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HEALTHCARE ETHICS AND LAW

PHILOSOPHICAL BIOETHICS: AUTONOMY AND PREGNANCY

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Philosophical Bioethics: SECTION 8

Autonomy and Pregnancy

LEARNING OUTCOMES at the end of this section you will be able to:

- explain maternal–fetal conflict and outline the ethical and legal tensions it creates between autonomy, fetal interests, and parental responsibility;
- evaluate the moral obligations of pregnant individuals toward future children, and distinguish between moral, legal, and policy-based obligations;
- analyse the ethical challenges of pregnancy-related interventions, including refusal of treatment, alcohol-use screening, and disability screening;
- apply core bioethical concepts (e.g. autonomy, harm, moral status) to case studies involving pregnancy and conception.

Philosophical Bioethics
SECTION 8

Autonomy and pregnancy

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Introduction

In earlier sections of this course unit, we explored the principle of respect for autonomy as one of the central foundations of modern medical ethics. Respecting autonomy requires that maximally or sufficiently autonomous decision are respected even if these decisions are considered unwise or harmful by others. This principle reflects both respect for individual agency and recognition of the importance of respecting personal values in healthcare decision-making.

Respecting autonomy in pregnancy, raises distinctive and difficult questions. Unlike most medical situations, decisions made by a pregnant individual may directly affect another - the future child they may bring to birth. This creates what is often described as a maternal[1]–fetal conflict : a potential clash between the autonomy of the pregnant individual and the interests of a future child.

This potential conflict brings together many of the themes we have already examined in this course unit:

- the moral status of the fetus,
- the scope and limits of individual autonomy,
- and the question of whether moral obligations should ever become legal obligations.



In this Section, we will examine the ethical issues around compulsory medical treatment in pregnancy, alcohol use, routine antenatal and genetic screening, and the broader question of whether, and to what extent, pregnant individuals have obligations to the children they will bring to birth.

Maternal–Fetal Conflict: Ethics and Law

One of the most complex questions in bioethics is whether, and to what extent, pregnant individuals have moral obligations to their future children at the fetal stage. This question becomes even more complex when we ask whether such obligations should be enforced or encouraged by law and policy.

The Ethical Problem

At the heart of the issue is a potential conflict between two sets of interests:

- the autonomy of the pregnant individual, and

[1] We will use the word 'maternal' to refer to any pregnant individual as is the convention in this literature, however, we recognise that an individual who identifies as any gender or non-binary might be pregnant.

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- the wellbeing of the future child that fetus may become.

Even those who accept that abortion can be ethically permissible may still argue that once a decision is made to continue a pregnancy, the pregnant individual acquires special obligations to avoid harming a future child at this fetal stage.

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 individuals to accept testing and screening for disorders in their fetus?
- Is it ethically acceptable to punish individuals for behaviour in pregnancy which might cause harm to the child they bring to birth?
- Is it ethically acceptable to force pregnant individuals 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 individuals 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 an individual with the interests of the child they intend to bring to birth. Even those of us who hold that abortion is ethically permissible may have serious problems with the notion that those who become pregnant 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 individuals 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 individuals 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:

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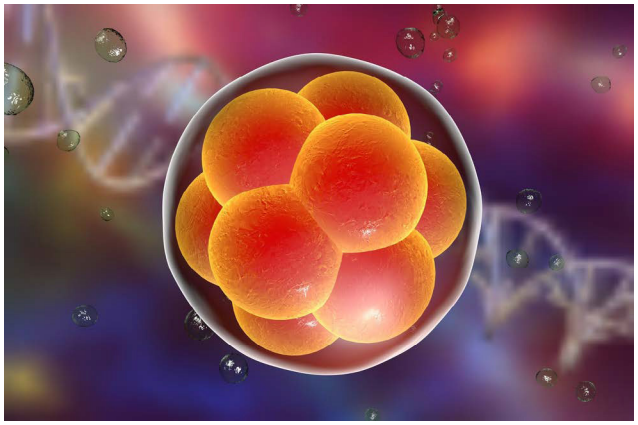

> mothers-to-be have especial responsibility to their children in utero. The absolute dependency of the future child on its mother increases, not diminishes her moral responsibility for its welfare. She can no more morally justify causing injury to that child than to any of her born children, or any other woman's children.[2]

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 a 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 and the interests of pregnant individuals, restricting access to abortion and curtailing rights to refuse treatment in pregnancy. Such legal restrictions of 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'.[3] If a legal obligation for fetal protection were established, given that a fetus can be harmed particularly in early pregnancy when an individual may not even be aware they are 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'[4]. Such a moral obligation would suspend any rights individuals 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 pregnant individuals 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 entity to the child this entity will become. The fetus

[2] M. Brazier, 'Parental responsibilities, foetal welfare and children's health in C. Bridge (ed), Family Law Towards the Millennium: Essays for PM Bromley (Butterworths 1998) p. 272 emphasis in original [see entry in library catalogue]

[3] Ibid p.273

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

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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 selfconscious 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.[5]

However, once prospective 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 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 argues:

> 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-willbe-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.[6]

[5] B. Steinbock, Life Before Birth - The Moral and Legal Status of Embryos and Fetuses (Oxford University Press, 1992), p.127 [available online via University library]
[6] Ibid p.128

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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 personality[7], 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."[8]

However, despite the law being clear on a) the lack of legal status of the fetus and b) a pregnant individual'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.[9] Further, under the criminal law the fetus is given some legal protection. Following the case of AttorneyGeneral's Reference (No. 3 of 1994)[10] 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 individuals 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 individuals, 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 individuals

7 See for example, Paton v Trustees of the Birth Pregnancy Advisory Service [1979] 2 All ER 987 [available online]

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

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

10 [1998] AC 245 (HL)

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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 pregnant individuals? Is it acceptable for those who are pregnant 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 pregnant individual'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 individuals 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 an individual 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 individuals 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.

Optional Further Reading

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

- M. Brazier E. Cave and R. Heywood, Medicine, Patients and the Law (7th edn.) (Manchester University Press, 2023) Chapter 13 [available online via University library]
- S. Fovargue and J. Miola, 'Are we still "policing pregnancy"?' in C. Stanton, S. Devaney, A. Farrell, A. Mullock (eds.) Pioneering healthcare law: essays in honour of Margaret Brazier pp. 243-254 (Routledge, 2016) [available as an ebook via University library]

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 lifesaving medical treatment – when to do so will only risk their life, such actions are viewed

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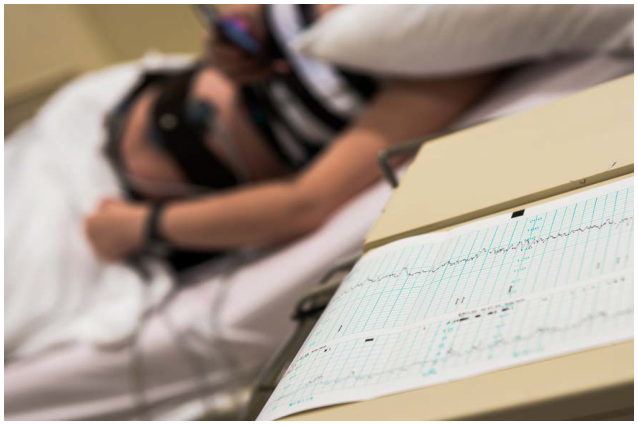

differently where other lives are at stake. The protection of others' physical wellbeing or autonomy sometimes dictates that an individual's autonomous choices should not be respected.

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 individuals 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 their fetus will become.

Many of the high-profile cases in which this dilemma is evident involve attempts to legally enforce caesarean 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.

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Activity 1: Case Study

Consider the following case study

In 1987, Angela Carder was diagnosed as having terminal lung cancer. 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 a 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 she had no interests and she was dying.

Sullivan cut across the ensuing argument by asking who had the best chances of surviving, the mother or the child. The answer was that the baby did and so he again ordered the operation to take place. The non-viable fetus died two hours after the caesarean was performed.

Angela died two days later. At no point in the proceedings did Sullivan speak to Angela personally. In 1990, two appeal hearings later, the District of Columbia Court of Appeal reversed Sullivan's decision, not for the benefit of Angela, but to avoid setting a precedent for future cases.[11]

[11] H. Draper, 'Women, Forced Caesareans and Antenatal Responsibilities' Journal of Medical Ethics (1996) 22 [6] pp. 327-333 [available online via University library]

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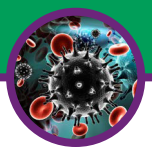

Activity 1, continued

Was the coercion of Angela Carder ethically justifiable? Explain your answer.

Suppose the details of the case were different; perhaps the treatment required was a blood transfusion, the woman was not terminally ill, or the woman was over 30 weeks pregnant. What impact would these different circumstances have on your opinion of whether coercion is justifiable? Again, explain your answer.

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Activity 1, continued

Do you think that it is possible to create policy to deal with this issue adequately? Explain your answer.

[To help you to think about this you might want to research this issue of attempts to force caesarean sections on pregnant individuals who do not consent to them. There are a number of commentaries both legal and ethical in this area which you may wish to read - use the further reading below to guide you.]

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Activity 1, continued

The number of caesarean sections performed in hospitals is increasing due not only to recommendations by health professionals to accept this option but often they are requested by pregnant individuals 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).[12]

If we should respect a pregnant individual's autonomy should we respect the individual's choice to give birth by caesarean section? Explain your answer.

[12] J. Gallagher, ' Women can choose Caesarean birth ' BBC News Online November 2011

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Activity 1, continued

Regarding whether a pregnant individual has the right to choose to have a caesarean section, it has been argued that 'Decisions should be made in the best interests of the patient. The patient has the right to decline to take one's advice, but, in my view, does not have the right to ask the doctor to perform a procedure which the doctor considers unwarranted by the evidence and which is not in the patient's best interests.'[13]

Do you agree? Is there good reason for respecting an individual's autonomous choice to refuse a caesarean section even if it causes harm to them or their child, while refusing another individual their choice for an elective caesarean section because we do not think it is in their best interests? What is this reason?

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

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Further Reading

Legal analysis of the issues around forced Caesarean sections:

- S. Fovargue and J. Miola, 'Are we still "policing pregnancy"?' in C. Stanton, S. Devaney, A. Farrell, A. Mullock, (eds) Pioneering healthcare law: essays in honour of Margaret Brazier pp. 243-254 (Routledge, 2016) [available as an ebook via University library]
- M. Brazier E. Cave and R. Heywood, Medicine, Patients and the Law (7th edn.) (Manchester University Press, 2023) Chapter 13 [available online via University library]
- S. Fovargue and J. Miola, 'Policing Pregnancy: Implications of the Attorney-General's Reference (No. 3 of 1994)' Medical Law Review (1998) 6(3) pp. 265-295 [available online via University library]

Ethical commentary:

- H. Draper, 'Women, Forced Caesareans and Antenatal Responsibilities' Journal of Medical Ethics (1996) 22(6) pp. 327-333 [available online via University library]
- H. I. M'hamdi and I. de Beaufort 'Forced Caesareans: Applying Ordinary Standards to an Extraordinary Case' Journal of Medical Ethics (2021) 47(4) pp. 233–238 [available online via University library]
- E. C. Romanis, 'Why the Elective Caesarean Lottery Is Ethically Impermissible' Health Care Analysis (2019) 27(4) pp. 249–268 [available online via University library]
- E. C. Romanis, 'Addressing Rising Cesarean Rates: Maternal Request Cesareans, Defensive Practice, and the Power of Choice in Childbirth' International Journal of Feminist Approaches to Bioethics (2020) 13(1) pp. 1–26 [available online via University library]
- E. C. Romanis, 'Appropriately Framing Maternal Request Caesarean Section' Journal of Medical Ethics (2022) 48.8 pp. 554–556 [available online via University library]
- S. R. Latham and E.R. Norwitz, 'Ethics and 'Cesarean Delivery on Maternal Demand" Seminars in Perinatology (2009) 33(6) pp. 405–409 [available online via University library]
- W. Savage, 'Caesarean Section: Who chooses?' in D. Dickenson (ed.), Ethical Issues in Maternal-Fetal Medicine (Cambridge University Press, 2002), p. 263 [ebook available via University library]
- G. F. Winter 'Caesarean Sections and Ethics' British Journal of Midwifery (2022) 30(4) pp. 237–238 [available online via University library]

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Further Reading continued

Some recent literature on forced treatment in pregnancy more generally:

- A. D. Lyerly, M. R. Waggoner, 'Reproductive Intrusions: Evidence and Ethics' American Journal of Bioethics (2024) 24(2):31-33 [available online via University library]
- D. Wilkinson, S. Teli, C. Litchfield et al. 'Ethics round table: choice and autonomy in obstetrics' Journal of Medical Ethics (2025) 51:588-592 [available online via University library]

Alcohol use in pregnancy

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

Since a link was established between alcohol consumption in pregnancy and Fetal Alcohol Spectrum Disorder (FASD) there have been attempts to reduce women's alcohol consumption during pregnancy. As a result, many jurisdictions, including the UK have taken what is called the 'abstinence only approach' as the basis for all policies on alcohol consumption in pregnancy, where women are advised that alcohol should be avoided completely not just during pregnancy but at any time that pregnancy may be a possibility. [14]

Pregnant people are currently routinely asked about their alcohol intake at the initial booking appointment for prenatal care, it has been proposed that this should be increased to all pregnant people being screened using standard questionnaires at every antenatal appointment. In addition, there is an evident appetite for the development of biomarker screening tools, testing blood, urine and even meconium to establish if a pregnancy is 'alcohol exposed'.[15]

While these attempts to prevent alcohol consumption in pregnancy are well meaning they are highly ethically problematic. It can be argued that these measures to 'police' alcohol consumption in pregnancy infringe women's autonomy unjustifiably as the evidence that this extra surveillance would prevent harm is not convincing.

[14] See for instance current NHS guidance Drinking alcohol while pregnant

[15] Public Health England (PHE) Guidelines Network (SGN): reducing the incidence of harms caused by alcohol in pregnancy: p12, 2020; Scottish guidelines: Guidelines Network (SGN): Children and young people exposed prenatally to alcohol: national guideline 156: p13, 2019

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Activity 2

Recently Rebecca Bennett and Catherine Bowden argued against this approach to alcohol prevention in pregnancy. Read one or both of the readings below and answer the question that follows:

- R. Bennett, C. Bowden, 'Can routine screening for alcohol consumption in pregnancy be ethically and legally justified?' Journal of Medical Ethics (2022) 48 pp. 512-516 [available online]
- Blog based on the above article: R. Bennett, C. Bowden, 'Why we must resist proposals for routine screening for alcohol in pregnancy' Journal of Medical Ethics Blog March 2022 [available online]

Do you think that Bennett and Bowden's arguments (that moves to increase screening of pregnant people for alcohol use are unjustified) are convincing? Explain and defend your answer.

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Further optional reading

- D. Campoamor, 'The WHO alcohol-pregnancy warning for childbearing women ove , as usual' Think, 21 June 2021 [available online]
- N. Grover, 'Plans to record pregnant women's alcohol consumption in England criticised', The Guardian, 16 September 2020 [available online]
- E. Wilkinson, 'NICE: GPs should routinely ask pregnant women about drinking and record details' Pulse, 17 March 2022 [available online]

Pregnancy and routine antenatal screening



As we have seen, routine screening can involve infringements of autonomy. Another area where it has been argued that screening in pregnancy infringes the autonomy of pregnant people is routine screening in pregnancy for conditions such as Down syndrome.

Routine 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 in pregnancy to individuals 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 individuals in developed countries are routinely screened for other genetic disorders, commonly chromosomal disorders such as Down syndrome, Patau syndrome and Edward syndrome, as part of established antenatal screening programmes.

With an 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. The development of whole-genome sequencing (WGS) means that we can nowgain a huge amount of information

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relatively quickly and cheaply about any human being's genetic make-up, whether this is an adult person or a pre-implantation embryo or foetus during pregnancy. As a result, there are calls to substantially expand the scope of routine prenatal screening by using WGS.[16]

Screening and autonomy

At first glance, the current policy of routine screening in pregnancy for conditions like Down syndrome seems to be a positive thing for pregnant people and their families. It might be argued that this kind of screening enhances pregnant people's autonomy by providing information about their pregnancy allowing them to make more informed choices.[17] Extending this kind of screening in the future using WGS could, it might be argued, provide even more information for pregnant people, and enhance their choices further.

However, it has also been argued that any programme of screening in pregnancy that aims to get a high uptake of screening rather than simply offering the test on an 'opt in' basis, may actually undermine autonomy and put pressure on some pregnant people to accept screening.

It is argued[18] that prenatal screening of this kind is seen as just another blood test that is added to a well-established provision of prenatal care that most pregnant people trust as having their best interests as central to its aims. There are concerns that this idea of recommendation puts pressure on pregnant people to participate in screening and that as a result '[i]t could be difficult for women to decline without appearing irresponsible and blameworthy".[19] The fact that screening is often seen as 'just a blood test' and one that is offered by 'trusted' medical professionals means that pregnant people can feel that they should accept screening and that by doing so they are being responsible parents.[20]

We know that at least some pregnant people report that they do feel pressure to accept this screening test and find refusing difficult. Studies consistently show that levels of knowledge adequate for consent to be considered sufficiently informed are not being achieved in a significant proportion of participating pregnant people, because people are often not aware that screening is optional,[21] many do not know why they

[16] H. Bowman-Smart et al. 'Non-invasive prenatal testing for "non-medical" traits: Ensuring consistency in ethical decision-making', American Journal of Bioethics (2023) 23(3) pp. 3–20 [available online]

[17] See, for example Royal College of Obstetricians and Gynaecologists, ' Supporting women and their partners through prenatal screening for Down's syndrome, Edwards' syndrome and Patau's syndrome ', 2020

[18] R. Bennett, The Welfare of Future Children: Reproductive Ethics and Disability Screening (Bloomsbury, 2025) p.28

[19] C. Williams, P. Alderson and B. Farsides, 'Too many choices? Hospital and community staff reflect on the future of prenatal screening', Social Science & Medicine (2002) 55 p. 747 [available online via University library]

[20] C. Lewis, C. Silcock and L. S. Chitty, 'Non-invasive prenatal testing for Down's syndrome: Pregnant women's views and likely uptake', Public Health Genomics 16(5) (2013): 226 [available online via University library]

[21] C. Lewis, M. Hill and L. S. Chitty, 'Offering non-invasive prenatal testing as part of routine clinical service. Can high levels of informed choice be maintained?' Prenatal Diagnosis 37(11) (2017): 1130–7 [available online via University library]

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are being screened[22] and there is evidence that routinized screening of this kind puts pressure on pregnant people not only to accept screening and testing but to opt for a termination of pregnancy with a positive result.[23] Thus, rather than empowering pregnant people's choices it may be argued that screening may erode people's ability to make free choices about their pregnancies.

On this view, it might be argued that if we really are to take pregnant people's autonomy seriously, it is important we work to ensure that pregnant people are able to make choices that are right for them whether this choice is to accept testing for Down syndrome or not and whether they wish to continue a pregnancy or to have a termination. It is argued that the current way that screening is offered routinely is often not a good way of enabling a voluntary choice of this kind and, if enhancing autonomy really is the goal of testing for Down syndrome in pregnancy that this test should be offered in a similar way to other genetic tests outside of pregnancy, that is with an emphasis on the voluntariness of this test and non-directive counselling.

Activity 3

What's wrong with routine antenatal testing for Down syndrome? Click on the link below to watch a video lecture by Professor Becki Bennett and answer the questions that follow:

- Is routine testing for Down Syndrome morally justifiable?

Note that since the video lecture non-invasive prenatal testing has been introduced into existing routine screening for Down syndrome.

If you prefer something written you can find similar arguments in this blog also by Becki:

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

[22] National Collaborating Centre for Women's and Children's Health (UK) Antenatal Care: Routine Care for the Healthy Pregnant Woman (RCOG Press; 2008)

[23] H. Statham and W. Solomou, 'Antenatal screening for Down's syndrome', The Lancet 352(9143) (1998): 1862 [available online from University library]

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Activity 3, continued

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

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

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Activity 3, continued

It It has been argued that where genetic disorders in fetuses are non-treatable and unlikely to render a child's life intrinsically harmful (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 (what might be seen as 'opt out' screening and testing) but provided on a similar basis to other genetic tests outside of pregnancy with a commitment to voluntariness and nondirectiveness ('opt in' screening and testing).[24]

Do you agree? Why/why not?

[24] R. Bennett, The Welfare of Future Children: Reproductive Ethics and Disability Screening (Bloomsbury, 2024) p.25.

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Further optional resources

- D. Balkissoon, 'The more you know: The ethics of prenatal testing', Today's Parent, 1[illegible]r 2014
- R. Bennett, The Welfare of Future Children: Reproductive Ethics and Disability Screening (Bloomsbury, 2025) [Available as a free PDF open access download on the Bloomsbury site]
- R. Bennett, 'Antenatal Genetic Testing and the Right to Remain in Ignorance', Theoretical Medicine and Bioethics (2001) 22(5) 461-471 [available online via University library]
- R. Bennett, 'Routine antenatal HIV testing and informed consent: an unworkable marriage?' Journal of Medical Ethics (2007) 33, 446-448 [available online via University library]
- L. S. Chitty et al. 'Uptake, outcomes, and costs of implementing non-invasive prenatal testing for Down's syndrome into NHS maternity care: prospective cohort study in eight diverse maternity units' BMJ (2016) 354 :i3426 [available online via University library]
- M. L. Constantine, M. Allyse, M. Wall, R. D. Vries and T. H. Rockwood, 'Imperfect informed consent for prenatal screening: Lessons from the Quad screen', Clinical Ethics (2014) 9(1) 17–27 p. 23 [available online - sign in to the University of Manchester to get access]
- A. de Jong, I. Maya and J.M.M. van Lith, 'Prenatal Screening: Current Practice, New Developments, Ethical Challenges' Bioethics (2015) 29, 1–8 [available online via University library]
- A. Kater-Kuipers et al. 'Ethics of Routine: a Critical Analysis of the Concept of 'routinisation' in Prenatal Screening' Journal of Medical Ethics (2018) 44.9, 626–631 [available online via University library]
- A. Kater-Kuipers, I. D. de Beaufort, R. H. Galjaard, E.M. Bunnik, 'Rethinking counselling in prenatal screening: An ethical analysis of informed consent in the context of non-invasive prenatal testing (NIPT)' Bioethics (2020) 34, 671– 678 [available online via University library]
- G. Kellogg, L. Slattery, L. Hudgins and K. Ormon, 'Attitudes of Mothers of Children with Down Syndrome Towards Noninvasive Prenatal Testing' Journal of Genetic Counselling (2014) 23(5) pp.805-813 [available online via University library]

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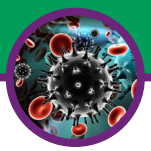

Further optional resources

- L. Page-Christiaens, and K. Hanns-Georg Noninvasive Prenatal Testing (NIPT) : Appl… Genomics in Prenatal Screening and Diagnosis (Academic Press, 2019) [ebook available via University library]
- P. Nakou, 'Is routine prenatal screening and testing fundamentally incompatible with a commitment to reproductive choice? Learning from the historical context', Medicine, Health Care and Philosophy (2021) 24(1) pp.73–83 [available online via University library]
- Nuffield Council of Bioethics, Non-invasive prenatal testing: ethical issues (Nuffield Council of Bioethics, March 2017) p.2
- E. Parens, 'The Thorny Ethics of Prenatal Testing', TIME, 5 February 2014
- V. Ravitsky,'The shifting landscape of prenatal testing: Between reproductive autonomy and public health', Hastings Center Report 47 (2017) S36 [available online via University library]
- R. V. van Schendel et al. 'NIPT-based screening for Down syndrome and beyond: what do pregnant women think?' Prenatal Diagnosis (2015) 35, 598–604 [available online via University library]
- H. Statham and W. Solomou, 'Antenatal screening for Down's syndrome', The Lancet (1998) 352(9143) 1862 [available online at University library]

Further optional media

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

- A World Without Down's Syndrome? 21:00 05/10/16, BBC2, England, 60 mins

(You will need to log in with your University username and password. Access is only available to those of you in the UK but if you search YouTube you should be able to find a copy of the documentary there.)

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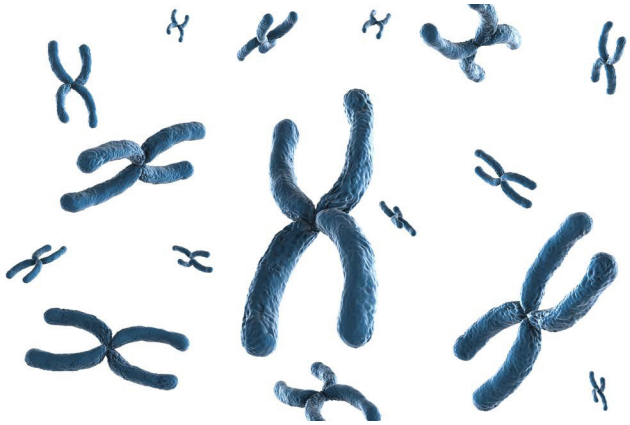
Do we harm someone by bringing them to birth with a disability?

In the video and blog above it is suggested that it is hard to make a case that routine screening empowers pregnant people when there is strong evidence to suggest that the usual standard of informed consent is often not met when it comes to routine screening. It has been argued that:

> the main problem here is that the routine nature of these screening programmes may not be compatible, in many cases, with gaining voluntary informed consent. Routine screening programmes are implemented in order to gain a higher uptake of screening than simply offering this screen and test in the way that we would normally offer other genetic tests as an elective 'opt in' test. Prenatal screening for Down syndrome has become a routine, established and accepted part of prenatal care around the world.[25]

If we accept that routine screening for Down syndrome cannot be justified by appeals to empowering the autonomy of pregnant people it may be that there are other factors that might justify this different approach to informed consent.



Public health goals?

As I explain in my forthcoming book:

> There is strong evidence to suggest that the introduction of routine prenatal screening was motivated not by women's empowerment (and the empowerment of other pregnant people) but by what are called public health goals. The public health goals in this context are to reduce the incidence of certain conditions in the population and, in the case of untreatable conditions such as Down syndrome, by preventing the birth of those with this condition, although this rationale 'has been mostly unspoken'.
>
> The development of routine screening for Down syndrome was at least in part motivated by concerns about avoiding the financial burden that those with this condition were thought to present. The cost of providing amniocentesis to pregnant people at higher risk of having a child with Down syndrome was routinely compared with the costs of care for

[25] R. Bennett, The Welfare of Future Children: Reproductive Ethics and Disability Screening (Bloomsbury, 2025) p.28

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those with Down syndrome. In addition to concerns about the costs of allowing children to be born with conditions like Down syndrome, routine prenatal screening for Down syndrome has been motivated by a concern about litigation from doctors where parents are not aware of their child's diagnosis before birth, financial considerations (prenatal screening has huge commercial value) and by notions of the welfare of future children born with what are usually considered to be disabling and undesirable conditions. Understanding the historical origins and motivations of prenatal screening helps us to the historical origins and motivations of prenatal screening helps us to understand why a high uptake of screening is seen as desirable and why information and policies around screening may not emphasize choices to refuse screening or to continue with the pregnancy after a positive diagnosis.

However, it can be argued that justifying routine prenatal screening for Down syndrome based on public health goals is challenging. While there will be some individuals with this condition who need extra educational and medical support, this will not always be the case and, of course, there are many individuals without Down syndrome who need extra support and public resources.

Even if we accept that routine screening of this kind is justified to save money, then it seems that we could justify all sorts of other interventions based on the same premise – for instance, limiting the number of children individuals are supported by the state to have. It has also been argued that attempting to reduce the costs of care for those with Down syndrome through the existence of routine prenatal screening 'may inadvertently increase these costs by propagating attitudes which restrict these people's independence and employment opportunities'.[26] The establishment of routine screening seems likely to perpetuate the often overly negative attitudes we may have to those with Down syndrome, which may then have an impact on the opportunities available to those with this condition.

Harm to future persons

The only other possible justification for the routinization of prenatal screening is evidence of harm prevention. It may well be that we are justified in recommending and even attempting to influence individuals' choices if there is good evidence that doing so will prevent serious harm to them or to others. This is, of course, the rationale behind government screening programmes for breast and bowel cancer. More extreme examples of justified overriding of individual autonomy to prevent harm might also include compulsory treatment and autopsies, speed limits and pressure to accept vaccinations.

[26] P. Alderson, 'Down's Syndrome: Cost, quality and value of life', Social Science & Medicine 53(5) (2001): 627

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However, if we take the view that being alive is generally a good thing for the person who experiences it (not everyone holds this view – see reading on antinatalism), then, it is very difficult to come up with a convincing account of who is harmed by bringing to birth a child with Down syndrome or other disabilities. A child is either born with Down syndrome or not at all and we know from speaking to those with Down syndrome that they are as likely as anyone else to value their own lives and to rate their lives as having high quality.[27] Thus, while it is important to respect the autonomy of pregnant people and provide access to testing for Down syndrome in pregnancy, it is difficult to make a case based, that the pressure that is inherent in routine screening for this condition is justified by harm prevention.

Optional Further Reading

- R. Bennett, The Welfare of Future Children: Reproductive Ethics and Disaiblity Screening Chapters 3-5 (Bloomsbury, 2025) [Available as a free PDF open access download on the Bloomsbury site]

Reading on Antinatalism in addition to the content above:

- D. Benatar, Better Never to Have Been: The Harm of Coming into Existence (Oxford University Press, 2008) [available online via University library]
- M. Häyry, 'A rational cure for prereproductive stress syndrome', Journal of Medical Ethics 30 (2004): 377 [available online via University library]

You might also find the following YouTube video interesting:

- Lawrence Anton, 'A New Argument for Antinatalism' featuring Amanda Sukenick and Matti Häyry

Reading on Procreative Beneficence:

- You might find this extract of the course materials from 'Ethics, Genetics and Genomics' on this issue useful – The Principle of Procreative Beneficence

This extract includes recommendations for reading but misses one paper that might also be useful:

- R. Bennett, 'When Intuition Is Not Enough. Why the Principle of Procreative Beneficence Must Work Much Harder to Justify Its Eugenic Vision' Bioethics (2014) 28.9 447–455 [available online via University library]

[27] See, for example, S. Glenn and C. Cunningham, 'Evaluation of self by young people with Down Syndrome', International Journal of Disability, Development and Education 48(2) (2001): 173; G. L. Albrecht and P. J. Devlieger, 'The disability paradox: High quality of life against all odds', Social Science & Medicine (1982) 48(8) (1999): 977–88

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Concluding remarks

As we have seen in this Section it is clear that pregnant individuals 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 individuals are morally obliged to avoid it? How much effort and/or personal risk are they obliged to put into preventing the harm?



A further question remains: should we attempt to transfer these moral obligations pregnant individuals 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 individuals have towards their future children and because we recognise the importance of respecting the autonomy of all individuals, including individuals who are pregnant, 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 a pregnant individual's autonomy. If we are to be able to justify, we must be able to provide a convincing account of this harm and an account of how serious the harm would have to be in order to justify these infringements of autonomy. But, as we have seen, providing this account of the harm done to what might be considered to be future children is not as straightforward as we would first imagine.

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Suggested further reading

- R. Bennett, 'The Acceptability of Routine Testing for Blood-borne Communicable Diseases' in H. Draper and W. Scott (eds.) Ethics in Anaesthesia and Intensive Care: Issues in Contemporary Practice (London: Butterworth, 2003) pp. 205-217 [available as a digitised reading via University library]
- R. Bennett, 'Why we Must Change the Bioethical Terminology around So-Called "Lives Not Worth Living," and "Worthwhile" and "Unworthwhile" Lives' Cambridge Quarterly of Healthcare Ethics (2025) 34(2):173-183 [available online via University library]
- P. de Zuleta and 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 (2007) 33 329-336 [available online via University library]
- L. M. Purdy, 'Are Pregnant Women Fetal Containers?' in Bioethics (1990) 4(4) 273-291 [available online via University library]
- R. Scott, 'Maternal Foetal Conflict' in R.E. Ashcroft, A. Dawson, H. Draper and J.R. McMillan Principles of Health Care Ethics (2nd edn.) (John Wiley & Sons, 2007) pp. 401-407 [ebook available via University library]
- R. Bennett, 'Is there a case for criminalising vertical transmission of Human Immunodeficienty Virus (HIV) from mother to child?' Journal of Medical Law and Ethics, (2013) 1(2) p.121-137 [available online via University library]
- C. 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 University library]
- S. S. Richardson et al. 'Society: Don't blame the mothers' Nature (2014) 512(7513) 131132 [available online via University library]

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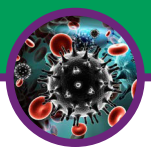

Summary

Autonomy and Pregnancy

- Maternal–fetal conflict arises when the autonomy of a pregnant individual comes into tension with the interests of the future resulting child. This conflict highlights difficult questions about autonomy, harm, moral status, and the extent of parental responsibility.
- Moral obligations toward future children are widely recognised but remain hard to define. While many argue pregnant individuals should avoid behaviours that risk serious harm to a child-to-be, translating such obligations into legal or policy requirements risks undermining autonomy and imposing intrusive forms of regulation.

Compulsory treatment

- English law accepts the principle of respect for individual autonomy, which if taken seriously means that individuals 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 pregnant individual 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 a (pregnant) individual's rights. For instance, contrast forcing a caesarean section in the interests of the child with declining an individual's wish to have a caesarean section in the absence of medical need.

Alcohol use in pregnancy

- 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 individual's autonomy in an attempt to protect future children. One of these examples is calls to screen for alcohol use in pregnancy.

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Summary, continued

- Before we move to infringe the autonomy of pregnant people, it is argued that there must be evidence that doing so will avoid serious harm to future people. It has been argued by Bennett and Bowden that this compelling evidence is not available.

Pregnancy and routine antenatal screening

- It has been argued that routine antenatal screening can also involve an infringement of the pregnant individual'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 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.
- 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 to refuse such tests in pregnancy.
- It is argued that justifying routine screening for Down syndrome based on empowering pregnant people is difficult as evidence points to the routine nature of the screening as a challenge to voluntary informed consent and thus sufficiently autonomous choice.
- It is also argued that justifying routine screening for Down syndrome based on harm prevention is equally problematic given that it is difficult to provide a coherent account of what harm is avoided by avoiding the birth of those with Down syndrome.

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Summary, continued

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 individuals towards their yet-to-be-born children is complicated, because any intervention involves an infringement of the individual'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.

Go to Section 9

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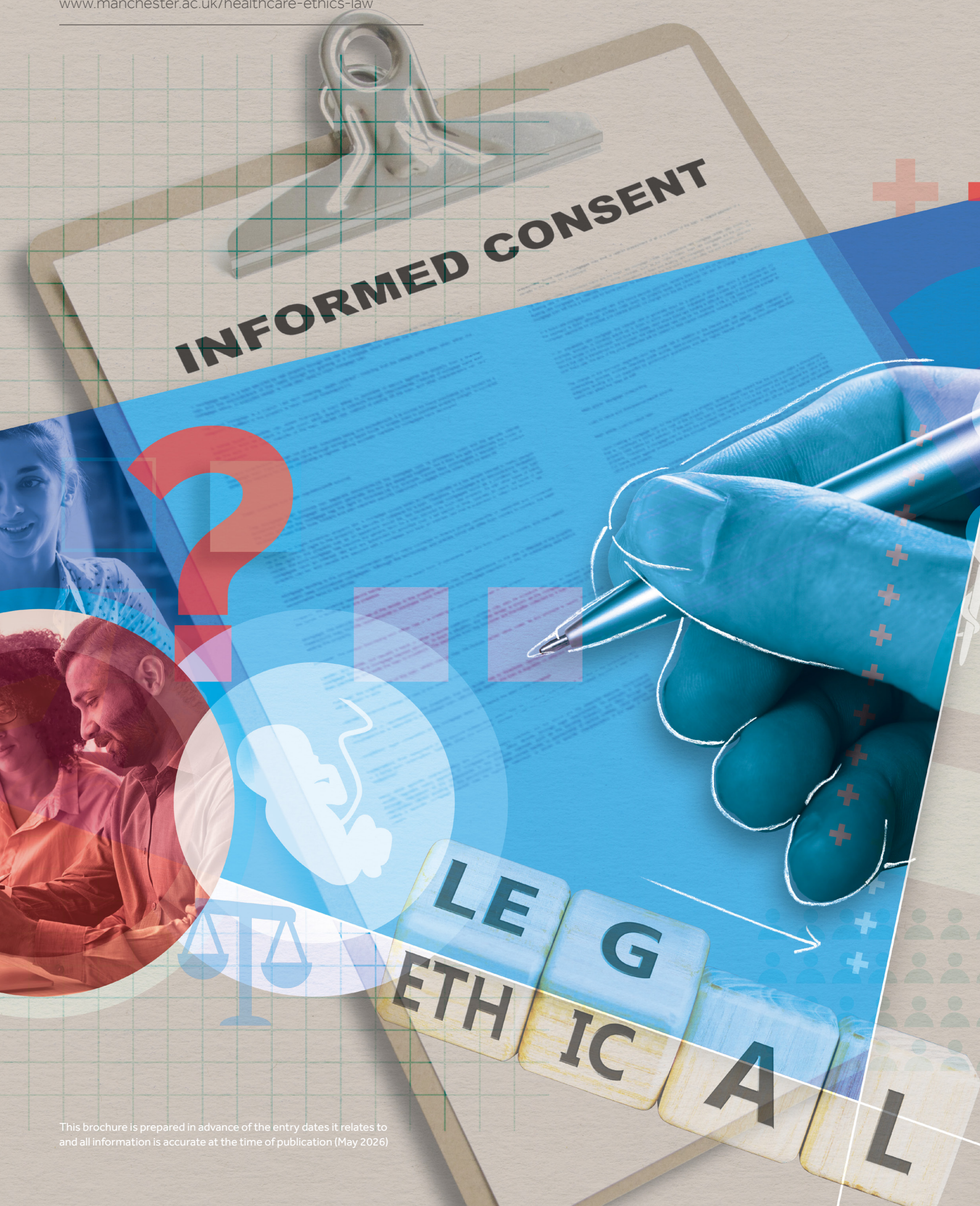

This brochure is prepared in advance of the entry dates it relates to and all information is accurate at the time of publication (May 2026)