overbroad generalizations' about the differences between sexes.") (quoting *Virginia,* 518 U.S. at 533). Priscilla Smith presciently made similar equality arguments in her pre-*Dobbs* article, *Give Justice Ginsburg What She Wants: Using Sex Equality Arguments to Demand Examination of the Legitimacy of State Interests in Abortion Regulation*. Priscilla Smith, *Give Justice Ginsburg What She Wants: Using Sex Equality Arguments to Demand Examination of the Legitimacy of State Interests in Abortion Regulation*, 34 HARVARD J. OF L. & GENDER 377, 377–412 (2011). Smith too argued that litigators needed to bolster liberty arguments with equal protection arguments, noting that an equality analysis allows for a true examination of the motives behind state's often articulated reasons for abortion restrictions: protecting fetal or maternal health/life. *See id.* at 382 n.20. An equality analysis would allow an examination of whether such justifications are "in fact based on stereotypes of women's proper place in society, such as a woman's duty—hers alone—to save the life of the fetus at her own physical expense." *Id.* at 407. If we "evaluat[e] abortion restrictions as a form of 'caste-enforcing' regulation," this allows us to distinguish between "regulation of reproduction that reinforces women's subordination and regulation of reproduction that supports equality for women." *Id.* at 408. Finally, Smith noted, "sex equality arguments shift the focus away from the physical aspects of reproduction, which are currently set in stone—the burden we women must bear, however nobly. The focus turns instead to the social conditions in which we are pregnant, and in which we bear and raise children." *Id.*

patient's advance directive to remove life support may not be honored in half of U.S. states on the simple basis of pregnancy.

While not all sex-based distinctions are fatal, under *Virginia*'s heightened scrutiny standards the state must demonstrate an "exceedingly persuasive" justification for the gender-based distinction, and must demonstrate "at least that the challenged classification serves 'important governmental objectives and that the discriminatory means employed' are 'substantially related to the achievement of those objectives.'"[107] The state's justification must be interrogated: it must be "genuine, not hypothesized or invented post hoc in response to litigation [, a]nd it must not rely on overbroad generalizations about the different talents, capacities, or preferences of males and females."[108] As Siegel, Mayeri and Murray argue, "Where matters of pregnancy are concerned, *Virginia* tells us that the law cannot enforce sex-role stereotypes that denigrate or impose constraints on individual opportunity. Those sex-role stereotypes include the belief that motherhood is a woman's 'paramount destiny.'"[109]

Applying their analysis of abortion restrictions to pregnancy exclusions, we examine the proffered justifications used for sex-based pregnancy exclusions: protection of informed patient decision-making and protection of fetal health. Under the searching scrutiny that a heightened equal protection analysis demands, it is clear that a state defending a pregnancy exclusion could not meet its burden of showing that the sex-based means employed are sufficiently tailored to meet these proffered justifications and goals. This analysis likewise reveals that pregnancy exclusions impermissibly serve to reinforce stereotypes about the "proper" role of women as mothers and act as a tool of subordination.

There are certainly cases where continuing life sustaining care could be both in accordance with the patient's wishes and result in a live birth; we do not contest that life-sustaining care could well be the wanted and appropriate intervention in such a case.[110] We contemplate a very different situation: when a pregnant woman is in a brain dead or persistent vegetative state, life-sustaining care would be necessary to continue to incubate the pregnancy for any possibility of a live birth, and the woman has previously executed an advance directive (either prior to or during her pregnancy) deciding to end life-sustaining care if she were incapacitated.[111] Such a case requires answers to highly individualized and patient-

107. *Virginia*, 518 U.S. at 533; s*ee also* Sessions v. Morales Santana, 582 U.S. 47, 59 (2017) ("the classification must substantially serve an important governmental interest today, for in interpreting the equal protection guarantee, we have recognized that new insights and societal understandings can reveal unjustified inequality [. . .] that once passed unnoticed and unchallenged.") (internal quotation and citation omitted).

108. *Virginia*, 518 U.S. at 533.

109. *How States Protect Life*, *supra* note 90, at 78.

110. As of this writing, "Chance," the baby delivered from Adriana Smith's body, has survived in the NICU.

111. While we focus on the cases like brain death/vegetative state, advance directive pregnancy exclusions could also be implicated in other more common situations. *See* Strand, *supra* note 15, at 2 ("But brain death and persistent vegetative states are just two reasons to look to an advance directive.

specific medical and ethical questions. A one-size-fits all state-imposed dictate that potentially requires physicians to "violate codes of conduct and subject pregnant patients and their nonviable fetuses to treatments to which other patients would not be subjected"—particularly when the woman has taken the time to indicate her wishes clearly in a legally binding document—does not allow for that consideration.[112]

1. Informed Patient Decision-Making

The argument that pregnancy exclusions serve to protect a woman's medical decision making—by nullifying her advance directive—assumes (1) that she had not considered a pregnancy and made a decision about the care she would consent to or (2) that the pregnancy would have changed her decision-making. These rationales rely on societal assumptions about women's willingness and duty to sacrifice their bodies, even in death, for a pregnancy—the very type of overbroad generalization that *Virginia* prohibits.

First, the woman may well have executed the advance directive while pregnant, or with the knowledge that she may someday be pregnant. Second, even if a woman had not contemplated pregnancy, the assumption that she would *of course* willingly and nobly turn her body into an incubator smacks of assumptions about women's "paramount destiny" as mothers. To abrogate a woman's otherwise legally binding end of life wishes—because of her role as the vessel for a pregnancy—relies on the very type of "overbroad generalizations about the different talents, capacities, or preferences of males and females" that *Virginia* demands we interrogate.[113] Villareal aptly illustrated this impermissible overbreadth:

> Pregnancy exemptions are innately coercive because they overestimate the likelihood that pregnancy will change a woman's health-care preferences towards more treatment [. . .] It is certainly plausible that a woman would choose to undergo expensive and painful treatments in the hopes of giving a fetus a chance at developing. But it is also plausible that a woman, if pregnant, would choose less medical intervention.[114]

Given that a man could have an identical advance directive, and his would be honored and indeed squarely constitutionally protected,[115] it is hard to ignore that a pregnancy exclusion is grounded in constitutionally impermissible "stereotypes

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Advance directives more commonly apply to patients with dementia, strong religious objections to medical care, or during cancer treatments, surgery, or acute injury with temporary loss of capacity. In surgery or acute lapses of capacity, a proxy may be asked to make decisions if complications arise. The number of women potentially affected by pregnancy clauses is significant").

112. Strand, *supra* note 15, at 2.

113. *Virginia*, 518 U.S. at 533.

114. Villarreal, *supra* note 37, at 1074.

115. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990) ("the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition").

of women's proper place in society, such as a woman's duty—hers alone—to save the life of the fetus at her own physical expense."[116]

Additionally, under heightened scrutiny, courts must examine the means employed to meet the government's asserted goals. Here, if the state invalidates a woman's advance directive to forgo life sustaining care, doctors may be compelled to undertake extreme medical interventions on the pregnant body. Let us be clear what those interventions are: a woman's "inert, unresponsive, unstable and legally lifeless body"[117] will be treated as an incubator and subjected to extraordinary and dehumanizing interventions. These could include, but are not limited to, "full ventilation, nutritional support and fluid administration, maintenance of normothermia, and the administration of hormone therapy, vasoactive and other drugs."[118] The effects on the pregnant body are profound. A "[brain dead] body still degenerates," and complications during life-sustaining care can include hemorrhage, hypotension, abnormal thermoregulation, panhypopituitaris, hypercoagulation issues, edema, anemia, sinus bradycardia often, lung collapse, infectious morbidity including urinary tract infections, pneumonia and drain, catheter and cannula infections.[119] Medical professionals who have provided such care to pregnant women have described these impacts: bodies "having a 'ghoulish' appearance [. . .] as the abdomen swelled with the growing fetus and the limbs became wasted," "physical decay [. . .] in which the whites of the eyes were so oedematous that the eyelids could not close properly, the entire body and limbs were grossly swollen and the head had an open wound through which pus and brain tissue were visible and exuding."[120] These are horrors that the pregnant woman's family would witness. As Adriana Smith's mother, April Newkirk, stated, "It's torture for me [. . .] I see my daughter breathing by the ventilator, but she's not there [. . .] This decision should've been left to us . . . Every day that goes by, it's more cost, more trauma, more questions."[121]

A state's prospective and sweeping assumption, without evidence and in the face of a patient's expressed contrary wishes, that a woman would consent to such interventions cannot survive any form of searching scrutiny.[122]

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116. Smith, *supra* note 89, at 407; *see also* Flanagan, *supra* note 4, at 988 ("Because most pregnancy exclusion laws void the advance directives of all pregnant women, even if they stated their wishes would not change in the case of pregnancy, it is evident that 'accurately capturing a woman's preferences cannot be legislators' only concern.").

117. Lynne Staff & Meredith Nash, *Brain Death During Pregnancy and Prolonged Corporeal Support of the Body: A Critical Discussion*, 30 WOMEN & BIRTH 354, 355 (2017).

118. *Id.* at 357. It is worth noting that the financial costs associated with such interventions are likely extraordinary.

119. *Id.* The authors note the traumatic impact these interventions can have on family members and medical staff.

120. *Id.*

121. Meghan Holohan, *Mom says she must keep her brain dead daughter on life support because she's pregnant due to Georgia law*, TODAY (May 15, 2025), https://perma.cc/8YLN-NH7B.

122. Importantly, though we focus on the question of whether life-sustaining care can be discontinued, there are significant questions about whether pregnancy exclusions nullify an entire advance directive, including proxy appointments. Thus, in addition to having her wishes about

2. Preservation of Fetal Life

Second, under an equal protection analysis, there are likewise significant questions about whether a state's justification for protecting fetal life is clinically supportable. Simply put, it is unclear whether pregnancy exclusions actually operate to meet the stated goal of preserving fetal life. Under equal protection principles, "a tenable justification must describe actual state purposes, not rationalizations for actions in fact differently grounded."[123] As discussed *supra*, some states nullify a pregnant woman's advance directive at any point in pregnancy, or at undefined and medically tenuous points in pregnancy. It is particularly in cases of early pregnancy that protection of fetal life justifications fail any heightened ends/means fit test.

Most clinical reviews of sustaining life support for pregnant women are based on case reports of pregnant women who have been declared brain dead. A 2010 study found that of "thirty reported cases where such posthumous gestation has occurred using life-support technology [. . .] twelve viable fetuses [were] successfully brought to term" [124] Importantly, this limited success occurred in more advanced pregnancies; the mean gestational age at the time of brain death was 22 weeks.[125] A 2017 study noted the complexities of providing this care, and that the interventions on the pregnant body themselves have potentially dramatic negative consequences for fetal health, particularly early in pregnancy: "Anything with the potential to impede maternal cellular health can disrupt fetal and placental metabolic requirements and jeopardise fetal and placental health. The destabilisation of the [brain dead] body in which the fetus grows often results in complications such as placental insufficiency, oligohydramnios, fetal growth restriction, [and] fetal distress."[126] That same study noted the gaps in medical knowledge about the impacts on a fetus gestating in a brain dead woman: "there does not appear to have been any discussion of the possible consequences for the fetus of developing inside an inert, unresponsive, unstable and legally lifeless body, and . . . there is a distinct lack of long term follow up and outcomes data for infants so gestated as fetuses."[127] A 2021 study made similar findings: In 35 cases of brain death in

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life-sustaining care nullified, it is possible that a woman's decision about who to trust with her medical care could also be ignored and placed in the hands of a stranger. *See* Strand, *supra* note 15, at 2 ("Though pregnancy clauses are a seemingly narrow focus, they can nullify an entire advance directive and restrict care not related to the fetus. By negating entire advance directives, the clauses negate proxy appointments, allowing decision-makers other than the intended proxy.").

123. Smith, *supra* note 89, at 410 (quoting U.S. v. Virginia, 518 U.S. 515, 535–36 (1996)).

124. Flanagan, *supra* note 4, at 973 (citing Majid Esmaeilzadeh, Christine Dictus, Elham Kayvanpour, Farbod Sedaghat-Hamedani, Michael Eichbaum, Stefan Hofer, Guido Engelmann, Hamidreza Fonouni, Mohammad Golriz, Jan Schmidt, Andreas Unterberg, Arianeb Mehrabi & Rezvan Ahmadi, *One Life Ends, Another Begins: Management of a Brain-Dead Pregnant Mother—A Systemic Review*, 8 BMC MED. 74, 79–80 (2010)).

125. Esmaeilzadeh, Dictus, Kayvanpour, Sedaghat-Hamedani, Eichbaum, Hofer, Engelmann, Fonouni, Golriz, Schmidt, Unterberg, Mehrabi & Ahmadi, *supra* note 124, at 74, 79–80.

126. Lynne Staff & Meredith Nash, *Brain death during pregnancy and prolonged corporeal support of the body: A critical discussion*, 30 WOMEN & BIRTH 354, 357–58 (2017).

127. *Id.* at 358.

pregnancy the rate of fetal survival before 19 weeks of gestation was only 54.5%.[128] Other studies have noted that it is unlikely that a pregnancy under 20 weeks can be prolonged to a live birth through life support care to the pregnant woman,[129] and still others have noted that "numerous [fetal] medical and chromosomal conditions are incompatible with life or present significant potential disabilities that may be accompanied by pain and suffering."[130]

The sweeping means employed—pregnancy exclusions, particularly those that prospectively invalidate an advance directive at any point in pregnancy—cannot withstand heightened scrutiny given the dearth of medical evidence that interventions would actually lead to a live birth.

3. State-Based Claims

Finally, we briefly note that the promise of equity-based arguments may be even stronger under state constitution analyses. A majority of states have some form of a state equal rights amendment, and many of these may require an even more searching scrutiny than demanded under current intermediate scrutiny equal protection jurisprudence.[131] Indeed, post-*Dobbs,* multiple courts have demonstrated a willingness to go farther than the *Dobbs* court in their state-based equal protection analysis, and have credited state-constitution based equal protection arguments in the abortion context.[132] A recent challenge to the Kansas Natural Death Act, which includes a pregnancy exclusion,[133] embraces this equal protection

128. Maria Gaia Dodaro, Anna Seidenari, Ignazio R. Marino, Vincenzo Berghella & Federica Bellussi, *Brain death in pregnancy: a systematic review focusing on perinatal outcomes*, AM. J. OBSTETRICS GYNECOLOGY 445, 446 (2021).

129. João P Souza, Antonio Oliveira-Neto, Fernanda Garanhani Surita, José G Cecatti, Eliana Amaral & João L Pinto e Silva, *The prolongation of somatic support in a pregnant woman with brain-death: a case report*, 3 REPROD. HEALTH 1, 2 (2006).

130. Strand, *supra* note 15, at 3.

131. *State-Level Equal Rights Amendments, BRENNAN CTR. FOR JUST.,* (Dec. 6, 2022), https://perma.cc/4XTW-Z7BJ.

132. *See, e.g.*, Allegheny Reprod. Health Ctr. v. Pennsylvania Dep't of Hum. Serv., 309 A.3d 808 891 (Pa. 2024) ("We take seriously the express recognition of the right to equality of the sexes under the law and the magnitude of this special protection against the denial or abridgment of rights under the law based on sex contained in our Equal Rights Amendment. [. . .] Thus, a challenge to a law as violative of Section 28 begins with the premise that a sex-based distinction is presumptively unconstitutional. It is the government's burden to rebut the presumption with evidence of a compelling state interest in creating the classification and that no less intrusive methods are available to support the expressed policy. The judicial inquiry will be searching, and no deference will be given to legislative policy reasons for creating sex-based classifications. Given these parameters, we acknowledge that few, if any, sex-based conferrals of benefits or burdens will be sustainable."); *see also* Final Order, Sistersong Women of Color Reproduc. Just. Collective v Georgia, Civil Action 2022CV367796, at 14 (Ga. 2024) (striking down the Georgia Living Infants Fairness and Equality Act, on the grounds that "Forcing a woman to carry to term an unwanted pregnancy—with the many concomitant physical, hormonal, and emotional changes involved—plainly constitutes 'an invasion of bodily integrity which implicates an individual's "most personal and deep-rooted expectations of privacy,"'" including discussion of equal protection principles but also engaging equal protection principles) (decision vacated).

133. KAN. STAT. ANN. § 65-28,103(a) (West, Westlaw through laws enacted during the 2025 Reg. Sess. of the Kan. Leg. effective on or before July 1, 2025).

strategy. The plaintiffs—patients who seek assurance that their advance directives will be honored regardless of pregnancy status and doctors who could be compelled by the Kansas law to ignore their pregnant patient's end of life wishes—assert that pregnancy exclusions run afoul of both privacy/autonomy and equal protection guarantees in the state Constitution.[134] The Kansas Pregnancy Exclusion, they argue,

> discriminates on the basis of gender by automatically invalidating the health care directives of pregnant people, and calling into question the enforceability of the directives of all Kansans capable of pregnancy. It further violates their rights to equal protection by subjecting them to a lesser standard of care than that afforded all other patients, in violation of their fundamental rights to medical-decision making and bodily autonomy. The Pregnancy Exclusion deprives all individuals capable of becoming pregnant of equal protection by offering them less certainty under the law that their end-of-life decisions will be honored.[135]

VI. CONCLUSION

Pregnancy exclusions operate during times of incredible trauma for families of pregnant incapacitated patients as they grapple with their own grief while making intensely difficult and personal decisions about whether to prolong care to sustain a pregnancy. Those decisions must be left to the patient's family and proxies, in consultation with the treating physician, and grounded in the woman's expressed wishes in her advance directive.

Pregnancy exclusions unconstitutionally usurp that consideration. They are, by definition, implements of forced motherhood that are imposed only on one sex. They are the embodiment of using a woman's body as—and only as—a vessel for incubating pregnancy. They nullify a woman's previously expressed medical wishes that would otherwise be legally binding and potentially subject her to monumental physical medical intrusions. They potentially "compel resistant women to continue pregnancy and to become mothers against their will,without recompense or support."[136] Examined under the heightened scrutiny that *Virginia* demands, the government objectives of protecting patient autonomy and fetal protection are revealed to rest on sex-based roles that subordinate women only as potential mothers/incubators and are steeped in assumptions and stereotypes about women's "essential" nature.[137] Pregnancy exclusions, by potentially compelling the use of a dead woman's body as an incubator, "transform what, when

134. Petition at 3–4, Vernon v. Kobach, DG-2025-CV-000252 (Dist. Ct. of Douglas Cnty. Kan. May 29, 2025), https://perma.cc/URU9-7WW9.

135. *Id.* at 6.

136. *How States Protect Life*, *supra* note 90 at 80 (speaking of abortion restrictions).

137. *Id.* at 78.

freely undertaken, is a wonder into what, when forced, may be a nightmare."[138] An equal protection analysis of pregnancy exclusions can reinforce existing privacy arguments and allow for a true examination of the purpose and effects of pregnancy exclusions.

138. *See* Dobbs v. Jackson Women's Health Org., 597 U.S. 215, at 362 (2022) (Breyer, J. dissenting) (referring to abortion restrictions).