



Philosophical Bioethics: **SECTION 8**

Autonomy and Pregnancy

LEARNING OUTCOMES at the end of this Section you will:

- have explored the ethical problem of maternal-fetal conflict, where the interest of the pregnant woman in some cases conflicts with the interests of her future children;
- have considered the difficult relationship between law and ethics in this area - should moral obligations always be transferred into legal obligations?

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The English Legal system

Compulsory Treatment

Essential reading



Before completing this Section you should read:

- Heather Draper, 'Women, Forced Caesareans and Antenatal Responsibilities' *Journal of Medical Ethics*, 22 [6] (1996), pp 327-333 [available **online** via the University library / see entry in **library catalogue**]
- Bonnie Steinbock, 'Maternal-Fetal Conflict: Pregnant Drug Addicts' in Bromham, D *et al* (eds), *Ethics in Reproductive Medicine* (Springer, 1992), pp 49-50 [available as a **digitised reading** via the University library / see entry in **library catalogue**]

NB: Remember, as always, in order to get the most out of this Section and understand the issues it addresses in more depth you should do your own research into the subject focusing particularly on papers in ethical journals and books with an ethical focus.

Introduction

So far in this Course Unit we have explored the 'tools' of bioethics – critical thinking etc. - and then some of the central concepts of bioethics such as what makes life valuable, the moral status of the fetus/embryo, the principle of respect for autonomy etc. In this Section we are going to explore an issue which is in the news a great deal and that combines many of the issues we have already looked at in this course unit. The issue of maternal-fetal conflict covers many different ethical issues including:

- When is abortion ethically defensible?
- Is it ethically acceptable to put pressure on pregnant women to accept testing and screening for disorders in their fetus?
- Is it ethically acceptable to punish women for behaviour in pregnancy which might cause harm to the child they bring to birth?
- Is it ethically acceptable to force women to accept treatment for the sake of the child they will bring to birth?



As we have seen, the principle of respect for individual autonomy, if taken seriously as it is in current English law, means that competent adults can usually choose to refuse any tests or treatments and act in ways that others may see as harmful. However, there are those who argue that pregnancy can change this situation at least in some circumstances. We will explore this claim in this Section.

The problem of maternal-fetal conflict for ethics and law

What moral obligations do pregnant women have towards the fetuses they carry and should these moral obligations be enforced or encouraged by law and policy? This question is a very difficult one ethically and legally as it involves weighing the interests of a woman with the interests of the child she intends to bring to birth. Even those of us who hold that abortion is ethically permissible may have serious problems with the notion that women do not have any moral obligations to protect the children they bring to birth.

Obligations to protect future children can be compatible with upholding a right to abortion

It is a commonly held view that pregnant women clearly have a moral obligation to protect their future children, or fetuses they intend to bring to birth, from harm during pregnancy. On this view pregnant women have a moral obligation not to harm their future children by inflicting harm or failing to prevent harm to these children in their fetal state. This is because harm caused to a fetus we intend to bring to birth will be likely to reduce the welfare of a child we will cause to exist later down the line. As Brazier explains:

mothers-to-be have especial responsibility to their children in utero. The absolute dependency of the future child on its mother increases, not diminishes her moral responsibility for its welfare. She can no more morally justify causing injury to that child than to any of her born children, or any other woman's children.¹

However such a moral obligation can be confusing and may be mistakenly interpreted as being incompatible with access to legal abortion. The acknowledgement of such moral obligations may also be seen as precursor to legal obligations in this area which would be very worrying for many. The reason this may be a worry is that a legal obligation to protect fetuses would revolutionize the way that we treat pregnancy

¹ Margaret Brazier, 'Liberty, responsibility, maternity' (1999) 52 *Current Legal Problems* 359; p272, emphasis in original [available online via the University library / see entry in [library catalogue](#)]



and the interests of pregnant women, restricting women's access to abortion and curtailing women's rights to refuse treatment in pregnancy. Such legal restrictions of women's rights in pregnancy are things, as Brazier argues, that '[w]omen rightly fear (...) not out of a lack of concern for their future child but because of the potential impact on their liberty and privacy during and prior to a pregnancy'.² If a legal obligation for fetal protection were established, given that a fetus can be harmed particularly in early pregnancy when a woman may not even be aware she is pregnant, then the law would be effectively demanding that 'fertile, sexually active women of childbearing age should act at all times as if they were pregnant'³. Such a moral obligation would suspend any rights women had over their own bodies for the length of their pregnancy and allow any behaviour that might be seen as harmful to the fetus to be questioned and challenged and even legal steps taken to ensure women fulfil these legal obligations of fetal protection. However, moral obligations to prevent harm to our future children while they are in their fetal state do not necessarily entail a moral obligation to protect all fetuses. The reason for this can be found in the rationale that usually justifies access to abortion in those jurisdictions where access to legal abortion is sanctioned.

Legal access to abortion is usually justified on the basis of the perceived moral status of the fetus. On this view of moral status that justifies legal abortion, the early fetus



is considered to be a very different creature to the child he or she will become. The fetus is something that does not yet have the ability to be able to value its existence. Thus, the justification used for abortion is that it does not involve the destruction of a self-conscious individual who can be aggrieved at this stage by the termination of their life and thus is morally acceptable. Bonnie Steinbock explains this stance, arguing that

*before becoming conscious and sentient, the fetus has no interests at all, and so no interest in continued existence. Without an interest in continued existence, the preconscious fetus is not harmed or wronged by being killed. Since abortion is not a wrong to the preconscious fetus, and the preconscious fetus has no right to life, the state should stay out of abortion decisions.*⁴

However, once parents have made the decision to bring a fetus to birth obligations become different. While this view of the moral status of the fetus may allow us to terminate this human life at this very early stage, this stance does not sanction harm inflicted on

² *ibid* 273

³ S.A.M. McLean, *Old Law, New Medicine* (Pandora Press, 1999) p. 66 [see entry in [library catalogue](#)]

⁴ B. Steinbock, *Life Before Birth - The Moral and Legal Status of Embryos and Fetuses* (New York: Oxford University Press, 1992), p. 127 [available [online](#) via the University library / see entry in [library catalogue](#)]



the fetus if a decision to bring this fetus to birth has been made. This is because once this decision has been made to bring this fetus to birth, it is possible to harm at the fetal stage, the self-conscious individual this fetus will become sometime after birth. Harm inflicted on a fetus who will be brought to birth will harm someone, it will harm the child that the fetus will become. Thus, harm inflicted on the fetus is morally reprehensible if it will affect a self-conscious born individual later in development. So as, Steinbock argues, while it is not wrong to kill the fetus, it is wrong to harm a fetus which will not be aborted but brought to birth. She explains:

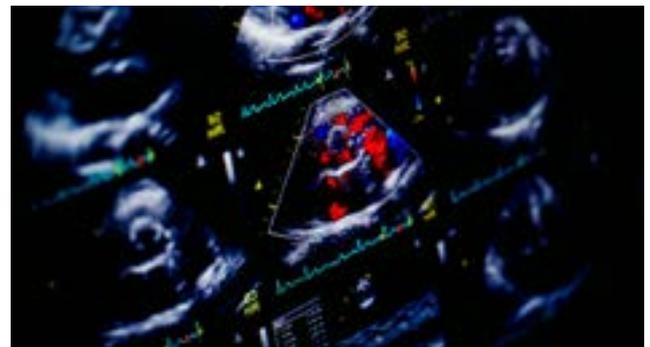
The moral situation changes when a woman decides not to abort, but to carry her baby to term. For once this decision is made, the fetus is not simply a potential child, but a child-who-will-be-born. Once born that child will have interests, including an interest in a healthy and painless existence. That interest can be adversely affected by his or her mother's behaviour during pregnancy. If she neglects her own health, if she has an inferior diet, if she smokes or drinks too much or uses illegal drugs, if she takes risks with the health of her future child. Insofar as these risks are unnecessary or unreasonable, taking them is morally wrong, a violation of parental duty.⁵

The current law is generally consistent with this view. It is an established principle in English law that it is live birth that confers

legal personality⁶, thus before birth a fetus is not a legal person and does not have the legal protection that legal persons enjoy. The law also holds that all those capable of making healthcare decisions should be free to do so even if that person is pregnant at the time or even in labour. Lady Butler-Sloss established this in the Court of Appeal saying:

"[...] a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, choose not to have medical intervention, even though [...] the consequences may be the death or serious handicap of the child she bears or her own death [...] The fetus up to the moment does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth."⁷

However, despite the law being clear on a) the lack of legal status of the fetus and b) a



⁵ B. Steinbock, *Life Before Birth - The Moral and Legal Status of Embryos and Fetuses* (New York: Oxford University Press, 1992), p. 128 [available [online](#) via the University library / see entry in [library catalogue](#)]

⁶ See for example, *Paton v Trustees of the Brith Pregnancy Advisory Service* [1979] 2 All ER 987 [available [online](#)]

⁷ *Re MB (an adult: medical treatment)* [1997] 8 Med LR 217



pregnant woman's right to refuse treatment there are often instances where this notion of moral obligations to future children appears to influence legal cases and legislation and things are not as clear cut as they may first seem. For instance, the *Infant Life Preservation Act, 1929* confers protection on the 'child capable of being born alive' by creating the offence of killing a viable fetus which is known as child destruction. While child destruction cases are rare there have been a number of such cases since 2007.⁸ Further, under the criminal law the fetus is given some legal protection. Following the case of Attorney-General's Reference (No. 3 of 1994)⁹ where a man attacked his pregnant girlfriend causing the premature birth and death of her fetus, the House of Lords endorsed earlier judgments that a charge of murder or manslaughter can be sustained where a fetus is injured *in utero* then born alive and later dies as a result of those injuries.

Thus, while it might seem uncontroversial to many of us that pregnant women do have moral obligations towards the children they will bear, this is a very difficult area for both ethics and law. Turning moral obligations to future children into legal obligations or allowing them to influence policy is hugely problematic. Firstly, it is very difficult to establish clearly what exactly these ethical responsibilities are. Are pregnant women, for instance, under a moral obligation to minimise every risk to their future children however small? Addiction or circumstances may also make it very difficult for women

to change their harmful behaviour. If law and policy is enacted that enforces moral obligations to protect fetuses from harm where does this leave the rights of women? Is it acceptable for pregnant women to be forced to have medical treatment against their will even if they pass all tests for mental capacity and understanding? Should healthcare professionals and even the women's partners have a say over what happens to their bodies in pregnancy and is this approach likely to have the effect it aims to have? Could it be that treating pregnant women in this way may make them less likely to be co-operative with any treatment options and have a detrimental effect on the future child particularly if a woman faces criminal sanctions? Because of the importance and complexity of these issues it becomes imperative to explore what we have reason to believe are the moral obligations of pregnant women and how these moral obligations should be represented in law and policy if at all. This Section helps you to begin to explore these ethical issues around maternal-fetal conflict in order that you can come to your own position on these issues that you can defend.



⁸ *R v Maisha Mohammed* (2007), *R v Carl Anthony Whant* (2012) EWCA Crim 2457, Prochaska, Elizabeth (21 September 2012), "**Sarah Catt, abortion and the legal rights of pregnant women**". *The Guardian*, Jamie Grierson, "**Man convicted of killing unborn baby by kicking pregnant ex-girlfriend**". *The Guardian*. London. 17 December 2015.

⁹ [1998] AC 245 (HL)



Optional Further Reading



For a great overview of the legal issues in this area read:

- Sara Fovargue and José Miola, 'Are we still "policing pregnancy"?' in Stanton, Catherine, Devaney, Sarah, Farrell, Anne-Maree, Mullock, Alexandra (Eds) *Pioneering healthcare law: essays in honour of Margaret Brazier* pp. 243-254 (Oxford: Routledge, 2016) [available as an **ebook** via the University library / see entry in **library catalogue**]
- Margaret Brazier & Emma Cave, *Medicine, Patients and the Law* (Manchester: Manchester University Press, 2016) Chapter 11 [see entry in **library catalogue**]

Compulsory medical treatment in pregnancy

As we have already discussed in detail in this course unit, the principle of respect for autonomy is a central principle of modern medical ethics and is often considered the most important principle in this area. However, as we have also discussed it can be argued that there are justifiable exceptions to this right to individual autonomy in medical decision-making. These exceptions usually relate to the interests of third parties. So while it is accepted that a competent adult can refuse medical treatment – even life-saving medical treatment – when to do so will only risk her life, such actions are viewed differently where other lives are at stake. The protection of others' physical wellbeing or autonomy sometimes dictates that an individual's autonomous choices should not be respected.

This is, as we have seen, the rationale behind established public health measures which

in extreme circumstances allow provision to detain or enforce treatment on those with dangerous infectious diseases, in order to protect the wider public from infection. It is also the motivating factor behind attempts to override the autonomous choices of pregnant women in order to prevent harm to any future child. Where this conflict exists between individual autonomy and the interests of third parties policy development will often be highly problematic. In such situations it is often impossible to uphold the individual autonomy of one individual without undermining the interests and/or autonomy of others. Difficult decisions have to be made in order to arrive at policy that provides the most just solution to this conflict.

So in the case of pregnancy we are left with the difficult situation where the adult with capacity would normally have the unqualified right to refuse any treatment or medical 'touching', but to do so may risk the life or wellbeing of the person her fetus will become.



Many of the high profile cases in which this dilemma is evident involve attempts to legally enforce caesarian section deliveries in labour.

NB: While much of the discussion in this area involves legal cases this Course Unit focuses on the **ethical** implications of these cases rather than the legal implications. The legal aspects of these issues will be explored in the legal Course Units.



Activity 1: Case Study

Consider the following case study.

In 1987, Angela Carder was diagnosed as having terminal cancer of the lung. She was twenty-five weeks pregnant and it was expected that she would only survive a week. Angela had lived under the shadow of cancer since she was thirteen, but had thought herself to be in remission when she planned her pregnancy. Whilst insisting that her own comfort must be the primary consideration, she agreed in principle to consent to any treatment that might enhance the survival prospects of her baby. Her husband, parents and physician were in full agreement with these wishes. Almost a week later, she refused her consent for caesarean section and the hospital decided to seek legal advice. Angela believed that it was unlikely that such an immature fetus would survive, and that if it did it would be likely to suffer multiple disabilities. Emmet Sullivan, the judge appointed to the case, decided that the pivotal issue was the fetus's chances of survival and what was in its best interests granted its mother's terminal condition. He ordered the caesarean section to take place. Angela still refused to consent so Sullivan again listened to both counsels but reaffirmed his original decision. Less than one hour later and with the section planned to occur within fifteen minutes, Angela's counsel argued that the operation would foreshorten her life and was not therefore in her best interests. Against this it was argued that



Activity 1, continued

The numbers of caesarean sections performed in hospitals is increasing due not only to recommendations by health professionals to accept this option but often women request a caesarean section either in what they believe to be the best interests of their child or for their own best interests (e.g. to preserve their pelvic floor).¹¹ If we should respect pregnant women's autonomy should we respect their choice to give birth by caesarean section? Explain your answer.



¹¹ James Gallagher, 'Women can choose Caesarean birth' *BBC News Online* November 2011 [available online at: www.bbc.co.uk/news/health-15840743]



Further Reading on forced Caesarean Sections



For an interesting legal analysis of the issues see:

- Sara Fovargue and José Miola, 'Are we still "policing pregnancy"?' in Stanton, Catherine, Devaney, Sarah, Farrell, Anne-Maree, Mullock, Alexandra (Eds) *Pioneering healthcare law: essays in honour of Margaret Brazier* pp. 243-254 (Oxford: Routledge, 2016) [available as an **ebook** via the University library / see entry in **library catalogue**]
- Margaret Brazier & Emma Cave, *Medicine, Patients and the Law* (Manchester: Manchester University Press, 2016) Chapter 11 [see entry in **library catalogue**]
- Fovargue, S & Miola, J, 'Policing Pregnancy: Implications of the Attorney-General's Reference (No. 3 of 1994)' *Medical Law Review* 6 [3] (1998), pp. 265-295 [available **online** via the University library / or at <http://medlaw.oxfordjournals.org/cgi/reprint/6/3/265> / see entry in **library catalogue**]

Ethical commentary:

- W. Savage, 'Caesarean Section: Who chooses?' in D. Dickenson (Ed.), *Ethical Issues in Maternal-Fetal Medicine* (Cambridge: Cambridge University Press, 2002), p. 266 [available as an **ebook** via the University library / see entry in **library catalogue**]

Pregnancy and routine antenatal screening

While forced caesareans provide a very dramatic and clear example of non-consensual treatment in pregnancy, it can be argued that other areas of antenatal care involve infringement of the pregnant woman's autonomy in an attempt to protect future

children. One such area is the routine testing of pregnant women for conditions such as Down's syndrome.





Antenatal genetic testing

Genetic testing in pregnancy is well established. There are routine and elective tests available for a number of genetic disorders. At present, prenatal diagnostic testing is offered to pregnant women who are deemed to be at increased risk of genetic disorders or congenital abnormality based on family history of a genetic disorder, the result of an ultrasound scan or maternal age. In addition to this, most pregnant women in developed countries are routinely tested for other genetic disorders, commonly chromosomal disorders such as Down's syndrome and Turner's syndrome, as part of established antenatal screening programmes.

With increased understanding of the human genome and of the genetic factors involved in a range of diseases, and with many existing genetic tests becoming safer and cheaper to administer, there is clear potential for a dramatic increase in prenatal genetic diagnosis.

What are the ethical issues here?

The main ethical issue with antenatal genetic testing goes back to the principle of respect for autonomy. As we have seen, it is generally accepted that individuals should be allowed to choose whether or not they



have diagnostic tests especially those that may indicate potentially serious conditions. While there may be temptations on the part of healthcare professionals to test for conditions without explicit and voluntarily given informed consent, such temptations are usually deemed unacceptably paternalistic. While there are those who argue that we need information about any genetic disorders that might be available to make an informed choice, in general the individual's right to autonomy and the legal framework that enshrines this right, upholds the individual's right to refuse any medical testing or treatment, even if this refusal is viewed as unwise by others. However, genetic testing in pregnancy is a bit different. It can be argued that making these tests routine or even offering them to specific groups of women means that the nature of the consent given is very different from the 'opt in' test most of us would experience when deciding to have a genetic test.



Activity 2

What's wrong with routine antenatal testing for Down's Syndrome?

Read the blog at the link below and answer the questions that follow:

blog.law.manchester.ac.uk/routine-antenatal-testing-for-downs-syndrome/.

Are you convinced by the argument that routine tests are coercive? Why/why not?

Do you think that routine testing for Down's syndrome is ethically justifiable?
Explain and defend your answer.



Activity 2

It has been argued that where genetic disorders in fetuses are non-treatable and *unlikely* to render a child's life unworthwhile (i.e. dominated by suffering) then the information gained by antenatal testing is only useful for the potential parents - it cannot be used to prevent harm to the resultant child. As a result, it is argued that antenatal testing of this kind should not be routine but opt-in and require the same kind of voluntary consent as other genetic tests that provide useful information for adults. Do you agree? Why/why not?

There are now some new cheap and accurate blood tests for Down's that are currently available privately and likely to be available soon as part of NHS care¹³. Because the blood test, unlike amniocentesis, does not carry a risk of miscarriage it has been argued that this blood test will be even harder to refuse than the current routine test for Down's and thus making this new test routine will be highly problematic. What do you think about this?

¹³ Anon 'Government approves new Down's syndrome test' BBC News online 31st October 2016 [available online at www.bbc.co.uk/news/health-37824048]



Optional Video Resource



If you would like to explore this issue further, below is a link to a video lecture by Becki Bennett who discusses these issues and the new blood test for Down's:

<https://youtu.be/nwZXIViysQw>

You might also find it interesting to watch a recent BBC documentary on this issue, for which Becki was the ethics consultant:

- A World Without Down's Syndrome?, 21:00 05/10/2016, BBC2, England, 60 mins <https://learningonscreen.ac.uk/ondemand/index.php/prog/0DA04B5A> [accessed 01 Nov 2016] (You will need to log in with your University username and password.)



Activity 2, continued

Routine testing for **HIV** in pregnancy has been established in the UK since 1999 with the target of 90% uptake of HIV testing by pregnant women by 2002.¹⁴ Unlike in Down's syndrome, measure can be taken to prevent HIV being transmitted to newborns if HIV infection is identified in pregnant women - women can take antiretroviral drugs, have a caesarean birth and not breast feed. Does this make routine testing and the inevitable pressure to be tested more justifiable in the case of HIV?

¹⁴ NHS Executive, 'Reducing mother to baby transmission of HIV', Health Service Circular [HSC 1999/183] (London: NHS Executive, 13 August 1999) [available [online](#)]



Activity 2

Do you think that women will be likely to accept these treatments if they feel they were pressured into being tested?

If a pregnant woman's HIV status is not known in pregnancy and she does not take these risk-reducing measures the chance of her child being infected is still below 15%¹⁵. Does this make a difference to the question of whether pressure to be tested is justified? Why/why not?

¹⁵ M. Newell & C. Peckham, 'Risk Factors for Vertical Transmission and Early Markers of HIV-1 Infection in Children', *AIDS*, Vol. 7, supp, 1993, S.591-7 [available [online](#) via University library / see entry in [library catalogue](#)]



Optional Further Reading



- Rebecca Bennett, 'Antenatal Genetic Testing and the Right to Remain in Ignorance', *Theoretical Medicine and Bioethics* 22 [5] (2001): 461-471 [available **online** via the University library / see entry in **library catalogue**]
- Rebecca Bennett, 'Routine antenatal HIV testing and informed consent: an unworkable marriage?' *Journal of Medical Ethics*, Aug 2007; 33: 446-448 [available **online** via the University library / see entry in **library catalogue**]
- Erik Parens, 'The Thorny Ethics of Prenatal Testing', *TIME*, February 5 2014 [available online at <http://time.com/4584/genetic-testings-brave-new-world/>]
- Denise Balkissoon, 'The more you know: The ethics of prenatal testing', *Today's Parent*, November 19 2014 [available online at <http://www.todaysparent.com/pregnancy/ethics-prenatal-testing/>]
- Antina de Jong, Wybo J Dondorp, Christine E M de Die-Smulders, Suzanne G M Frints and Guido M W R de Wert, 'Non-invasive prenatal testing: ethical issues explored', *European Journal of Human Genetics* 18, (2010): 272-277 [available **online** via the University library / see entry in **library catalogue**]

Maternal-Fetal Conflict

There are many other factors which may cause harm to the fetus during pregnancy. Consider the following examples of possible harm:

A 1988 survey of 36 hospitals across America indicated that 11% of women were using drugs in pregnancy, resulting in 375,000 drug exposed infants annually [...] New evidence is emerging about the danger that cocaine can pose to fetal health. As recently as 1982, medical texts on high-risk obstetrics maintained that

cocaine had no deleterious effects on fetuses. More recent studies indicate that the effects of fetal exposure to cocaine include retarded growth in the womb and subtle neurological abnormalities, leading to extraordinary irritability during infancy, and learning disorders later. In extreme cases, cocaine can cause loss of the small intestine and brain-damaging strokes. Cocaine-exposed babies face a tenfold increase in the risk of cot (crib) death. Some of the worst effects occur during the first 3 months of pregnancy, when the woman may not even know she is pregnant. Some researchers think even a single cocaine 'hit' during pregnancy can cause fetal damage.



[...]

*Heavy drinking during pregnancy – especially binge drinking – is particularly risky. It can cause fetal alcohol syndrome (FAS), which is often marked by severe facial deformities and mental retardation. One study showed that even moderate drinking – defined as one to three drinks daily – during early pregnancy can result in a lowering of as much as five IQ points. Perhaps most important, there is no established ‘safe’ level of alcohol consumption. While there is no evidence that a rare single drink during pregnancy does damage, there is no guarantee that it does not.*¹⁶

The number of ways in which maternal behaviour can put fetuses (or the children these fetuses become) at risk is seemingly unlimited. Obvious harmful behaviour includes the use of illegal and legal drugs such as cocaine, alcohol and tobacco, but other behaviours such as failing to attend for antenatal care, overworking, living in an industrial area where pollutants are high, living with a heavy smoker and even skiing may be equally harmful to fetal development. With this in mind and the added complication that not all these harmful behaviours may be autonomously chosen, what are the moral obligations of pregnant women and how far is society justified in intervening on behalf of the children these fetuses will become?



¹⁶ Bonnie Steinbock, ‘Maternal-Fetal Conflict: Pregnant Drug Addicts’ in D. Bromham, *et al*, *Ethics in Reproductive Medicine* (London: Springer, 1992), pp. 49-52 [available as a **digitised reading** via the University library / see entry in **library catalogue**]



Activity 4, continued

Why might it be morally acceptable to intervene to prevent harmful behaviour where a woman is incapable of stopping this behaviour herself and it is not morally acceptable to intervene to prevent harmful behaviour if the woman is capable of stopping herself but refuses to do so?

What do you think about the framework and qualifications (pp. 143-144) that Bewley puts forward to justify intervening with pregnant women's actions? Do you think that non-consensual caesarean sections or mandatory antenatal HIV testing could be justified by this framework?



Concluding Remarks

As we have seen in this section it is clear that pregnant women have some moral obligations not to harm the people their fetuses will become. However, what exactly these moral obligations are is less clear. How serious must the harm be before pregnant women are morally obliged to avoid it? How much effort and/or personal risk is she obliged to put into preventing the harm?

A further question remains: should we attempt to transfer these moral obligations pregnant women have towards their future children into legal obligations? That is, should we attempt to 'encourage' the fulfilment of these obligations through government policy or even legal sanctions? We are left with a very difficult situation. Either:

- we decide that as it is difficult to be clear what specific moral obligations pregnant women have towards their future children and because we

recognise the importance of respecting the autonomy of all individuals, including pregnant women, we decide that developing policy that attempts to 'encourage' or enforce these moral obligations is not ethically justifiable especially where any treatments 'encouraged' are invasive;

or

we decide that the benefit of preventing harm to future children is so important that we are prepared to sacrifice pregnant women's autonomy. If we are to do this, we must decide how serious the harm would have to be and how effective the treatment in order to justify these infringements of autonomy. For instance, we might decide that while it is acceptable to give pregnant women information about the possible harm caused by smoking and heavy drinking, it is not acceptable to put pressure on her to accept a HIV test and the pressure to accept invasive treatment that that test entails.





Activity 5

What do you think is the answer to this problem of policy relating to maternal-fetal conflict? Explain your answer.

Do you think that the introduction of coercive testing regimes and directive counselling in pregnancy may lead to a slippery slope that ends in routine enforced caesarean deliveries? Why/why not?



Suggested Further Reading



- Rebecca Bennett, 'The Acceptability of Routine Testing for Blood-borne Communicable Disease' in Draper, H and Scott, W (eds) *Ethics in Anaesthesia and Intensive Care: Issues in Contemporary Practice* (London: Butterworth, 2003) pp. 205-217 [available as a **digitised reading** via the University library / see entry in **library catalogue**]
- P. de Zuleta & M. Boulton, 'Routine antenatal HIV testing: the responses and perceptions of pregnant women and the viability of informed consent. A qualitative study', *Journal of Medical Ethics* 33 (2007): 329-336 [available **online** via the University library / see entry in **library catalogue**]
- Laura M. Purdy, 'Are Pregnant Women Fetal Containers?' in *Bioethics* (1990): 273-291 [available **online** via the University library / see entry in **library catalogue**]
- Rosamund Scott, 'Maternal Foetal Conflict' in *Principles of Health Care Ethics* [Second edition], R.E. Ashcroft, A. Dawson, H. Draper and J.R. McMillan, (London: John Wiley & Sons, 2007) pp. 401-407 [available as an **ebook** via the University library / see entry in **library catalogue**]
- Bennett, R. (2013). 'Is there a case for criminalising vertical transmission of Human Immunodeficiency Virus (HIV) from mother to child?' *Journal of Medical Law and Ethics*, 2 [available **online** via the University library / see entry in **library catalogue**]
- Colin Gavaghan, "'You can't *handle* the truth"; medical paternalism and prenatal alcohol use' *Journal of Medical Ethics* (2009) 35 [3]: 300-303 [available **online** via the University library / see entry in **library catalogue**]
- Sarah S. Richardson, Cynthia R. Daniels, Matthew W. Gillman, Janet Golden, Rebecca Kukla, Christopher Kuzawa and Janet Rich-Edwards, 'Society: Don't blame the mothers' *Nature* (13 August 2014) 512 [7513]: 131-132 [available **online** via the University library / see entry in **library catalogue**]



Summary

Autonomy and Pregnancy

Compulsory Treatment

- During pregnancy many of the bioethical issues explored in this course unit arise. The key issue is maternal-fetal conflict, i.e. the balancing of the autonomy and interests of the mother-to-be and the fetus she carries.
- English law accepts the principle of respect for individual autonomy, which if taken seriously means that mothers are free to consent to or refuse any tests or treatments, and engage in behaviour others consider harmful.
- However, some suggest that pregnancy changes this situation of individual autonomy at least in some circumstances, because maternal decisions affect the life of a fetus and child-to-be. Special obligations arise, it is argued, whenever a woman intends to bring the fetus to birth.
- Whether such special obligations exist and how far they extend is controversial, not least because it can lead to a significant restriction of (pregnant) women's rights. For instance, contrast forcing a pregnant woman to undergo a caesarean section against her wishes in the interests of the child with declining a woman's wish to have a caesarean section in the absence of medical need.

Pregnancy and routine antenatal screening

- It has been argued that routine antenatal screening can also involve an infringement of the pregnant woman's autonomy, albeit a less dramatic one than forced caesarean.
- The ethical issue with genetic testing goes back to the principle of respect for autonomy: making such tests routine or even simply offering them to specific groups of women means that the nature of the consent given is not the same as the usual 'opt in' when someone decides to have a genetic test.



Summary, continued

- Where genetic disorders are non-treatable, the information gained by such antenatal testing is only useful for the potential parents but it cannot prevent harm to the resultant child. Therefore, it is argued, such tests should require the same kind of voluntary consent as other genetic tests directed at adults.
- Given that testing is increasingly becoming cheaper and safer (such as the blood test for Down's syndrome), it might become harder for pregnant women to refuse such tests.

Maternal-Fetal Conflict

- Many other factors may cause harm to the fetus during pregnancy, not all of which are autonomously chosen. Examples include the taking of legal and illegal drugs, as well as engaging in certain high-risk activities or sports, being overworked, living in a polluted area or eating an unhealthy diet.
- Defining the moral obligations of pregnant women towards their yet-to-be-born children is complicated, because any intervention involves an infringement of the woman's autonomy which needs to be justified. If we decide that there are such special moral obligations in pregnancy, the question arises as to whether these should also be turned into legal obligations.

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