Legal and ethical issues regarding-the autonomy of the pregnant woman with special reference to foetal surgery and treatment

Pickworth, Emma Gail Gillian

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Emma Gail Gillian Pickworth

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Department of Social Sciences

CONTENTS

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Abstract

Though the pregnant woman usually wants her foetus to be born a healthy child, and though she usually concurs with the physician as to the best method by which to attain this goal, there are circumstances when their goals and wishes will not concur. Due to the recent 'reproduction revolution', the foetus is now treatable in a multitude of circumstances and is no longer a mysterious entity whose protection lies solely in the hands of God or chance. Therefore, a possible conflict of interests arises between the physician or the government, who may have the interest of the foetus at heart (due to their interest in the sanctity of life) and the pregnant woman, who may have her interest in freedom from unwanted bodily intrusion at heart.

Gerald Dworkin's theory of autonomy is compared to other theories of liberty and autonomy, and is favoured for its legal applicability and then applied to the scenario of the pregnant woman. The thesis aims to legally regulate the conflict of interests recommending that out of a concern for her individual autonomy, the pregnant woman should at no point be forced into unwanted bodily intervention. On the other hand, it is recommended that her right to demand treatment on her own behalf, or on behalf of the foetus should be made subject to governmental control due to the potential of the foetus to become human, and due to its human origins. However, the pregnant woman will still retain some protection due to the inequality with other woman that would otherwise arise.

It is with the most recent technologies that this thesis proves most important, for the possibilities of genetically or cosmetically altering the foetus are increasing, and it is important that the law controls such treatments to prevent the trampling of rights.

Acknowledgements

Thank you, Tom Allen for your help throughout the year.

Declaration of Material Previously Submitted for a Degree

In part fulfilment of my LL.B. at the University of Newcastle-upon-Tyne in 1995, I submitted a dissertation entitled "Foetal Rights; the Need for Compassion". This dissertation covered abortion, wrongful life litigation and infanticide, none of which expressly concern this thesis. However, the LL.B. dissertation did eliminate the need for some of the ground work for this thesis, and some of the abortion commentators referred to there are also considered in this thesis.

INTRODUCTION

Many commentators have deliberated over the ethical status of the foetus[1] and found that the arguments are so subjective as to be futile. Here the status of the woman is concentrated on, for she is an entity which we are more capable of knowing and understanding. As John Eekelaar says:

> "Rather than determining what a woman's duties should be on the basis of whether or not a foetus has rights, it might be more fruitful to inquire what duties social morality requires of the mother (and others) towards the unborn ... by focusing on the mother, not the foetus it becomes possible to relate the choices before her and their effects on her to analogous situations and in this way to construct a coherent moral framework."[2]

However, though it is the status of the pregnant woman that we wish to determine, in the final chapter deliberation on the status of the foetus is added to test and add to the conclusions made about the pregnant woman.

It is not the purpose of this thesis to examine morality and ethics in a vacuum, but rather to consider principles with a view to their application in present English law. It is for this reason that discussion of abortion is largely avoided. Abortion has been discussed many times before and the more recent technological innovations and their impact on the pregnant woman must be considered in order to prepare the law for their common application. The new methods of screening the pregnant woman to diagnose foetal abnormalities and the growing range of treatments that are available for foetal illnesses (be they in the form of maternal diet, drug administration or surgery) are discussed and the new dimensions that they add to the debate over the status of the foetus are considered.

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[1]. Whenever the term 'foetus' is used it shall be taken to include all the stages of embryonic development from implantation in the womb to birth.

[2]. John Eekelaar 'Does a Mother have Legal Duties to her Unborn Child?' in Peter Byrne (ed.) Health, Rights and Resources: King's College Studies 1987-8 (London: Oxford University Press, 1988), 55 at 58.

The above treatments of the foetus are similar in that in order to treat the foetus, the woman must first be touched. As any hostile touching constitutes a battery, the woman's consent must be obtained before they are carried out. However, the recent case of Re S (adult refusal of medical treatment)[3] throws her right to decline that consent into confusion. In Re S a pregnant woman declined to consent to a caesarean section operation which was needed to save both the foetus and herself. A court order was obtained and the operation went ahead regardless of her refusal to consent.

Perhaps it is the recent technological advances, making the foetus more treatable and therefore increasingly perceivable as a patient by the physician[4], that has nurtured the Re S scenario. For there has recently been a reproduction revolution[5] and legal response to the progression has been inadequate. Philosophers have broached the subject, as have legal commentators and theologists and there is no general consensus regarding a solution to the problems created by the revolution.

The technological advances are evident in methods of screening, in prenatal diagnosis, in correction of foetal deformities (from drug therapy to foetal surgery[6]) and in the birthing process. It is important that we view the reproduction revolution in a way that will provide a sound legal basis that is of practical use to society. Some say that philosophical analysis leads us no-where[7]. This is not only defeatist, but is also irresponsible. The law needs to be

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[3]. [1992] 3 WLR 806.

[4]. Whenever the word 'physician' is used, it shall be taken to refer to any member of the health team responsible for the care of pregnant woman and foetus (or of the patient in general).

[5]. See S.L. Barron and D.F. Roberts (eds.) Issues in Fetal Medicine. Proceedings of the 29th Annual Symposium of the Galton Institute, London 1992 (London and New York: Macmillan Press Ltd., 1995).

[6]. For an analysis of the surgical considerations involved in foetal surgery see M.R. Harrison, and S. Adzick 'The Fetus as a Patient: Surgical Considerations' Annals Surgery 213 (March 1991), 277. Michael Harrison pioneered foetal surgery.

[7]. See Patricia King. 'The Judicial Status of the Fetus: A Proposal for Legal Protection of the Unborn' (1979) 77(2) Michigan Law Review 1647. Here King relies on a biological rather than philosophical rationale for protecting the foetus: she believes that the foetus deserves protection once viable.

legitimate in the eyes of the majority and this can only be achieved through valid philosophical appraisal of provisions before they become law. The reproduction revolution must be monitored, confined or expanded by the law and the law must be formulated with due reference to morality and justice.

The pregnant woman has many options regarding detection, correction or termination of her defective foetus. The foetus was once a medical mystery; a part of the woman that could not be controlled. Now, however, we are far better equipped to deal with the variety of events which occur during pregnancy *if* the pregnant woman consents to the procedure in question. The trouble arises when she refuses that consent. She may refuse it out of a desire to injure the baby, but this is in the main part unrealistic[8]. Usually, her reasons for refusing intervention will concern her religious beliefs or her fear of surgeons; in short her primary aim will be to protect the foetus. If her belief is ignorant, should she be forced to undergo the intervention? Perhaps she would even thank the doctor when the baby is saved as a result of that forced intervention. Alternatively, should she be left to decide these issues for herself? How paternalistic should the state be in this area?

Great Britain is democratic and supports a liberal rationale and at present individuals are largely protected from forced medical intervention by the doctrines of informed consent and the remedy of battery. However, there is an ever present danger that the problems arising from the reproduction revolution are remedied in a way similar to that of the United States. There, caesarean section operations have been ordered by the courts against the will of the woman[9], and women have been subject to criminal liabilities for neglect of their unborn children. There are already signs that English law is following the same

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[8]. However, see Lieberman, Mazor, Chaim and Cohen in 'The Foetal Right to Live' Obstetrics and Gynaecology 53 (1979), 515 at 515. They say "It is probable that the patient hopes to be freed in this way (i.e. by refusing intervention) of an undesired pregnancy and in no case will the patient share her secret thought with the physician."

[9]. See V.E. Kolder, J. Gallagher and M.T. Parsons 'Court Ordered Obstetric Interventions' New England Journal of Medicine 316 (1987), 1192; R. Jurrow and R.H. Paul "Caesarean Delivery for Fetal Distress without Maternal Consent" Obstetrics and Gynaecology 63 (1984), 596; and W.A. Bowes and B. Selegested 'Foetal Versus Maternal Rights: Medical and Legal perspectives' Obstetrics and Gynaecology 58 (1981), 209.

course, as was shown in Re S. The aim of the thesis is to show the error of this legal direction and to attempt to recommend a more acceptable course.

This is achieved under the rationale of the autonomy principle. Valuing an individual's autonomy can be roughly equated to valuing an individual's self-determination. This is a principle that has been much used and much abused in the past and has as a result lost favour. It is suggested that the reason for this loss of favour is that the autonomy principle has been blurred. The first chapter comprises a reappraisal of the autonomy principle and sharpens and refines the definition of autonomy enabling its application to the case of the pregnant woman. Much use is made of Gerald Dworkin's theory of autonomy[10] for he recognises that a person need not be totally uninfluenced in order to be autonomous provided that his action is a product of his weighing up of his personal preferences. This theory is compared with other theories and favoured because of its legal applicability and sound philosophical base.

Once the principle of autonomy has been examined, it is applied to the case of the pregnant woman, with regard to the recent technological advances in foetal diagnosis and treatment. It is suggested that autonomy is important enough for us to protect the pregnant woman's absolute right to refuse treatment. In the third chapter, however, I suggest that other values, such as patient well-being and other factors, such as resource allocation, mean that the autonomy principle cannot always be cited in defence of the pregnant woman's right to *demand* treatment for herself or her foetus. The distinction between demanding and refusing treatment is crucial. The intrinsic value of autonomy requires that we respect all competent individual's wishes concerning refusal of treatment even if their own life, or that of the foetus is endangered or lost as a result. However, the third chapter identifies society's interest in the foetus as a potential human being and of human origin. Because of its importance to society, the pregnant

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[10]. Found largely in his book The Theory and Practice of Autonomy (Cambridge and New York: Cambridge University Press, 1988).

woman's right to demand treatment, such as abortion or surgery should only be acquiesced after weighing up the harm caused to woman and foetus.

This is not to say that the woman should always be refused treatment that may harm her foetus. At no point should the woman be refused any treatment that an unpregnant woman would be allowed, hence a woman that would be offered radiotherapy for cancer should not be refused it on the grounds that she is pregnant and her foetus would be harmed. Further, the importance of the foetus will not necessarily outweigh the importance of the health of the woman, and the present abortion laws reflect this factor. However, there will be circumstances when abortion will be refused, or foetal surgery or treatment[11] will be refused on the grounds that the foetus is important to society and so the woman's demands must be limited and her autonomy curtailed. This is particularly apparent with the new technologies.

Hence her right to refuse a caesarean section operation or foetal surgery that will save the foetus (or even her own life) is sacrosanct. This applies whether or not the foetus will be harmed by her refusal; regardless of the expense caused to society by the production of a handicapped child; regardless of the symbolic affect of the death of a viable foetus; and regardless of the economic effect of a refusal to consent that results in more expensive treatment at a later date. However, her right to demand treatment such as screening, surgery or abortion whether it be on behalf of the foetus or on her own behalf can, I submit, legitimately be limited by the state, and indeed must be limited by the state for the good of society.

[11] It is possible to envisage foetal treatment or surgery that is not in the best interests of the foetus as will be seen in chapter three. For example the altering of the cosmetic appearance of the foetus.

1. AUTONOMY

Introduction

The aim of this chapter is to define autonomy and to enable an application of the principle to the case of the pregnant woman. The intention is not merely to deliberate on the moral ambits of autonomy but to derive a legally applicable definition of autonomy for present day England and Wales. The definition of autonomy must be generally applicable, for a definition of a general term that is subject specific is liable to criticism.

To sum up a word such as autonomy one may call it 'self-government' for the etymology of the word implies as much.[1] However, autonomy is far more complicated than this may suggest. It is a term of art and can be divided in many ways: in terms of its application (be it state or individual autonomy) or in terms of its ambits (be it a subjective or objective definition). On the widest level, we use our autonomy to appoint a government that it might take over a part of our autonomy for the good of the whole; a type of agency. On a smaller scale, it is the right of individuals to be free from governmental interference in certain areas of their lives. On the smallest scale it is the right of every individual to choose how to act in a given situation.

Various commentators have worked on the definition of autonomy. These commentators can largely be classified into two groups; those who propose a 'negative liberty' stance, and those who propose a 'positive liberty' stance. Both these groups are examined and rejected in favour of a contemporary theory of autonomy by Gerald Dworkin due to the practical applicability of his theory.

What is an autonomous act? Am I autonomous in my every action because I always have an element of choice? Am I never autonomous because there are always constraints such as the government, my family or my peers fettering my freedom of choice? Is autonomy somewhere in the middle? It may be that there is no correct definition of the term because it is used in such a variety of

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[1]. G. Dworkin The Theory and Practice of Autonomy (Cambridge and New York: Cambridge University Press, 1988) at 108: "The central idea that underlies the concept of autonomy is indicated by the etymology of the term; *autos* (self) *nomos* (rule or law)."

situations. However, it is the aim of this chapter to expound the virtues of Gerald Dworkin's definition and discount the positive and negative liberty standpoints. The definition of autonomy will be used in the following chapters to suggest when and how the pregnant woman's right to refuse treatment and her right to demand treatment should be heeded.

The Difference Between State and Individual Autonomy

It is important to note from the start that it is not only individuals who can be autonomous. So too may the government, thereby limiting the individuals autonomy. However 'state'[2] and 'individual' autonomy are closely related:

> "The autonomous person (like the autonomous state) must not be subject to external interference or control but must, rather freely direct and govern the course of his (or her) own life."[3]

Disparity can clearly be contemplated, for state and individual autonomy will inevitably come into occasional opposition. The state is autonomous if it acts without the control of another state, but it must also remain within the rules set by the people to which it owes its autonomy. In Great Britain there is a democracy, and were that democratic element to be lost the legitimacy of the state autonomy would be called into question.

Protection of the individual's autonomy is also found in the fact that laws are made not merely on political whims, but on the basis of morals. The legal philosopher attempts to aid the creation of laws by debating the rights and wrongs of a given situation. In debating the ambits of 'autonomy', the law can be guided so that it encroaches on the individual's autonomy (or protects that autonomy) to a rational extent. Hence the government will wish to interfere with an individual's autonomy only when it is morally correct to do so. In chapter two, it is proposed that it is unacceptable for the government to interfere with the individual's right to refuse medical treatment, largely due to the importance

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[2]. 'State autonomy' is synonymous with 'governmental autonomy'.

[3]. Robert Young Personal Autonomy: Beyond Negative and Positive Liberty (New York: St. Martin's Press, 1986), 1.

of individual autonomy and in chapter three it is proposed that limiting the individual's right to demand treatment is an acceptable infringement of his autonomy in certain situations.

Positive and Negative Freedom

First, however, the ambits of positive and negative freedom are examined. Rather than defining the ambits of state autonomy, we will look from the other side of the picture, at individual autonomy, for it is the individual pregnant woman with which we are concerned. The commentary on this subject has long been taking place, and not always under the specific name of 'autonomy' which is a relatively new term. Instead, many have referred to 'liberty' or 'freedom' and as it is only recently that autonomy has been separated form these terms, some of the older theories on liberty contribute to the debate. Two themes of liberty run throughout the philosophical thinking. These are termed 'negative liberty' and 'positive liberty'. The former is the view that liberty or freedom constitutes firstly a lack of constraint, and secondly a willingness to consider the options available. The latter view demands much more of an individual before he is to be considered free, or at liberty. Autonomy has to be placed within this debate.

Even though it is proposed that autonomy must be separated from these concepts, it is useful to place the term 'autonomy' in relation to them. It is also clear that liberty and freedom in their own right will be of great importance when defining the limits of the pregnant woman's rights in relation to her foetus.

a) The 'Negative Theory'

The debate that the following commentators are concerned with, is whether freedom is positive or negative; the debate that *we* are concerned with, is whether or not we can separate freedom and autonomy by this very positive / negative distinction, so in fact our purposes are very similar. Hence, the fact that the philosophers debated only the issue of freedom will not preclude us from, firstly drawing conclusions as to the nature of autonomy, and secondly from drawing a distinction between autonomy and freedom.

There are many variations on the negative theory, some of which will be discussed below. As a general definition, however, Milne describes the negative theory in the following terms: "You are free or at liberty to the extent that you are not subject to constraint in the shape of compulsion, coercion or interference by any other human being."[4]

i) J.S. Mill

J.S. Mill worked extensively on the definition of liberty or freedom and is a negative liberty theorist. However, unlike the pure definition that is given in the above section, he embellishes the theory in that he demands certain features of society before he will consider it to comprise of free individuals. For example, he believes that freedom of speech is a necessary constituent.

What constitutes a society of free individuals?

Mill claims that in a civilised society, liberty can only be interfered with in the prevention of harm to others. In other words a person should not be constrained for his own good:

> "The only freedom which deserves the name is that of pursuing our own good in our own way so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are the greater gainers by suffering each other to live as seems good to themselves than by compelling each to live as seems good to the rest."[5]

Therefore, for Mill, a society could not be called free if it were to force a pregnant woman to undergo surgery for the purpose of saving her life, or saving the life of the foetus for the sole reason that the woman would later be grateful, because freedom is incompatible with constraint for the 'good' of an individual.[6]

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[4]. A.J.M. Milne Freedom and Rights (London: George Allen and Unwin Ltd. New York: Humanities Press Inc., 1968), 17.

[5]. J.S. Mill On Liberty (Oxford: Basil Blackwell, 1946).

[6]. See also Sir Isaiah Berlin, page 16.

For Mill, a society is free if that freedom exists in procedural terms. Scanlon defends Mill's view in the following terms:

> "I will defend the Millian principle by showing it to be a consequence of the view that the powers of a state are limited to those that citizens could recognise while still regarding themselves as equal, autonomous, rational agents."[7]

Hence Mill allows constraint only on the grounds of prevention of harm to others. It must be fair constraint organised by the government. Therefore, if we were to decide that the foetus constitutes 'another' then Mill would object to its being harmed for the sake of the woman's freedom. Mill is a utilitarian, in other words he believes in the securing of the greatest amount of happiness among the greatest possible numbers of people, within his definition of freedom.

What constitutes a free individual?

For an individual to be autonomous, Scanlon says:

> "To regard himself as autonomous in the sense I have in mind, a person must see himself as sovereign in deciding what to believe and in weighing competing reasons for action."[8]

And later,

> "What is essential to the person's remaining autonomous is that in any given case his mere recognition that a certain action is required by law does not settle the question of whether he will do it."[9]

Hence, his autonomy is not secured merely by there being a law that grants him freedom in a particular instance. What is needed is an actual freedom of the mind: a questioning of any given fact and acting accordingly. If a person were to

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[7]. Thomas Scanlon "A theory of freedom of expression" (Winter 1972) 1 Philosophy and Public Affairs 215.

[8]. Thomas Scanlon ibid..

[9]. Thomas Scanlon ibid..

act wholly without thinking, he would not be acting autonomously. In this way, the pregnant woman cannot claim to be autonomous merely because she chooses one of the limited options granted by the physician, she must look deeply at her own preferences and decide on a course of action accordingly. To be told that she can choose amniocentesis or merely endure a scan does not make her autonomous in her choice of a scan if she really does not desire either of the screening methods.

ii) Maurice Cranston

Cranston[10] is a negative theorist in the purest form for he believes that any society in which there is wide agreement is considered free, regardless of the political ideals within that society. He does not believe that freedom is best preserved through a total lack of constraint. Instead, he sees it as a society which governs its people according to two considerations (as outlined by Milne[11]):

1. That (constraint) is never used except to enforce obedience to orders and rules which in social contexts have either a pragmatic or substantive justification.
2. That it should be exercised to compel obedience to such rules and orders only when there is a net advantage to the life of the society in doing so.

In short, there must be wide agreement within society for it to be free. Cranston rejects the positive theory on linguistic grounds, believing that the word 'freedom' ought to be construed in a way that it would be used by society, rather than in a specialised manner.

iii) Sir Isaiah Berlin

Berlin,[12] like Cranston, is a contemporary negative theorist, but Milne notes that rather than criticising the positive view on the basis of its linguistic inaccessibility to the populous (as is Cranston's method), he adopts the theoretically more satisfactory standpoint of basing his criticism on substantive

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[10]. Freedom, a New Analysis (London: Longman Green and Co., 1953).

[11]. Milne op. cit., 145.

[12]. Two Concepts of Liberty (Oxford: Clarendon Press, 1958).

grounds.[13] Like Mill, he views lack of governmental interference as constituting greater freedom.

What constitutes a society of free individuals?

According to Berlin, no society is free unless it accords to two interrelated principles:

> "First that no power but only rights can be regarded as absolute so that all men whatever power governs them, have an absolute right to refuse to behave inhumanely; and second that there are frontiers not artificially drawn within which men should be inviolable, these frontiers being defined in terms of rules so long and widely accepted that their observance has entered into the very conception of what it is to be a normal human being and therefore also of what it is to act inhumanely and insanely, rules of which it would be absurd to say for example, that they could be abrogated by some formal procedure on the part of some court of sovereign body."[14]

So men in a free society should be governed only by accepted principles and rules and no rule should demand inhumane behaviour of the individual. Presumably, what is 'inhumane' is for the individual to decide. This principle is recognised in the medical arena, in that physicians may object to courses of action to which they are morally opposed, provided that they refer the patient to another physician. The same could be argued on the behalf of the pregnant woman; that if she feels that a course of treatment is inhumane then she should to able to refuse to take any part in it, and as interference with the foetus inevitably necessitates interference with the woman, she would be able to veto any proposed foetal treatment.[15]

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[13]. Milne op. cit., 32.

[14]. Sir Isaiah Berlin Two Concepts of Liberty op. cit. 54..

[15]. However. there could be difficulties with this line in that the pregnant woman may feel that she is behaving inhumanely if she does not abort the foetus. English laws restrict abortion in certain circumstances for extremely valid reasons. My thesis that there should be a perceived difference between the right to refuse treatment (which is sacrosanct) and the right to demand it (which is limitable by the government) would solve this difficulty.

What constitutes a free individual?

Berlin sees freedom of choice as the key to individual freedom:[16]

> "The world that we encounter in ordinary experience is one in which we are faced with choices between ends equally ultimate, the realisation of some of which must inevitably involve the sacrifice of others. Indeed it is because this is their situation that men place such immense value on the freedom to choose."[17]

He criticises the positive theory for leading too easily to the conclusion that people are not being coerced if they are coerced for their own good. The self, he believes, is not a metaphysical concept: It does not comprise of two elements: the natural side and the rational side. A person, he believes, cannot be split into two in this manner. Such a splitting of the person leads the positive theorists into thinking that if only the rational side of the personality could overcome the natural side, then people would voluntarily do what they are being forced to do. In this way they see such a coerced individual as truly free. Berlin prefers the negative theory because it recognises the individual's ability to choose and the importance of that ability.

b) The 'Positive Theory'

The positive theory demands more of the individual before he is considered free or at liberty. Milne characterises it in the following way: "I wish above all to be conscious of myself as a thinking, willing, active being, bearing responsibility for my choices ...".[18]

i) Green

T.H. Green contrasts:

> "... the man who directs his life on the basis of rational moral convictions with the man who is content to allow his inclinations of the

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[16]. But see chapter two, page 47.

[17]. Berlin ibid., 53.

[18]. Milne op. cit., 36.

> moment and his desire for personal enjoyment to be his guide without considering his personal well-being on the whole or his responsibilities to others. In one sense both are equally free for each is equally the author of his actions and is free from compulsion by others. But in another sense the former is free while the latter is not, for he is at the mercy of his inclinations and desires." [19]

For Green freedom is dependant upon rationality, whereas for the negative theorists the most important factor in freedom is the lack of restraint.[20] Hence only a rational decision by a pregnant woman would be considered a free decision.

ii) Bosanquet

Bernard Bosanquet contends that one is free to the extent that one achieves real selfhood. In its turn, real selfhood is achieved to the extent that one is a rational moral agent. For him, liberty is something to be achieved; we do not start with liberty which is gradually curbed by the state; other individuals are equally adept at reducing the liberty of a man:

> "To become fully ourselves, we must become all that we have in us to be. In order to be ourselves, we must always be becoming something which we are not, liberty as the condition of being ourselves cannot simply be something which we have, still less something which we have always has ... It must be a condition relevant to our continuous struggle to assert the control of something in us which we recognise as imperative upon us or as our true self but which we obey only in a very imperfect degree."[21]

Milne later sums up the positive theory according to Green and Bosanquet in the following manner:

> " ... its central thought may be summed up in the proposition that rational moral conduct, self-realisation, and freedom are co-extensive.

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[19]. See Lectures on the Principles of Political Obligations (London: Longman Green and Co., 1941), 3.

[20]. According to Milne (op. cit., 21), versions of this theory were put forward by Rousseau, Kant and Hegal before Bosanquet restated the theory.

[21]. Bosanquet The Philosophical Theory of the State (London: Macmillan Press, 1951), 118.

> They are different but complementary aspects of a single idea: that of a society devoted to the harmonious development by all its members of their various gifts and capacities."[22]

Milne concedes that the positive theory as argued by Green and Bosanquet heads in the direction of supposing that there is a single way of life in which each of us can become the best we have in us: That there is always a rational way to resolve a conflict. Berlin on the other hand, is of the view that not all human values are compatible: That men must 'choose between ends equally ultimate'. For Berlin, the rational solution is not necessarily a free solution. If a man would have reached a particular decision had he been rational, it is not made a free decision by virtue of that fact. Therefore a man who is coerced, is not a free man, for a man cannot be forced to be free.[23]

Milne recognises the validity of these claims but defends the positive theory from attack by pointing out that Berlin's conclusion is reached by abusing it in taking the positive theory to illogical extremes. "But the fact that a theory can be abused does not of itself show that it is false. People can abuse anything if they have a mind to."[24]

iii) Milne's observations

Milne admires the positive theory, for it includes the negative theory and then adds to it. The pure negative theorists see freedom as comprising only an external side. The positive theory adds to this, also comprehending an internal side to freedom:

> "On its internal side it is the condition of mind and character of the rational moral agent. Such an agent is emancipated from subjection to the natural impulses and inclinations which make up his merely empirical self and is free to become the best that he has it in him to be. But the significance of the external side of freedom is also recognised. What is important is not the absence of external constraint as such but

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[22]. Milne op. cit., 147.

[23]. J.S. Mill represents a similar view. See page 10.

[24]. Milne op. cit. 36. Here Milne acknowledges that Berlin also notes this objection to his conclusion. Milne concludes that more discussion is needed.

> its absence in the form of interference by anyone, with anyone else's rational moral conduct and hence with his self-realisation. This external freedom can be secured by a system of rights maintained by law, and a society in which it is secured is a free society."[25]

In effect, this is to say that "the negative aspect of personal freedom is a by-product of its positive character as self-determination."[26]

Improvements on Green and Bosanquet: Self-Determination

Milne is critical of Green and Bosanquet, for they fail to make a distinction between personal and moral freedom.[27] Milne sees the latter as the more important because if we concentrated on personal freedom morality would be undermined. He is also critical of the fact that Green and Bosanquet fail to recognise that:

> "... at the level of social morality, the rational agent must accept his society's existing way of life uncritically ... His moral freedom is therefore freedom within his society's existing way of life."[28]

He therefore suggests some refinement of their views. His proposed improvement of Green and Bosanquet's positive theory involves the recognition of two forms of self-realisation. To be free, individuals must be self-determining in respect of both their personal and moral freedom. This is achieved by placing the importance of social responsibility and justice over personal well-being. A rational agent at the level of social morality, rather than at the level of personal well being is the most fully free.

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[25]. Milne op. cit., 146.

[26]. Milne op. cit., 148.

[27]. For Milne a person's 'personal freedom' is his own survival. More than this is needed in order to be free, according to Milne. Participation with others is indispensable to us. "But there can be fruitful co-operation only where there is mutual trust. ... It follows that there is a sense in which morality is relevant to rational activity at the level of personal well-being." (Milne op. cit., 151) At the level of social morality, the individual will do his best to promote his personal well-being, but the social morality will take precedence. Self-determination at its highest level involves social morality over personal well being.

[28]. Milne, op. cit., 153.

Self-determination then, is not just a matter for the individual in his personal capacity (as Green and Bosanquet believe), it is also a matter of being a moral agent and being self-determining in that role. In order to be able to carry out such a role, it is necessary that each individual is equal:

> "A society in which some, by virtue of their status as members, enjoy better opportunities than others for becoming morally and personally free, is something less that a free society properly so called."[29]

So for the pure negative theorists, agreement is the only criterion for a free society. No matter what system is used. Green and Bosanquet modify this, as positive theorists, demanding that laws and rights protect the individual's external freedom. A society of free individuals for them must be self-determining. Milne goes further still, and believes that an individual is free only if he is both morally and personally self-determining, which is possible only if each individual is on equal footing. When applied to the scenario of the pregnant woman, ambiguities develop. For example, whether it would mean that the pregnant woman must have equality with other women in order to be free (and hence would not have to suffer forced intervention because no other competent women are so forced) or that the pregnant woman and foetus should be on equal footing so necessitating forced intervention of the woman in order to protect it, is impossible to say. It depends entirely on the perceived moral status of the foetus, which will be looked at in the third chapter. It is largely this ethical ambiguity and its legal inapplicability that makes the theory unacceptable.

Gerald Dworkin: Procedural not Substantive Autonomy

We cannot incorporate autonomy under either the 'negative liberty' or the 'positive liberty' headings. For, what we mean by 'autonomy' must come up to certain specifications. Firstly it must be applicable in England today rather than an ethical consideration. Secondly, autonomy is to be used in a legalistic context. It may be that the positive theory proves too metaphysical to be applicable in a real-life situation.

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[29]. Milne, op. cit., 155.

Gerald Dworkin is a contemporary positive theorist writing in 1988[30] and he refers expressly to 'autonomy' rather than to 'freedom' as a general concept. He cannot be called a negative theorist, because he does not see substantive independence as being necessary for a person to be autonomous, he merely demands that individuals be procedurally free.[31] On the other hand, he does not accord with the positive theorists, because though he believes (contrary to the negative theory) that a person must be able to reflect on his own desires and preferences, he does not believe that they need to satisfy moral criterion as the positive theorists advocate. Dworkin believes that neither the positive nor the negative theory exactly fit the concept of autonomy and therefore modifications must be made. Hence we will examine Dworkin's view of what constitutes individual autonomy and then see how it differs from the liberty theorists.

a) What is Individual Autonomy?

Gerald Dworkin's defines individual autonomy thus:

> "Autonomy is a second-order capacity to reflect critically upon one's first order preferences and desires, and the ability either to identify with these or to change them in light of higher-order preferences and values. By exercising such a capacity we define our nature, give meaning and coherence to our lives, and take responsibility for the kind of person we are."[32]

This is a subjective definition of autonomy. We have first-order desires, second-order desires and perhaps third and forth and so on. Dworkin gives the example of a person who desires to smoke (his first-order desire) and also desires not to have that desire (his second-order desire). In accentuating the difference between first and second-order desires, he delivers us from the mistake of thinking that autonomy merely comprises of a persons wishes. Dworkin believes

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30. G. Dworkin op. cit..

31. The terms 'procedural' and 'substantive independence' will be examined in the section 'Procedural over substantive independence'.

32. G. Dworkin op. cit., 108.

that it is that person's ability to reflect upon his desires that makes him autonomous:

> "It is not the identification or lack of identification that is crucial to being autonomous, but the capacity to raise the question of whether I will identify with or reject the reasons for which I now act."[33]

In the case of the pregnant woman, she may have many first-order desires (such as the desire to smoke, eat unhealthily or not to undergo a hospital birth or foetal surgery) that she rejects in the light of her higher-order preferences (such as the health of the foetus, the health of the future child, the wishes of her family or the general consensus within society).

Though reflection and the ability to change one's first-order desires is necessary for autonomy, Dworkin does not demand that the individual exercises this autonomy in any particular way, and it is here that he differs greatly from Milne, Green and Bosanquet.

It is also here that the distinction between his positive theory and the negative theories can be clearly distinguished. For Mill, Cranston and the other negative theorists, the key is substantive independence. They believe that lack of interference from the government constitutes greater freedom, that laws should not be obeyed without reflection. Wolff, for example, is a negative theorist and says:

> "(t)he autonomous man ... may do what another tells him, but not because he has been told to do it ... By accepting as final the commands of others he forfeits his autonomy."[34]

Dworkin on the other hand lays no importance on substantive freedom;

> "Suppose we have a person who has not been subjected to the kinds of influence - whatever they turn out to be - that interfere with procedural

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[33]. G. Dworkin op. cit., 15.

[34]. R.P. Wolff, In Defence of Anarchism (New York: Harper and Row, 1970), 14.

> independence. Suppose the person wants to conduct his or her life in accordance with the following: Do whatever my mother or my buddies, or my leader or my priest tells me to do. Such a person counts, in my view, as autonomous."[35]

b) Procedural over Substantive Independence

Dworkin separates substantive independence (an autonomy with a particular content) and procedural independence (an actual independence). He says:

> "... there is a tension between autonomy as a purely formal notion (where what one decides for oneself can have any particular content), and autonomy as a substantive notion (where only certain decisions count as retaining autonomy whereas others count as forfeiting it)."[36]

He does so out of a desire to make autonomy compatible with human values such as love, loyalty and commitment. He considers both sides of the argument; that a person who decides to follow every whim of his priest is not autonomous because he is not thinking for himself; is not forming independent judgements about what to do or how to do it. On the other hand, however, it was his decision to follow the whims of his priest so surely he is autonomous in his actions. Dworkin believes that the negative theorists cannot reconcile values such as love, loyalty and commitment with autonomy. This is because they see autonomy as a fixed rationale, with a certain content. For example R.S. Downie and Elizabeth Telfer, say:

> "An autonomous agent must be independent-minded. He must not have to depend on others for being told what he is to think or do ... a person is 'autonomous' to the degree that what he thinks and does cannot be explained without reference to his own activity of mind."[37]

Dworkin, on the other hand, does not believe that a particular content is necessary for a person to be autonomous:

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[35]. G. Dworkin op. cit., 21.

[36]. G. Dworkin op. cit., 12.

[37]. "Autonomy"(1971) 46 Philosophy 301.

> "What is valuable about autonomy is that the commitments and promises a person makes be ones he views as his, as part of the person he wants to be, so that he defines himself via those commitments. But whether they be long-term or short, prima facie or absolute, permanent or temporary, is not what contributes to their value. Though, indeed, there may be good reasons for limiting one's abandonment of substantive independence."[38]

The last sentence is a recognition by Dworkin that substantive independence, though not a necessary constituent of autonomy, still forms part of the picture and that liberty (as defined by Dworkin as recognition of first-order preferences) is important. For Dworkin, independence is a freedom from coercion rather than a freedom from influence, for we are influenced in every action that we undertake. Hence a person can be acting autonomously even if his choice is not independently deduced. The only independence that Dworkin demands is independence in the form of choice; not independence in the form of freedom from all influences. A pregnant woman is not necessarily autonomous merely by making a choice, for she must first follow her personal preferences.[39] However, subject to this, should she choose to follow the advice or even the whim of her doctor or her partner, or any other group, individual or God on the issues of her pregnancy, then for Dworkin, she is still acting autonomously.

Dworkin's view conflicts somewhat with Milne and the other positive theorists examined above. Some of the positive theorists believe that morality is an integral part of autonomy. For these theorists, autonomy involves not only a commitment to personal freedom but that to be truly free morality is necessary. The reasons for this conflict are twofold: Firstly, Dworkin is concerned with individual autonomy rather than what makes a free society: Secondly Dworkin has in mind a certain constraints. He is of the view that a theory of autonomy is satisfactory only is it satisfies various criteria.[40] Thus, amongst others, it must

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[38]. G. Dworkin op. cit., 26.

[39]. Also she may have been coerced, threatened or deceived, the ambits of which will be discussed in the following chapter.

[40]. The following criterion are outlined by G. Dworkin op. cit., 7-12.

be logically consistent with other concepts, empirically possible, ideologically neutral and have judgmental relevance. For Dworkin, his concept of autonomy is not theoretical but practical.

c) Liberty and Autonomy

Dworkin differs from the other positive theorists in that he takes the theory of freedom and divides it. He separates liberty and autonomy. The earlier theorists did not do this, where they see liberty as being of great importance, Dworkin sees autonomy in the same light and reduces the importance of liberty.

Dworkin defines liberty as "roughly, the ability of a person to do what she wants, to have (significant) options that are not closed or made less eligible by the actions of other agents."[41] Autonomy, on the other hand, he sees as the power of self-determination. The two are different, he claims because only coercion and force can interfere with liberty, but to interfere with autonomy, deception will also suffice. Dworkin cites an example, to aid this distinction, that was originally provided by John Locke. A person is put into a police cell and told that it is locked when in reality it is not locked. The man does not move because he believes that he is locked in the room. His freedom is uncompromised, but, according to Locke and to Dworkin, his autonomy is violated. For Dworkin, liberty is concerned with first-order desires whereas autonomy is the ability to use the first-order desires together with higher-order desires. To define what is truly free, he believes that the second-order desires must not be ignored.

Hence his view is positive, or subjective, because he believes that autonomy is internal as well as external. It is a condition of the mind rather than just a condition imposed on the mind. Dworkin defends what he calls a 'rather weak' definition of autonomy in that it has no particular content, however, the positive or subjective theory lies within:

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[41]. G. Dworkin op. cit., 14.

> "... it is only through a more adequate understanding of notions such as tradition, authority, commitment and loyalty, and the forms of human community in which these have their roots; that we shall be able to develop a conception of autonomy free from paradox and worthy of admiration."[42]

However, unlike Bosanquet, he does not see rationality as the key to autonomy; it is not, he claims, necessary to be a rational moral agent. Milne, on the other hand, emphasises the need for moral as well as personal freedom and that a free person must be self-determining in both respects in order to be free.

i) Self-determinism

Dworkin aims to avoid the difficulties that arise out of a reliance on a strict interpretation of the term self-determination. The main difficulty with the concept is as follows:

> "In all three areas - moral, political, social - we find that the is a notion of the self which is to be respected, left unmanipulated, and which is, in certain ways, independent and self-determining. But we find certain tensions and paradoxes. If the notion of self-determination is given a very strong definition - the unchosen chooser, the uninfluenced influencer - then it seems as if autonomy is impossible. We know that all individuals have a history. They develop socially and psychologically in a given environment with a set of biological endowments. They mature slowly and are, therefore, heavily influenced by parents, peers, and culture. How, then, can we talk of self-determination?"[43]

Dworkin defends the usage of the term self-determination, but only in its moderate form. If taken to the limits of its definition it could be argued that we are never self-determining because we are always influenced by our society. Self-determination must therefore be used to refer to decisions that are made by the individual because he uses his capacity for choice. This ties in with his preference for procedural over substantive independence. He sees independence as comprising freedom from coercion and not freedom from all influence.

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[42]. G. Dworkin, op. cit., 47.

[43]. G. Dworkin op. cit., 12.

Similarly, he believes that an individual can be self-determining even though his view is inevitably shaped by society. Unlike Milne, Dworkin does not claim that an autonomous individual must be morally self-determining as well as personally self-determining.

Conclusion

The aim is to find a theory of autonomy which can be of use to the legal philosophers who propose laws on the restricting of that freedom. It is on this point that the concept of rationality and social morality must be kept out of a theory of individual autonomy (thought there is relevance to state autonomy). The freedom of a person must depend on his own mind not on the minds that decide what is and is not rational or moral. On the other hand, the theory must not demand substantive freedom. If I decide to follow the instructions of my doctor I must be considered autonomous in that decision in the same way that if I decide to play tennis with a friend tomorrow, and then feel I must honour that obligation to the friend, I will be autonomous in my decision to play tennis.

No decision is totally independent. If we felt no obligation to any person, not even to our-selves, would we truly starve in the same way as the donkey placed between two equally tasty bales of hay? It is almost impossible to fathom, because in this world; in this society, we live with others. We are not only an entity alone, but a part of the whole. Few decisions could ever be made without considering its effects on those other than our selves. But we can still be autonomous in our decision if first we are not coerced or forced and second if we personally make the decision, regardless at why it is reached.

Harvey Teff notes that patients primarily want to get well, and self-determination is less important to them than good communication with the doctor, or 'collaborative autonomy' as he calls it.[44] Such a view is not so greatly removed from Dworkins' as may seem to be the case, for Dworkin's procedural independence allows reliance and collaboration with others. In the next chapter, this concept of autonomy will be applied to the medical context,

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[44]. Harvey Teff Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship (Oxford: Clarendon Press, 1994), xxvii.

and more particularly to the case of the pregnant woman, affirming the importance of autonomy as Dworkin has defined it.

2: THE PREGNANT WOMAN'S RIGHT TO REFUSE TREATMENT

Introduction

The various definitions of autonomy have been examined it has been decided that neither the negative nor the positive liberty view are suitable. It is contended that Dworkin's model of autonomy combines the better aspects of the two views and then adds to them, hence separating the terms liberty and autonomy.

The purpose of this chapter is to apply Dworkin's definition of autonomy to the case of the pregnant woman and her right to refuse treatment.[1] This will involve looking at standard practice, and at how the courts have dealt with contentious areas. The proposition that autonomy is hard to protect is examined, as is the relationship between autonomy and choice. Following this, other claims are considered that may outweigh the claim to autonomy, such as patient welfare, or the principle of paternalism.

Note also that it is the right of the woman to *refuse* treatment rather than her right to demand it that concerns us. The pregnant woman's right to demand treatment is considered in the third chapter. Support will be given to the thesis that it is ethical to limit the autonomy of the pregnant woman by limiting her right to demand treatment, but not to do so by limiting her right to refuse treatment. Hence the chapter will consider first the courts' treatment of the pregnant woman and her right to refuse treatment with special reference to the doctrine of informed consent and the landmark case, Re S [2]. This will be followed by an examination of the relationship between choice and autonomy and finally by challenges to patient autonomy such as patient welfare goals.

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[1]. Treatment that affects the foetus.

[2]. Re S (adult: refusal of medical treatment) [1992] 3 W.L.R. 806 (Hereafter Re S).

The English Courts and the Right to Refuse Treatment

a) Consent

In English law, the competent patient must consent to any treatment proposed by the physician before treatment can commence.[3] Any physical force applied by the physician without consent constitutes a battery in English tort and criminal law. Failure to adequately inform a patient can lead to a successful negligence claim.[4] The consent doctrine may be specifically referred to as 'informed consent', 'voluntary consent' or 'real consent' (though 'informed consent' is the usual name given to the doctrine and the one that shall be used from here onwards) and each varies. However, there are collectively two sides to the doctrine; the first is that of ensuring that the patient freely consents; and the second is that of ensuring that the patient has sufficient information with which to make the decision.

The information a patient needs differs according to the nature of the individual and his illness. Because of this, it is hard for the courts to ensure that patients are sufficiently informed. On the other hand, the courts do concern themselves with disclosure (or lack of disclosure) of risks to the patient,[5] though this does not specifically concern this debate and shall be circumvented. Instead, the debate will follow the legal dilemmas surrounding the actual consent, such as whether or not consent was actually given and when the courts should ignore the requirement of consent and order the physician to proceed with treatment regardless.

There are various exceptions to the rule that a patient must consent to treatment, such as emergencies (where the patient is presented to the physician in a state whereby he is unable to give consent due to the severity of his condition), the therapeutic privilege (where the physician misrepresents the information to the patient in order to avoid excessive harm) and age or mental

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[3]. Subject to the exceptions noted in this section.

[4]. The test for negligence is outlined in Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582, especially at 586 where the 'reasonable doctor' test is outlined.

[5]. See Sidaway v. the Board of Governors of Bethlem Royal Hospital and Maudsley Hospital [1986] W.L.R. 480.

illness (where the physician or the state act on behalf of an incompetent patient). In these cases the welfare of the patient is said to overcome his interest in self-determination and the requirement of consent is waived. However, for the purposes of this thesis it shall be assumed that the pregnant woman is competent[6] and able to give consent.

In most medical areas there is little question of the right to refuse treatment, however, problems do arise when an individual's life is at stake, because the government has an interest in the sanctity of life. Hence a patient who refuses treatment that would save his life, or a woman who refuses treatment that would save the life of her foetus, present a particularly great dilemma. In a sense, there is less of a dilemma in the case of the patient who refuses treatment that would save his own life because he is harming no-one else by his action. The pregnant woman on the other hand, is harming an entity that is arguably separate from herself. Also the recent technological advances in foetal surgery and treatment have made the foetus much more treatable. Though most women will welcome any intervention that may save or aid her foetus, some inevitably will not and this chapter suggests a rationale for their protection.[7]

b) The Rationale Behind Informed Consent

The primary rationale behind the doctrine of informed consent is autonomy, though privacy and liberty also play a large part. It is suggested there is a place for autonomy (as Dworkin defined it) as a competent patient's right to grant or refuse consent in every aspect of medicine, including the scenario of the pregnant woman.

i) Autonomy

The protection of an individual's liberty is considered by many commentators to be of extreme importance, and indeed, liberty is protected by the consent requirement. For Hobbes and Mill, lack of interference with an individual's

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[6]. Though at page 45 the definition and application of incompetence is considered.

[7]. See Katherine Knopoff 'Can a Pregnant Woman Morally Refuse Fetal Surgery?' (1991) 79 Californian Law Review 499, who answers her question in the affirmative.

options enhances his liberty, which is regarded as important in order to prevent men turning into 'industrial sheep'.[8] For Rousseau and Green, on the other hand, more than a mere lack of interference is involved; for them there must be a presence of a range of alternatives and opportunities.[9] Always, however, the key lies in being able to *act out* one's preferences.

However, as is noted in the first chapter, autonomy goes further than liberty. Though interfering with one's liberty usually involves interfering with one's autonomy, the opposite does not always apply. In cases of deception, as Dworkin points out, the individual's autonomy can be lost without reducing his liberty.[10] Dworkin believes that autonomy rather than liberty or even privacy underlies the doctrine of consent, though he recognises that these concepts do influence the doctrine. Mason and McCall Smith in their Medico-Legal Encyclopaedia also place the concept of autonomy at the heart of the doctrine of informed consent:

> "The concept of autonomy can be seen as regulating the doctor / patient relationship. On the one hand the doctor has the power to choose whether he will take part in a particular treatment and, on the other, the prerogative of the patient must, in the modern moral climate, be to retain the right to decide what is to be done with his body. Autonomy is therefore at the heart of the doctrine of informed consent."[11]

Hence, the patient's right to give or refuse informed consent is largely derived from a respect for autonomy. One reason for this is outlined in the dictum of Lord Goff in Collins v. Willcock: "The fundamental principle, plain and incontestable, is that every person's body is inviolate."[12]

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[8]. See Mill and Tocqueville in Lukes, Individualism, (Oxford: Basil Blackwell, 1973), 56.

[9]. See G. Dworkin, The Theory and Practice of Autonomy (from the Cambridge Studies in Philosophy range) (Cambridge, New York and Melbourne: Cambridge University Press, 1988), 105.

[10]. See chapter one, page 23.

[11]. J.K. Mason and R.A. McCall-Smith, Medico-Legal Encyclopaedia (London: Butterworths, 1987), 52.

[12]. [1984] 3 All E.R. 374 at 378.

ii) Privacy

Privacy, on the other hand, involves the following scenario:

> "A private existence within a public world, an area within which the individual is or should be left alone by others and able to do and think whatever he chooses - to pursue his own good in his own way, as Mill puts it."[13]

This notion of privacy is, perhaps, too closely related to autonomy. Gerald Dworkin makes a sharper distinction between the two:

> "[Privacy] is intimately linked with the idea of being scrutinised by others ... Thus, typical interference's with privacy include observations of our bodies, behaviour, and interactions with others. The more control we have over ourselves, the more privacy we maintain."[14]

According to Dworkin, the main distinction between the two is as follows:

> "(With autonomy) what is controlled is the information coming to you, not the information coming from you. I do not know something about you that you might wish to conceal. I conceal something from you that you might wish to know. Thus, autonomy but not privacy is diminished."[15]

Hence the pregnant woman suffers an invasion of her privacy when she is put under observation against her will, or forced to answer certain questions.

A more subtle invasion of privacy is noted by B.A. Lawrence Beech, who believes that the routine hospitalisation of the pregnant woman (to give birth) is largely to make the job easier for the physician rather than to protect the woman and her baby.[16] This may constitute unnecessary observation and therefore an invasion of privacy, and Beech claims that it may result in post-natal depression, or even in the woman avoiding future pregnancies (or facing them with trepidation). Caroline Whitbeck feels similarly regarding pre-natal screening.

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[13]. Lukes, op. cit. 59.

[14]. G. Dworkin, op. cit. 103.

[15]. G. Dworkin, op. cit. 104.

[16]. 'Women's Views of Childbirth' in Chard and Richards (eds.) Obstetrics in the 1990s: Current Controversies (Oxford: Mac Keith Press, 1992), 153.

Though she notes the value of the technique, she claims that its over-use has a negative effect on pregnant women.[17]

Others go even further in their claims that the privacy of pregnant women is under assault. Barbara Katz Rothman claims that pregnant women are being treated as marketable products.[18] As the pregnant woman is de-humanised, she is scrutinised in order to protect the foetus and her privacy is disregarded. Tabitha Powledge takes a similar view contending that commercialised surrogacy is damaging in that it de-humanises the woman.[19] Elaine Hoffman Baruch claims that the new technologies increase the likelihood of intervention which in turn appeases men's envy of women's reproductive powers.[20] Baruch believes that there will soon come a time when the birthing process can be taken out of the woman's body altogether. Should this prove to be the case (as seems likely with recent technological interventions and news reports), then the woman's privacy could still be said to suffer because something (pregnancy) that was private to her would no longer be so.

These invasions of privacy may also invade the autonomy of the woman. For her self-determination may be unduly swayed by norms which, upon closer examination, should not be accepted. Hence, the patient may consent to screening or to hospitalisation out of a misconceived appreciation of the risks, and hence the decision to consent could be said to be misinformed. However, the solution to this reduction of autonomy is unclear, for the disadvantages that Beech and Whitbeck speak of are frequently offset by the advantages offered by the new technologies. Further, it is not at all clear that the time saved by such

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17. 'Fetal Imaging and Fetal Monitoring: Finding the Issues' in E. Hoffman Baruch, A.F. D'Adamo and J. Seager (eds.), Embryo Ethics and Women's Rights: Exploring the New Reproductive Technologies (New York and London: Harrington Park Press Inc., 1988), 47 (hereafter Hoffman Baruch). See also G.R. Dunstan 'Calming or Harming? The Ethics of Screening for Fetal Defects' in S.L. Barron and D.F. Roberts (eds.) Issues in Fetal Medicine, Proceedings of the 29th Annual Symposium of the Galton Institute: London 1992 (London and New York: Macmillan Press, 1995), at 134 (hereafter Barron and Roberts).

18. 'Reproductive Technology and the Commodification of Life' in Hoffman Baruch, op. cit. 96.

19. 'Reproductive Technologies and the Bottom Line', in Hoffman Baruch, op. cit., 203.

20. 'A womb of His Own', in Hoffman Baruch, op. cit., 135.

routine is not a necessity in our health system where resources are far from unlimited. However, bad effects can be limited by ensuring that screening is followed up with good after care especially where an abnormality is found and foetal surgery, treatment or abortion options need to be considered.[21] Therefore, though the pregnant woman should never be legally forced into such medical treatment, it may be acceptable that the physician advises such a course of action in the interests of pregnant women as a group.

c) Is the Foetus Viewed as a Patient in Medicine?

The challenge to the pregnant woman's autonomy lies in the fact that she carries a foetus which (it shall be assumed) deserves a certain measure of protection, due to its human origins and potential human status.[22] It could be argued that the pregnant woman should not have the power to refuse treatment that would benefit the foetus, because the foetus can now be medically viewed as a patient. Because the foetus is becoming increasingly medically controllable and methods of screening the pregnant woman (including ultrasound, amniocentesis and chorionic villus sampling) are now possible to discover abnormalities of the foetus[23], the foetus is becoming humanised. Before ultrasound, an abnormal foetus could rarely be detected. Now, not only can a physician detect abnormalities, but he can occasionally offer various therapeutic, medicinal and surgical remedies, including (if, indeed, this can be called a remedy) termination of the foetus. These treatments differ from post-natal treatments in that they necessarily affect the pregnant woman. There has been a gradual change of terminology with the onset of these new technologies in that there is sometimes not only considered to be one patient, but two. This is especially true in the United States of America where Michael Harrison and his team at the University of California have pioneered the work on foetal surgery. He specifically refers to

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[21]. See W.R. Barclay, R.A. McCormick, J.B. Sidbury, M. Michejda and G.D. Hodgen 'The Ethics of In Utero Surgery' Journal of the American Medical Association 246 (1981), 1550 at 1551.

[22]. This assumption will be tested in chapter three.

[23]. Ultrasound emerged in the late 1970s and amniocentesis and chorionic villus sampling are only now becoming widely used.

the foetus as a patient.[24] When the physician treats an entity, he is attempting to make it well and it can therefore be seen as a patient. In the case of the foetus, the physician considers not only the welfare of the woman, but also that of the foetus. Still, it may not be true that woman and foetus deserve equal protection. The physician would perhaps feel duty bound to prevent unnecessary pain to the foetus (if it actually feels pain at the relevant point in gestation), but it would be a mistake to demand that the woman's informed consent be overlooked whenever the foetus is in need of attention. This is largely because of the ill-effects that would result to the pregnant woman from a denial of the opportunity to consent, for this would necessitate coercion of the woman. It should be clear that such coercion would be vastly at odds with the respect for autonomy that has been outlined in chapter one.[25] However, it is equally true that the physician should never be forced to carry out procedures to which he is morally opposed. Instead he should refer the patient to another physician.

As the techniques improve and more protection can be offered to the foetus, so too must the guidance to the physician be increased.[26] He must be made aware of the danger of treating the woman and foetus as legal equals, and the woman's informed consent must not be subjugated. But equally, he must be made aware that some measure of protection must be given to the foetus and that a woman's request for treatment must not be heeded without careful consideration. Again the distinction between the woman's right to refuse treatment and to demand treatment, is crucial. The latter may be tempered whereas the former must be respected provided that the pregnant woman is competent. Such legal certainty would help the physician's position considerably.

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[24]. See 'The Foetus as a Patient' Annals Surgery, 213 (March 1991), 279.

[25]. For an ethical perspective on this issue see Anne Gilmore 'Is the Fetus a Patient?' Canadian Medical Association Journal 128 (1982), 1472.

[26]. See S.L. Barron 'The Changing Status of the Fetus' in Barron and Roberts op. cit., 1 for an overview of the historical changes in our perception of the foetus and its effects on the treatment of the pregnant woman.

In English law, the woman's individual autonomy is protected in that the foetus has no civil legal personality (according to Re F (in utero)[27]). In Re F, the Court of Appeal decided that the court has no jurisdiction to make an unborn child a ward of court. This was the sole question put to the court. However, the dictum of the judges shows that some sympathy for the Local Authority's cause exists. The Local Authority wished to make the foetus a ward of court because the mother already had one son in care (with adoption proceedings initiated) and had disappeared. Lord May offered the following view, *obiter*:

> "On these facts... I have no doubt myself that if the court had the power I would give leave to issue the necessary originating summons and make the unborn child a ward of court."[28]

The court, however, felt bound by Paton v. Trustees of BPAS[29] where the pregnant woman's husband was refused his claim to prevent the abortion of the foetus due to a lack of *locus standi* and C v. S[30] where, again, the father was said to have no *locus standi* because the foetal rights crystallise at birth and not before.

In Re F however, Lord Balcombe, contrary to Lord May feared the consequences of allowing the claim (having recognised that it could not proceed on the authorities). He said:

> "Approaching the question as one of principle, in my judgement there is not jurisdiction to make an unborn child a ward of court. Since an unborn child has, ex hypothesis, no existence independent of its mother, the only purpose of extending the jurisdiction to include a foetus is to enable the mother's actions to be controlled."[31]

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[27]. [1988] 2 All E.R. 193, reaffirmed in Rance v. Mid Downs Health Authority [1991] 1 All E.R. 801.

[28]. Re F (in utero) op. cit., 194.

[29]. [1978] 2 All E.R. 989.

[30]. [1987] 1 All E.R. 1230.

[31]. Re F (In utero) op cit., 200.

Lord Balcombe then went on to quote Lowe on the dangers of such a concession:

> "It would mean for example, that the mother would be unable to leave the jurisdiction without the court's consent. The court being charged to protect the foetus' welfare would surely have to order the mother to stop smoking, imbibing alcohol and indeed any activity which might be hazardous to the child. Taking it to the extreme were the court to be faced with saving the baby's life or the mother's it would surely have to protect the baby's."[32]

In other words, over zealous protection of the foetus, despite its values, would create such a deficit of the pregnant woman's autonomy so as to be not only unproductive, but positively harmful. Derek Morgan recognises that both the 'Slippery Slope' argument and the consideration of 'Therapeutic Conflict' between the parties lay behind Lord Balcombe's argument.[33]

The physicians face a complicated scenario. On the one hand, the courts deny that the foetus has a legal personality, but on the other hand, the new technologies provide the physician with a means by which to protect the foetus. The law has simplified this slightly by conferring a duty of care upon the physicians (to be owed to the foetus), should it survive for 48 hours. However, Re S[34] has recently confused the physicians duty to the foetus and woman respectively.

d) Re S

As already mentioned, the consent issue rather than the information the woman receives forms the centre of this debate. The ethical divergences of this contentious area are evidenced in the confusions at court. The courts are inconsistent in their affirmation of patient autonomy, they seem to see autonomy

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[32] Lowe, 'Wardship and Abortion Prevention - Further Observations' (1980) 96 Law Quarterly Review 29 at 30. As referred to by Balcombe LJ in Re F (in utero) op. cit., at 200.

[33]. 'Judges on Delivery: Change, Continuity and regulation in Obstetric Practice' in T. Chard and M.P.M. Richards (eds.) Obstetrics in the 1990s: Current Controversies (Oxford and New York: Mac Keith Press, 1992), 24 - 43, at 28.

[34]. Re S op. cit..

as an all or nothing doctrine, as opposed to the definition proposed by G. Dworkin.

The courts face situations where the woman's wishes clash with the physician's view of the welfare of the foetus (and / or the welfare of the woman herself), and seem unable to resolve the situation in the face of the ethical tensions. As yet, there has not been a case where the pregnant woman is forced to undergo foetal surgery, for the technique is not yet sufficiently advanced. However, there have been cases of forced treatment for the sake for the foetus, which set an unwelcome and dangerous precedent.

In England, it has been deemed that a capable adult may refuse treatment, even if his health, or indeed his life, will decline as a result.[35] Hence in Airedale National Health Service Trust v. Bland, Lord Keith said (*obiter*):

> "... it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent: In Re F (Mental Patient: Sterilisation) [1990] 2 AC 1. Such a person is completely at liberty to decline to undergo treatment, even is the result of his doing so will be that he will die."[36]

However in Re T[37] this principle was thrown into some confusion. The facts of Re T are useful in order to shed a light on the later Re S. In Re T the pregnant T was injured in a car crash. T's parents were separated, and T's mother, a Jehovah's Witness, had brought T up having promised not to raise her as a Jehovah's Witness (largely because the father was not of that religious persuasion). T retained some of the beliefs of the sect, though she was not a practising Jehovah's Witness.

In the early stages of her hospitalisation, T, after being alone with her mother, informed the medical staff that she did not want a blood transfusion.

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[35]. For medical case examples and analysis see S. Finfer, S. Howell, J. Miller, K. Willett and J. Wilson-MacDonald 'Managing Patients who Refuse Blood Transfusions: an Ethical Dilemma' British Medical Journal 308 (May 1994), 1423.

[36]. [1993] 1 All ER 821, at 860. See Elizabeth Roberts 'Re C and the boundaries of autonomy' (1994) 10 Professional Negligence 98-101.

[37]. Re T (adult: refusal of medical treatment) [1992] 4 All E.R. 649 (Hereafter Re T).

The staff told her that it was extremely unlikely that she would need one, and that there were limited alternatives to a transfusion in any event, following which, T signed a form withholding consent. Though T was pregnant upon entry to hospital, her baby was stillborn, hence the issue was not about the protection of the foetus, but about T's consent. In the first hearing it was held that a transfusion was permissible because it was in T's best interests. In the second hearing it was held that the transfusion was permissible because T had neither consented nor refused the treatment. At the final hearing it was held that T had been competent to withhold consent, but that firstly her mother had unduly influenced her decision and secondly, the staff had not adequately explained that her life could depend on the transfusion (as indeed turned out to be the case). Hence the transfusion was permissible despite the lack of consent. It seems that the court was anxious to find a way, by whatever possible means, to justify the transfusion. Because there was ambiguity in T's affirmation that death was preferable to a blood transfusion, society's interest in preserving life superseded the individual interest in autonomy.

However, in the case of the pregnant woman, the case is more complicated still, for her refusal to consent to treatment may harm not only herself, but her foetus. In the 1992 case Re S, despite the legal precedents affirming that the foetus has no civil legal personality, the courts favoured a forced Caesarean operation.

In Re S both woman and foetus were fated to die (according to the testimony of the surgeon) unless the Caesarean was hurriedly performed, for the baby was well overdue. S refused the operation on religious grounds (she was a 'Born Again Christian') but the High Court judge, Sir Stephen Brown, in a 20 minute hearing (for time was of the essence) ordered the Caesarean regardless. The matter had been left open by the dictum of Lord Donaldson MR in Re T, which he quoted in his judgement:

> "An adult patient who ... suffers from no mental incapacity has an absolute right to ... refuse [treatment]. ... The only possible qualification is a case in which the choice may lead to the death of a viable foetus ... when ... the courts will be faced with a novel problem of considerable legal and ethical complexity ... This right of choice is

> not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."[38]

In other words, Lord Donaldson expressly contemplated the Re S situation. Harvey Teff denies the possibility that Lord Donaldson justified such intervention merely to prevent injury to the pregnant woman, and contends that the protection of the foetus was the all important element in Re S[39]. This, he notes, raises the objection that the conferral of judicial status of the foetus was expressly denied in Paton v. BPAS[40], Re F (in Utero)[41], C v. S[42] and Rance v. Mid Downs Health Authority[43].

Re S is an undesirable decision in that it implies that the foetus has a judicial status which binding decisions prohibit. Further, it makes a distinction between pregnant women and all other patients,[44] though pregnant women surely deserve protection of their religious and cultural ideals as much as any other citizen.[45] Also, as Harvey Teff notes "The lack of a clearly delineated

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[38]. Re T op. cit., 786.

[39]. Harvey Teff Reasonable Care: Legal Perspectives on Doctor-Patient Relationship (Oxford: Clarendon Press, 1994) (Hereafter Teff, Reasonable Care), says: "It therefore appears that in Re S the judge must have seen the interests of the unborn child as determinative ... the terms of the declaration authorising the operation referred to it as being 'in the vital interests of the patient and the unborn child she is carrying.' (Re T op. cit., 807)". Teff, Reasonable Care op. cit., 154.

[40]. [1979] Q.B. 276.

[41]. Re F (in utero) op. cit..

[42]. [1989] Q.B. 135.

[43]. [1991] 1 All E.R. 801.

[44]. Though Re T is also disturbing in this area.

[45]. The religious persuasion of an individual can effect his views concerning the foetus. For example, Jakobovits 'Respect for Life: Embryonic Considerations', in D.R. Bromham, M.E. Dalton, J.C. Jackson and P.J.R. Millican (eds.), Ethics in Reproductive Medicine (London, Berlin, New York: Springer-Verlag, 1992), 47, speaks from the Jewish perspective, contending that although the foetus is not a human, it deserves very stringent protection. He believes that even the destruction of potential life is a sin.

Another often cited perspective is that of the Roman Catholic Church, who claim that there is a gradual importation of the soul. The important factor is therefore that the process is left in God's hands and is not subject to harmful interference by man (rather than arguments as to humanness). See R.D. Lawler 'Moral Reflections on the New Technologies: A Catholic Analysis', in E. Hoffman Baruch, op. cit., 167.

approach, however understandable, could in theory facilitate coerced medical treatment in less drastic circumstances."[46] This criticism was noted by Derek Morgan:

> "There is no slippery slope more perilous than that which is falsely supposed not to be slippery ... if enforced medical regimes are countenanced, the occasionally perceived need for non-therapeutic Caesarean section, hospital detention or inter uterine transfer might trigger demands for court ordered prenatal screening, fetal surgery and restriction on diet, athletic and sexual recreations of pregnant women. ... If non-consensual Caesarean can be described as doing the mother no harm then it is difficult to imagine how the possible interventions could be refused."[47]

Morgan also notes that the position of the putative father could arguably have changed since Re S. He advises that:

> "... the price which we must be prepared to pay for protecting the integrity and autonomy of all competent adults is the rare, occasional risk of death or serious injury to an unborn fetus or to the woman herself."[48]

This is clearly not the view of the judge in Re S, for as Harvey Teff says:

> "That the courts are reluctant to take the legal implications of patient autonomy to their logical conclusions, even as regards adult patients who are not deemed incompetent, was graphically demonstrated in Re S."[49]

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[46]. Teff, Reasonable Care op. cit., 155.

[47]. Derek Morgan 'Whatever happened to consent?' 142 New Law Journal (1992), 1448, at 1448.

[48]. Derek Morgan ibid..

[49]. Teff Reasonable Care op. cit., 153.

What is also questionable about Re S, is its application of the United States decision Re A.C.[50]. In Re A.C., A.C. had a relapse of cancer whilst pregnant. The hospital decided that a Caesarean section was needed to save the foetus when her condition became terminal and refused to treat the cancer for fear of injuring the foetus. A court order was sought in order to carry out the Caesarean, and granted despite the fact that the operation would probably kill A.C.. A.C. was resuscitated and told of the impending operation whereupon she refused consent and her parents appealed against the decision, but the appeal was dismissed. The baby was delivered by Caesarean and tragically soon died. A.C. died two days later, partly as a result of the operation. The parents sued the hospital and the Court of Appeal held that the judge at first instance had erred.

> "... in virtually all cases the question of what is to be done is to be decided by the patient - the pregnant woman- on behalf of herself and the fetus. If the patient is incompetent or otherwise unable to give an informed consent to a proposed course of medical treatment, then her decision must be ascertained through the procedure known as substituted judgement. Because the trial court did not follow that procedure, we vacate its order and remand the case for further proceedings."[51]

In Re A.C., A.C. was incompetent and the trial judge followed the wrong procedure according to the American law on incompetence. It is hard indeed to comprehend how Sir Steven Brown in Re S thought that Re A.C. was a precedent for forced intervention.

Barbara Hewson concludes of Re S:

> "Re S flies in the face of Re F [in utero]. It has all the features which in Re AC militated against forcible intervention: powerful arguments for upholding a competent patient's decision not to undergo surgical procedure for another's benefit, or her own; civil liabilities and public policy arguments; no effective legal or medical representation for the patient; impossibility of enforcement; failure by counsel and judge to

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[50]. 533 A. 2d 611 (District of Columbia Court of Appeals (1988), Re AC, 573 A. 2d 1235 (1990) appeal court.

[51]. Per Judge Terry 573 A. 2d 1235 at 1237.

> consider critical legal issues; lack of important factual and expert evidence, which might cause a judge to decide otherwise; a shortage of time, which can prevent a judge from acting judicially."[52]

Since Re S the commitment to patient autonomy in general seems to have been affirmed in the 1994 decision, Re C[53]. Here the patient's decision to refuse consent for an operation to remove his gangrenous foot was validated by the court even though the patient would probably die as a result. Despite the fact that C was a chronic paranoid schizophrenic, expert evidence confirmed that his capacity to consent was evident.[54] However, though the patient in general can expect to find respect for his autonomy in withholding or granting consent, the pregnant woman is still suffering unacceptable instances of forced intervention. Joanna Bale, on the 23rd September, 1996 reported that further instances of forced Caesarean operations have taken place and that one such recipient is taking legal action against the responsible hospital. A separate action is also being instigated by the Association for Improvement in Maternity Services (Aims) on similar grounds. This follows two recent unreported court orders for Caesarean operations. Disturbingly, Bale notes:

> "Now that a further case has emerged, lawyers believe many more women have undergone forced Caesareans after secret emergency court rulings in which the patients were unrepresented. A legal Source said: "We know of five family division judges who have done this and there may be many more."[55]

Though the precise grounds of these actions are unknown, it is hoped that the courts will put a stop to forced Caesareans and the precedent it sets for the other interventative treatments that are developing.

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[52]. Barbara Hewson, 'Mother Knows Best' New Law Journal 142 (1992) 1538 at 1550.

[53]. Re C (adult: refusal of treatment) [1994] 1 W.L.R. 290 (hereafter Re C).

[54]. Some are critical of this decision. For example Elizabeth Roberts op. cit., 101 says "Perhaps to err on the side of protection might have been more appropriate in this case and the enunciation of the importance of autonomy might have been saved for some other case in which the ability to exercise that autonomy seemed clearer."

[55]. 'Woman Challenges Hospital's Rights to Impose Caesarean' The Times (Monday 23rd September) 6, col. 1.

S withheld consent, but the court ordered the operation to proceed regardless. This is perhaps the greatest dilemma in this area. However there is also the problem seen in Re T whereby it is sometimes hard to ascertain whether or not consent was given, and the ambits of that consent, or whether the circumstances surrounding the consent should make it void. In other words, it may seem that because a patient is never informed of every single aspect of his condition and because he is always slightly influenced by his experiences, he can never give fully informed consent. From this premise it could be argued that consent is an unworthy goal because it can never be fully attained. However, an application of Dworkin's definition of autonomy proves this to be a false assumption, and reaffirms the importance of informed consent.

Again the two sides of consent can be separated. Edwards and Graber point them out:

> "Consent fails to be voluntary to the extent that it is manipulated by external forces ... To the extent that one's decision is less than fully voluntary, it falls away from full autonomy ... Similarly, lack of information impairs rational[56] autonomy. In order to be a *law* unto oneself, one's decisions must relate fundamental life-plans to the facts of the situation at hand. But, to the extent that persons are unaware of some of the facts ... then they will be unable to compare these to their life-plans."[57]

At first sight this appears to conflict with Dworkin's view of autonomy, for it seems to demand that autonomy requires more than a consideration of personal desires. Hence an individual can act autonomously in consenting to treatment even if he refuses to listen to the physicians explanation of the treatment, provided that this course of action corresponds to his considered desire. However, the patient who is forced to make a decision as to whether to consent

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[56]. By 'rational' Edwards and Graber do not mean objective rationality, but that the individual is able to consider various options (in other words this is similar to Dworkin's first and higher-order desires distinction).

[57]. Rem B. Edwards and Glenn C. Graber, Bioethics (San Diego: Harcourt Brace Jovanovich Publishers, 1988), 113.

to treatment usually requires information as to the consequences of that decision. Such an individual cannot act autonomously unless he is given that required information. It could be argued that since the patient will rarely attain full knowledge of his condition, he is never truly informed when making a decision. However, full knowledge is unnecessary, for as Dworkin so clearly enunciated, all that is needed is enough knowledge for the individual to make a considered preference of his first and higher-order desires.[58] Hence each individual will make different demands of the physician before his thirst for information is satiated.[59]

The other side of consent involves the appearance of consent (in other words, whether consent was actually given; whether any factors vitiate it; and whether consent should be, or was overridden in the face of competing interests). Again, this is based on autonomy, and the revelations of the first chapter show that though an individual is never free from influence, this does not prevent him from making an autonomous decision.[60]

The courts are aware of the fact that informed consent can never be 'full'. Lord Staughton in Re T (Adult: refusal of medical treatment) said:

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[58]. See page 19.

[59]. However, some claim that an objective standard is useful in some circumstances. Hence Agneta Sutton, Prenatal Diagnosis: Confronting the Ethical Issues, (London: The Linacre Centre for the Study of the Ethics of Health Care, 1990), 162, believes that an autonomous decision requires *all* the facts. When concerning decisions as to foetal treatment this, she claims, involves information on foetal life and development and discussions on humanity and the perceived rights of the foetus before such a decision is properly informed. However, it has already been noted that a decision can be autonomous even when every possible fact is not made known to the recipient. He needs enough to enable an evaluation of his first and higher-order desires, and no more.

[60]. Yet the doctrine of consent is often criticised on the basis that we are never free of influence. As Frithjof Bergman On Being Free (Notre Dame and London: University of Notre Dame Press, 1977), 72 says:
"One standard philosophical formulation says that a choice is free if I possessed all the relevant information, and was not subjected to (irrational) methods of persuasion and are not under duress. This can be rejected; ... we never do possess all the relevant information, and we are never only influenced by rational arguments (even the most rational argument is advanced by a person, and not even his tone of voice can be completely separated from the 'rational' weight of his reasons) and we are above all never free from all duress. Every choice has its consequences, and we always make a choice under certain kinds of pressure. ... though we do speak of degrees of freedom, the word 'free' all the same suggests a division, which in these terms cannot be drawn. ... [Further] a threat does not render me 'unfree'... A threat simply raises the cost of some action I might take."

> "Every decision is made as a result of some influence: a patient's decision to consent to an operation will normally be influenced by the surgeon's advice as to what will happen if the operation does not take place."[61]

In the same way as Dworkin, the courts are willing to accept that though a decision is never free from influence, it can represent a valid personal determination that is worth protecting.

a)What Constitutes Incompetence?

But this all depends on the patient being deemed competent to make the decision, and it could be argued that the pregnant woman who does not desire to save her foetus is in some way incompetent (though such an argument is not accepted here). For example, Komrad maintains that "... all illness represents a state of diminished autonomy."[62] He said this because an ill person is not his normal self and his reasoning is impaired by a desire to end, or cope with the illness. Could it be said that because illness diminishes autonomy, autonomy is not valuable and decisions would be better made by the physicians on behalf of the patient? Could pregnancy be placed in the same category as illness for such purposes?

Edwards and Graber put forward the theory that the primary good is the well-being of the patient, and that the well-being of the patient may best be served by the physician making the decision on the patient's behalf.[63] They suggest that patient welfare is the ultimate goal, and that this may best be preserved through paternalism. They even suggest that this could be the best way to secure the autonomy of the individual in the long term.[64] Edwards and Graber,

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[61]. Re T op. cit., 669.

[62]. 'A defence of Medical Paternalism: Maximising Patient's Autonomy' Journal of Medical Ethics 9 (March 1983), 1. Note that there is no suggestion here that pregnancy is an illness. This section involves a general appraisal of informed consent. See also Zbigniew Szawarski 'Presumption of Incompetence' in D.W. Hodgkinson, A.J. Gray, B. Dalal, P. Wilson, Z. Szawarski, T. Sensky, G. Gillett and D.W. Yates, 'Doctors' Legal Position in Treating Temporarily Incompetent Patients' British Medical Journal 31 (July 1995), 115 at 117.

[63]. Edwards and Graber merely put forward this theory, they do not support it, and believe ultimately that informed consent is a worthy doctrine.

[64]. Edwards and Graber, op. cit., 115.

however, contend that if the patient's consent is not fully informed and free from all influence then autonomy is unworthy as a goal.

Dworkin, on the other hand, believes that the key lies in the patient being able to arrive at a considered decision. He does not demand that *all* the physician's knowledge is passed on the patient.[65] In other words, that first, autonomy is so important that we must give the patient the opportunity of practising it and that second, informed consent usually presents that opportunity to an acceptable degree. One of the main reasons for the particular significance of autonomy in the medical context, is that our bodies are of such importance to us that we should be able to stop others invading them. "My body is me, failure to respect my wishes concerning it is a particularly insulting denial of autonomy."[66] Therefore, on Dworkin's analysis strong paternalism (taking away the patient's option of consent)[67] cannot be justified merely on the grounds that the patient's autonomy is diminished through his illness. It is wrong to hold that merely by virtue of being pregnant, autonomy can be removed.

However, incompetence has not been accurately defined by the courts in England. Where a case arises where the patient seems incompetent, the issue before the court is usually the nature of treatment that he should receive rather than whether or not he is actually incompetent (which is usually a matter of expert opinion). Elizabeth Roberts examines the case and statute law in this area and suggests that where the law does touch the issue of incompetence, three main factors are, rightly or wrongly, used.[68] The first, she terms 'understanding

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[65]. G. Dworkin op. cit., 109.

[66]. G. Dworkin op. cit., 112 This is not to say that Dworkin places autonomy on a higher plain than the well-being of the patient (or other values such as dignity, health, integrity and security). Indeed he recognises that: "If denial of autonomy is justified in terms if promoting the benefit of my body, then paternalism would seem to have the strongest claim in the medical context." p112 Hence he recognises that there are situations when informed consent is undesirable. These include emergency, incompetence and waiver. In other circumstances, autonomy is usually of sufficient importance to outweigh competing values.

P.H. Schuck 'Rethinking Informed Consent' (January 1994) 103 The Yale Law Journal 899-960 at 924 also says: "The more private the choice - that is, the more it concerns the integrity of the individual's own projects and self-conception and the less is directly effects others - the more robust this right should be."

[67]. Strong and weak paternalism are further defined and considered on page 55.

[68]. Elizabeth Roberts op. cit., 99.

information'. For example, by ss. 57 and 58, of the Mental Health Act 1983 the patient must by 'capable of understanding the nature, purpose and likely effect' of the proposed treatment. Roberts is critical of using this test alone, for she claims that the patient should also understand the risks, benefits and effects of a refusal to consent before he be deemed competent. The second category she deems 'mental stability and maturity' which is similar to the Gillick test for children (only here it is applied to adults). The final category is 'reasonableness of the decision'. This aspect of the competence test is expressly denied in Re T, and is something that any believer in autonomy would refuse to sanction. However, Roberts recognises that though it is an undesirable category, it is still employed by some physicians. To say that a pregnant woman is incompetent because her decision to refuse foetal surgery or a Caesarean section (which is necessary to save the life of the foetus and / or her own life) is incomprehensible to the reasonable man, does not fit with the autonomy viewpoint. This is because the objective good of the decision is irrelevant in a consideration of an individual's personal preferences.[69]

Choice and Autonomy

Hence, even if the patient's capacity for autonomy is diminished by virtue of his illness, autonomy is still valuable to him. It would be a mistake to assume that autonomy is less valuable merely because it cannot be procured, for it is the *opportunity* to be autonomous that is important. This is all that the law can provide, the rest is up to the individual. Legally the individual can be granted greater opportunity to be autonomous by giving the individual a choice in a given area. For example, telling the pregnant woman that she can have her baby at home or in hospital will not predetermine an autonomous decision on her behalf, because she cannot be forced to compare her first and higher-order desires and make an autonomous decision. It may not even give her the opportunity to be autonomous if she wants to bear the child in the local swimming pool, for neither option represent her considered desire. However,

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[69]. This was one of the underlying rationales of G. Dworkin's theory of autonomy. See page 18.

taking away that choice and demanding that she have her baby in hospital takes away the opportunity for autonomy unless it happens to match her considered desire. Hence, an autonomous decision always involves an internal choice between preferences. As Lord Donaldson MR, said in Re T:

> "Just because adults have the right to choose, it does not follow that they have in fact exercised that right. Determining whether or not they have done so is a quite different and sometimes difficult matter. And if it is clear that they have exercised their right of choice, problems can still arise in determining what precisely they have chosen. This appeal illustrates both these problems."[70]

State granted options do not create autonomy, but they do enhance the opportunity for autonomous action.

Challenges to Autonomy: Paternalism and Patient Welfare

In this section challenges to the view that autonomy is the primary goal are acknowledged. First the value of autonomy is considered and it is suggested that autonomy has both intrinsic and extrinsic value. Following this, cases of instrumentally disadvantageous choices are examined (such as when the burden of responsibility is hard to bear). Because autonomy is not possible or even desirable in every instant, the advantages of paternalism are then considered and it is asked when coercion in general, and coercion of the pregnant woman are justifiable.

a) The Value of Autonomy

If autonomy is the main rationale behind informed consent, the value of autonomy must be considered. McCormick argues that autonomy has extrinsic valuable and therefore if a better result could be achieved without it, it should not be used:

> "A moral right is always with regard to a good. The good in question is self-determination in the acceptance or rejection of medical treatment. This self-determination ... is a conditional or instrumental good - that is, it is a good precisely insofar as it is the instrument whereby the best interests of the patient are served by it. If, for example, the best

[70]. Re T op. cit., 653.

> over-all good of patients would be better achieved without self-determination, it would be senseless to speak of self-determination as a right."[71]

Young,[72] on the other hand, believes that autonomy has more than mere instrumental value. He uses, as an example, the scenario of the famous novel Brave New World by Aldous Huxley, in which the characters were content but were not autonomous. The rationale of the book is that the vital autonomy was missing from their lives and that being content was not enough, for they desired to be the *authors* of that contentment. Skinner illustrates this point: "Autonomy - the business of genuinely choosing and acting so as to forge one's own lot in life - is an excellence which contributes to personal dignity and self esteem."[73] Hence Young believes that autonomy has intrinsic value:

> "According to this position, autonomy is part of the moral basis of personhood. To the extent that a person is at the mercy of his (or her) urges or impulses, or lacks scope for actively placing and then achieving goals and purposes, it is the person's circumstances, not the person himself (or herself), that governs. Accordingly the person's life lacks self-direction."[74]

Even a prisoner of war could be autonomous; being able to think for oneself is enough because " ... to the extent that we are able to shape our lives in ways that we consider worthwhile, our self-esteem will be enhanced."[75]

Hence, there is much to be said for Young's belief that autonomy can be instrumentally valuable, but that its primary value is intrinsic.[76] Hence in Re S, S

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[71]. Richard McCormick How Brave a New World? Dilemmas in Bioethics (London: SCM Press Ltd., 1981), 359. Note that Edwards and Graber criticised informed consent on the same grounds. This view would not stand up to the demands set at the beginning of this thesis because the theory is not legally applicable; it would create further uncertainty. This chapter ascertains that though there are circumstances when autonomy is trying for the pregnant woman, it is valuable because the law must create a clear cut division between when it will support her autonomy and when it will sacrifice it for other values.

[72]. R. Young Personal Autonomy: Beyond Negative and Positive Liberty (New York: St. Martin's Press, 1986).

[73]. B.F. Skinner Beyond Freedom and Dignity (London, 1972).

[74]. Young op. cit., 25.

[75]. Young ibid..

wished to refuse the blood transfusion, a course which the surgeon felt would result in her own and the foetus' death. The value of life is extremely high, and hence this situation is not desirable. However, even if after the Caesarean she had been thankful for the overruling of her refusal to consent, it is still undesirable that her autonomy was overruled, because autonomy has value in itself.

It has been acknowledged that sometimes choice is not desirable to a patient, but the scenarios that give rise to this conclusion have yet to be examined. This section is to fulfil that role: to consider the claim that patient welfare is more important than autonomy or that a choice is instrumentally bad in a given situation. As H.L.A. Hart says:

> "Choice may be made or consent given without adequate reflection or appreciation of the consequences; or in pursuit of merely transitory desires; or in various predicaments when the judgement is likely to be clouded; or under inner psychological compulsion; or under pressure from others of a kind too subtle to be susceptible of proof in a law court. Underlying Mill's extreme fear of paternalism there is perhaps a conception of what a normal human being is like which now seems not to correspond to the facts."[77]

In Re S, the purpose of the court-ordered Caesarean was to protect the foetus rather than to protect the welfare of the woman, but it should be noted that decisions made by the pregnant woman are especially hard by virtue of the fact that the foetus is affected and hence it could be claimed that the welfare of the woman particularly demands strong paternalism in this area (though this claim will be rejected).

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[76]. Yet, according to Young, there are two models of the intrinsic value standpoint. The first is extrapolated by G.E. Moore Principia Ethica (Oxford, 1903), who believes that autonomy is intrinsically valuable for its own sake; hence it has value even when there is no valuer to value it. Young prefers the second opinion, which has previously been contended by C.I. Lewis The Theory of Knowledge and Valuation (La Salle, Illinois, 1946). This is the view that autonomy is intrinsically valuable only if it is worth having for its own sake.

[77]. Law, Liberty and Morals (London: Oxford University Press. 1963), 34.

b) The Burden of Responsibility

When giving the patient the right to decide certain factors concerning his treatment, the patient is in fact forced to make a choice (even if it is the choice to delegate responsibility to another, or to toss a coin). The patient may occasionally desire *not* to have a choice, because, as Dworkin notes, with choice comes responsibility (be it legal responsibility or the social need to conform): "In addition to bearing the responsibility in one's own mind, there arises the possibility of being held responsible."[78] And, Capron says:

> " ... autonomy is centrally associated with the notion of individual responsibility. The freedom to make decisions for oneself carries with it the obligation to answer for the consequences of those decisions."[79]

Dworkin gives the example of a pregnant woman who decides to use amniocentesis to screen for Downs Syndrome. The Abortion Act 1967 recognises that should the foetus be so afflicted, abortion would be an option. Once she has consented to the amniocentesis and heard the results, she and her partner are responsible for bringing the child into the world (or aborting). "The defective child, if they choose to have it, can no longer be viewed as bad luck or a curse or an act of God."[80]

The doctrine of informed consent demands that even if an individual autonomously decides to do exactly what the physician tells him (as has been determined to be quite synonymous with autonomy), he still bears responsibility for decisions made by the physician. In this way it can be seen that a choice can be onerous. Michael Bayles,[81] on the other hand, puts forward the theory that the more extensive our choices the more content we are. This is firstly because the greater the number of alternatives, the lower the risk of being dissatisfied and secondly because our actions express our character and desires, and the more

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[78]. G. Dworkin, op. cit., 68.

[79]. A.M. Capron, 'Informed Consent in Catastrophic Disease Research and Treatment' (Dec. 1974) 123 The University of Pennsylvania Law Review, 356.

[80]. G. Dworkin, op. cit., 67.

[81]. Principles of Legislation (Detroit, 1978).

options we have, the better we can express ourselves. However, such claims are subject to criticism. Young[82] comments on Bayles' first point, saying that mere proliferation of choices does not as such promote autonomy (as has been previously noted) and on the second point, he answers that often the greater the number of choices, the more agonising the choice is to make.

Yet, the responsibility that the patient is *forced* to bear is minimal, for though he must determine who to delegate the decision to, he need not make the actual decision. He can autonomously appoint an agent, or he can reject the opportunity of autonomy, hence he need not accept responsibility for the whole decision. He need only accept responsibility for his choice of agent, or for his decision to toss a coin to decide his fate. Further, there are ways of helping the patient come to a decision. For example Lilford and Thornton refer to the 'expected utility theory'.[83] This is the belief that there is an overall best decision that has 'the greatest prospective chance of maximising utility'. Factors, such as the safety of the pregnant woman; the safety of the foetus; the long-term health of the baby; and the psychological health of the parents,[84] contribute to the decision as to how to advise the woman to act.

In this way the physician can allow the patient to reach her own decision, and also advise her as to the outcome of the various alternatives, so aiding the decision process. The flaw in the 'expected utility theory' is that it may take a great deal of time to evaluate the necessary considerations. However, it is certainly a valuable way of helping a patient who is fearful of making the difficult choice alone, and still protecting his autonomy to some degree.

This still leaves the patient with important choices to make which, despite the help, he may find burdensome. However, this minimal amount of forced choice is better placed with the patient than with the physician, for the intrinsic

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[82]. Young op. cit., 27.

[83]. Richard J. Lilford and James G. Thornton 'Making Difficult Decisions' in T. Chard and M.P.M. Richards (eds.) op. cit., 105.

[84]. This list is supplied by Lilford and Richards ibid..

value of autonomy sufficiently outweighs the bad effects of the limited responsibility.

c) The Particular Choice is Immoral.

Dworkin also recognises that choice may be negative *per se*. He gives the example of the bad effect that would be created by allowing people to purchase exemption from subscription to the army. The existence of this choice, he claims, is immoral. Just because the individual could refuse to exercise the choice does not make it acceptable.[85] In this instance, the moral significance is in the choice itself rather than in whether or not it is exercised. Hence, the mere existence of a choice can be bad even though it need not be exercised, for the temptation to exercise may be so strong, and the result so wrong that it is better that the choice never existed. However, the value of informed consent (as a choice) has been expounded and is not in question hence the granting of this choice to pregnant women is not immoral in this sense.

Though Dworkin does not view choice as intrinsically valuable, he does believe that "What does have intrinsic value, is not having choices but being recognised as the kind of creature capable of making choices."[86] This lends more support to the to the case of the pregnant woman, especially as she should not be separated from other citizens into a group which is deemed incapable of making choices, merely by virtue of the fact that she is pregnant.

Therefore even though there will be occasions when the pregnant woman will deem other values more highly than autonomy, she has the chance to reject the opportunity of autonomy, and the appropriate aids should be at hand to act in her best interests should she so need them.[87] However, the opportunity to be autonomous should remain present.

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[85]. G. Dworkin op. cit., 75.

[86]. G. Dworkin op. cit., 78.

[87]. See Alister Campbell 'Dependency Revisited; the Limits of Autonomy in Medical Ethics' in Margaret Brazier and Mary Lobjoit (eds.) Protecting the Vulnerable: Autonomy and Consent in Health Care (London: Routledge, 1991), 110 who claims that often the patient requires love and protection rather than autonomy. Note that for Dworkin, love and protection are not incompatible with autonomy; Dworkin op. cit., 108.

d) Paternalism

In a society with a government there will inevitably be areas where the government acts in a paternalistic manner in order to protect the weaker members of society. This means that choice will be limited, and in respect of values such as autonomy the limitation of choice must be legitimate. Dworkin suggests that the appropriate maxim for limiting choice is as follows: "A decent respect for autonomy of individuals will lead us to be very wary of limiting choices even when it is in the rational self-interest of the individuals concerned."[88] Hence, though a woman may believe that were she to fall pregnant, she would like to give up smoking tobacco, it would not mean that she would welcome the law that prohibits her from smoking.

The problem is neatly outlined by Sir Norman Anderson:

> "The competing interests of contemporary life are, moreover, so diverse and interdependent that an ever increasing intervention by the law seems inevitable. The basic problem is ... how to maintain a proper balance between individual liberty and law control."[89]

According to J. Areen *et. al.*, this balance can be achieved by basing paternalism on a mixture of concern for others; concern for the individual; and concern for those who cannot decide for themselves.[90]

Moreover, it has been seen that choice is not always the best solution to a problem, hence it must be controlled. Paternalism (often seen as the antithesis to freedom and autonomy) is necessary to ensure that the individual's freedom is not compromised unduly by the freedom of the next individual. "The red light

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[88]. G. Dworkin op. cit., 77.

[89]. Law, Liberty and Justice (London: Stevens and Sons, 1978), 7.

[90]. J. Areen, P.A. King, S. Goldberg and A.M. Capron , Law, Science and Medicine (Mineola, New York: Foundation Press, 1984), 415.

which I have to obey keeps fifty others out of my way for every time it forces me to stop."[91]

Paternalism, according to Young, can take two forms. Strong paternalism is "intervention to protect or benefit a person, despite that person's informed and voluntary denial of consent to the paternalistic measures proposed."[92] Weak paternalism:

> "... involves interference where there is (or is believed to be) a defect in the decision making capacities of the person interfered with, or where it is necessary to ascertain whether the person's behaviour is fully reflective."[93]

Weak paternalism is thought to be more justifiable than the strong version. Re T is of the former kind, because the judges believed that the mother unduly influenced the daughter's decision to refuse a blood transfusion. Re S, on the other hand is an example of strong paternalism, and, as a result, is all the more worrying.

In the first chapter it was noted that J.S. Mill demands certain features of a state before he considers an individual to be free. Mill believes that weak paternalism is justifiable and will actually enhance freedom (for example limiting the right of an individual to sell himself into slavery). Young on the other hand sees neither strong nor weak paternalism as compatible with autonomy (unless that paternalism is consented to as in Dworkin's example of Odysseus commanding his men to ignore his orders until the ship passed the Sirens.[94])

However, even if autonomy and paternalism are incompatible, other values will occasionally prove more important than autonomy.[95] The argument here is that the pregnant woman's refusal of medical intervention is not one of those circumstances. A balance must be sought, as Mark Siegler points out:

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[91]. Bergman, op. cit., 187.

[92]. Young, op. cit., 64.

[93]. Young ibid.

[94]. G. Dworkin op. cit., 14.

[95]. See further page 64.

> "The principle of respect for autonomy surely recognises that different autonomous individuals will wish to be treated in different ways by the health professional ... The critical question ... [is how] morally conscientious physicians and patients .... determine where on a spectrum of paternalism / consumerism or dependence / independence their professional relationship will and ought to be stabilised."[96]

e) What is Coercion?

Paternalism involves the balancing of considerations. Inevitably, rules will be necessary to allow certain actions and prohibit others. This will in turn involve restraint (refusing to allow an individual to act in a particular way) and coercion (forcing a person to act in a particular way). Coercion is less likely to be tolerated for it constitutes the intrusion of an individual's autonomy. Hence, in the distinction between forcing treatment upon the pregnant woman and refusing her that treatment the latter constitutes a greater infringement of autonomy. Further, by drawing the line at strong paternalism (coercion), so allowing only weak paternalism, the pregnant woman's rights remain balanced with other women's rights. Strong paternalism can then be largely reserved for those who are mentally incompetent. Even though there will be instances when the woman wishes that the choice of whether or not to consent to treatment is not hers, it is still desirable that the legal line is drawn here to prevent injustices to the majority of pregnant woman.

However, the term 'coercion' is more complicated than may seem to be the case. Bosanquet, who speaks from the positive liberty perspective, defines coercion (or constraint) in the following way: "It is constraint when my mind is interfered with in its control of my body, either by actual or threatening physical violence in the direction of another mind." He also recognises that constraint is not a clear cut term; "A man can be a long way more than a slave and yet a long

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[96]. M. Siegler 'Search for Moral Certainty in medicine: a Proposal for a New Model of the Doctor-Patient Encounter' Bulletin New York Academy of Medicine 57 (Jan. - Feb. 1981), 56-69, as quoted by Mark S. Komrad 'A Defence of Medical Paternalism: Maximising Patient's Autonomy' in Rem B. Edwards and Glenn C. Graber op. cit., 144.

way less than a citizen."[97] Clearly, however, the Re S situation falls within his definition. According to Harry Frankfurt "A person who is coerced is compelled to do what he does, for he has no choice but to do it."[98] If the force does not come up to that standard then there is no absolution from moral responsibility. There is not, says Frankfurt, an objective standard to coercion, but the person in question must have no other choice but to act in a given way:

> "It requires that the victim of a threat should have no alternative to submission, in a sense in which this implies not merely that the person would act reasonably in submitting and therefore is not to be blamed for submitting, but rather that he is not morally responsible for his submissive action."[99]

Hence, the reasonableness of his action is irrelevant. Frankfurt gives the example of a person who sees a spider in the corner of the room and burns the building to prevent it coming into contact with his face. This constitutes coercion. In this way coercion is subjective for it depends on the character of the individual. The pregnant woman may feel that if the physician recommends a course of action she has absolutely no choice but to follow his recommendation. Such a situation will prove extremely rare, for few of us feel so compelled by mere advise. However, it is important to recognise that this is one instance when coercion is a necessary evil in our attempt to nurture the opportunity to be autonomous. For the physician's advice is one of the components of informed consent without which a decision by the pregnant woman cannot be truly autonomous. Though it seems strange that the very information that can make a decision autonomous for one woman can make it a coerced decision for another, this fits entirely with Dworkin's concept of autonomy. Again, all the law can do is to create the greatest opportunity for autonomous decisions and this can be

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97. Both quotes appear in The Philosophical Theory of the State (London: Macmillan, 1951), 125.

98. Harry G. Frankfurt 'Coercion and Moral Responsibility' in Ted Honderich (ed.) Essays on Freedom of Action (London: Kegan Paul, 1973), 63.

99. Frankfurt op. cit., 77.

best achieved by the physician advising the patient and then allowing her to decide whether or not to consent.

f) When is Coercion Justified?

Christian Bay calls coercion "the supreme political evil."[100] Similarly H.L.A. Hart finds it abhorrent:

> "I shall advance the thesis that if there are any moral rights as all, it follows that there is at least one natural right, the equal right of all men to be free."[101]

J.S. Mill concentrates specifically on the question 'when is constraint justified?'. He does not advocate constraint for the person's own good, because he is of the view that we are each the best guardians of our own health, but nevertheless, he advocates constraint in the following circumstances:

> " ... the sole end for which mankind are warranted individually or collectively interfering with the liberty of action of any of their number is self-protection; that the only purpose for which power can be rightfully exercised over any member of a civilised community against his will is to prevent harm to others."[102]

Hence, in the same way that this thesis has proposed that autonomy is not a universal good, but has intrinsic value, Mill believes that even if the good of the individual is best served by interference with his liberty, that interference should not be tolerated. It is only for the sake of 'others' that liberty should be compromised. In other words, to curb the liberty of an individual is wrong because it is his right to be free. But to curb the liberty of a society in order that the general good of that society will be forthcoming, is acceptable.

Even if we were to decide that coercion is inherently bad, there is a possibility that its use could nevertheless be justified by applying the 'Principle of Double Effect'. By this principle, a distinction is made between what is directly

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[100]. The Structure of Freedom (Stanford, California: Stanford University Press, 1958), 92.

[101]. 'Are There Any Natural Rights?' Philosophical Review 64 (1955), 174.

[102]. On Liberty (Oxford: Basil Blackwell, 1946), 5.

and indirectly willed. A greater evil is avoided by practising a lesser evil. According to McCormick, there are four conditions to follow before the doctrine can be applied:

> "(1) The action from which evil results is good or indifference in itself; it is not morally evil. (2) the intention of the agent is upright - that is, the evil effect is sincerely not intended. (3) The evil effect must be equally immediate casually with the good effect, for otherwise it would be a means to the good effect and would be intended. (4) There must be a proportionately grave reason for allowing the evil to occur."[103]

McCormick uses this method to justify the killing of a foetus to save the pregnant woman who has cancer when the foetus and the woman would both have died without the operation.

Would the Re S situation fall within the Doctrine of Double Effect? A Caesarean operation is not inherently evil; it is often used with good intentions (though the coercion of the woman could possibly be classed as inherently evil). The intention is to save the foetus and the coercion is equally immediate casually with the saving of the foetus but it is anyone's argument as to whether coercion of the woman is less evil than allowing the foetus to die or suffer. It seems unlikely that the Principle of Double Effect would be useful in the majority of situations, especially with regard to the woman's right to refuse to act in the best interests of the foetus. It is also true that the theory is dependant on a decision as to what is morally evil, which is a complex (and probably unanswerable) question indeed.

Coercion is necessary for the exceptional circumstances such as the necessity to imprison offenders who pose a sufficient threat to society. It has no place in the maternity ward (except in the very limited scenario outlined by Frankfurt) and that the courts in America and now in England have resorted to it in order to force the pregnant woman to bow to an objective set of values concerning the value of the foetus, is abhorrent. Restraint is a sufficient weapon to protect the foetus, for to remove from the woman, by virtue of her pregnancy, the

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[103]. McCormick op. cit., 413.

opportunity to be autonomous in a hospital setting that would (supposedly) honour the wishes of every other patient, must not be tolerated.

The view that coercion must not be used against the woman in a way that leads to any gross inequality between her and the rest of society, is contended (from an American perspective) by Dawn Johnsen:

> "By creating an adversarial relationship between the woman and her fetus, the state provides itself with a powerful means for controlling women's behaviour during pregnancy, thereby threatening women's fundamental rights. A woman's right to bodily autonomy in matters concerning reproduction is protected by the constitutional guarantees of liberty and privacy. Furthermore, the Fourteenth Amendment guarantee of equal protection of the laws should be interpreted to prohibit the state form using women's reproductive capability to their detriment."[104]

Johnsen gives examples of American decisions where this warning has not been heeded. Hence in Grodin v. Grodin[105], a child sued his mother for taking tetracycline whilst pregnant, for this resulted in the discoloration of his teeth and in Curlander v. Bio-Science Laboratories[106], the court hinted at the possibility of a claim of wrongful birth when a woman failed to abort a severely defective foetus and the child went on to suffer pain. Johnsen also points out that the criminal law on child abuse has been extended to cover the abuse of the foetus, and, most patently, injunctions against pregnant women have been actualised. Hence, though the foetus cannot be made a ward of court in England and Wales (Re F (in Utero)[107]) it can in certain state of America, [108] and, as previously noted, there is some sympathy for the cause in England.[109] Also, as Johnsen

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[104]. Dawn E. Johnsen 'The Creation of fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection', (1986) 95 Yale Law Journal 578, at 579.

[105]. 102 Mich. App. 396, 301 N.W. 2d 869 (1980).

[106]. 106 Cal. App. 3d 811, 165 Cal. Rptr. 477 (1980).

[107]. [1988] 2 All E.R. 193.

[108]. Johnsen refers to Chicago Trib., Apr. 9, 1984, at 1, col. 4 and Boston Globe, April 27, 1983, at 8, col. 1. op. cit., 584.

[109]. See page 35.

pointed out, in the American case Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson[110], a woman objecting to a blood transfusion on religious grounds was nevertheless forced to undergo one for the sake of her foetus, and a woman wishing to avoid Caesarean delivery was coerced into one.[111] Johnsen is convinced that these concessions to the foetus will continue to expand due to the physical dependence of the foetus on the woman. She is worried that the coercion used in these, perhaps, extreme cases, could easily be extended.

At present in England, breach of informed consent does not usually vitiate consent, but can lead to an action in battery or negligence. Injury to the foetus only leads to a claim if the foetus is born and survives for forty-eight hours. Yet in America not only tort law, but criminal and family law are involved in the protection of the foetus. (Though note that the criminal law can be used here if the foetus is born and survives 48 hours). The possibility that the English courts are following the same course remains to be tested in the recent legal action against a hospital who forced a pregnant woman to undergo a Caesarean operation for the sake of the foetus.[112]

Conclusion

The education and information a pregnant woman receives before making a decision as to treatment is essential, however the law has access to limited action in this respect. What it can do, is to affirm the value of autonomy by resisting the temptation to coerce the pregnant woman into treatment that she renounces. Though it may seem harsh to draw the line so firmly, legal certainty demands as much. The pregnant woman may have other interests that conflict with her interest in autonomy and these she must weigh up so that she can reject the opportunity to be autonomous if she so desires. However, this should be a decision reserved strictly for the patient. As far as the physician or the government is concerned, a woman's interest in autonomy (when deciding whether or not to consent to treatment) is an interest that outweighs the

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[110]. 42 N.J. 421, 201 A. 2d 537, *cert. exel.* 377 U.S. 985 (1964).

[111]. In Jefferson v. Griffin Spalding County Hospital 247 Ga. 86, 274 S.E.2d 457 (1981) (*per incurium*).

[112]. See page 42.

whether or not to consent to treatment) is an interest that outweighs the physician's (or government's) interest in avoiding pain for the woman, or in reducing expenditure, or in avoiding harm to the foetus. Her opportunity to be autonomous is of paramount consideration. As the recent technological advances become more widespread, such an affirmation will prove of extreme importance if the law is not going to be taken unprepared at the expense of the pregnant woman's rights.

The government's policies seem to show commitment to patient autonomy. For example the Patient's Charter, effective from 1 April 1992, grants every citizen a right to receive health care on the basis of clinical need, regardless of ability to pay and it promises every citizen (limited) access to his medical records.[113] Further, it promises that:

> "*Every* citizen has the following National Health Service Rights ... to be given a clear explanation of any treatment proposed, including any risks and any alternatives, before you decide whether you will agree to the treatment ..."[114]

This implies that both agreement to treatment and full information should be forthcoming. Yet only six months later in the landmark case Re S, the pregnant woman's desire to avoid a Caesarean operation was overruled in the interests of the foetus. Clearly the commitment to patient autonomy is not as great as the Charter would have us believe. Further, the standard promised in the Charter is misleading in that it promises what cannot possibly be delivered. The disclosure of 'any risks and any alternatives' clearly places an unacceptable and impossible burden on doctors.

The Maternity Services Government Response to the Second Report from the Health Committee, Session 1991-1992 on Maternity Services re-iterates the need for informed consent, with special reference to the pregnant woman, saying at paragraph three:

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[113]. Department of Health The Patient's Charter: Raising the Standard London HMSO, 1991.

[114]. The Patient's Charter op. cit., 8 - 9.

> "The Government has a responsibility for ensuring that women receive the best possible maternity care. We also believe that the service must be sensitive to the views of those who use it, so that women are empowered to take decisions about their care. ... The [Patient] Charter makes the needs and wishes of those who use the health service paramount." [115]

If Re S had stood alone as a one-off case, then the policies represented here may have been believable. Unfortunately the recent revelations concerning forced Caesarean operations throw doubt upon the intentions of the government concerning their respect for the autonomy of the pregnant woman. It can only be hoped that the recent challenges to the courts undermining of the pregnant woman's power to withhold consent, will prove successful.

In the next chapter the perceived status of the foetus and its bearing on the autonomy of the woman will be considered in an effort to determine the ambits of the woman's rights to demand treatment on her own behalf, or on behalf of the foetus.

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[115]. London HMSO Cm 2018.

3: THE PREGNANT WOMAN'S RIGHT TO DEMAND TREATMENT

Introduction

In the second chapter it is suggested that though limitation of the pregnant woman's autonomy in the field of refusing medical treatment is unacceptable, limiting her autonomy by curbing her right to demand treatment is both acceptable and necessary.[1] The first chapter outlined the importance of autonomy, but G. Dworkin at no point claimed that it was the only important value. In fact, he expressly recognised that values such as "... health, dignity, well-being, [and] security ..."[2] may supersede autonomy for: "To promote these it is sometimes necessary to limit autonomy."[3] The aim of this chapter is to give some format to the limitation of the pregnant woman's autonomy by curbing her rights to demand treatment. The format must be certain enough to be legally applicable, but liquid enough to move with the advancing technologies.

Firstly, the status of the foetus is reviewed and it is put forward that arguments about the foetus being human and the protection that should result therefrom are defective, but that the foetus should be protected due to three considerations, namely; the foetal potential human status; the fact that the foetus is human derived; and the harmful symbolic effect a lack of foetal protection would have on society.

Secondly, the question of the extent of protection that the foetus deserves is tackled. A broad definition of 'health' is proposed as a worthy societal goal (for both foetus and pregnant woman) and the famous 'Four Principles' are used to guide the debate. It is important to recognise that just because autonomy is no longer the primary goal does not make it an unimportant consideration. It is

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[1]. Though the pregnant woman's autonomy is not to be ignored; it must be considered along side the welfare of the foetus.

[2]. G. Dworkin, The Theory and Practice of Autonomy (from the Cambridge Studies in Philosophy range) (Cambridge, New York and Melbourne: Cambridge University Press, 1988), 14.

[3]. G. Dworkin ibid.

shown that true health cannot be achieved without a measure of autonomy as is reflected in the 'Four Principles' which include beneficence, non-maleficence, respect for autonomy and justice. In the interests of autonomy, it is desirable to allow many patient demands to be heeded, and in the interests of justice, it is desirable to ensure that women are not treated adversely due to their pregnancy. Hence any treatment that would be forthcoming to a non-pregnant woman should be made available to the pregnant woman, though risks to the foetus should obviously be iterated by the physician. There is also a cogent argument for heeding a pregnant woman's demand for abortion albeit in limited circumstances.

It may seem at this point, that having decided that the foetus is indeed important it is granted very little protection because of the significance still placed on the pregnant woman. However, the distinction between the right to refuse treatment (which is unlimited) and the right to demand it (which is limited) becomes crucial when considering the modern technologies of foetal surgery and treatment. For these treatments are not forthcoming to all women; they are peculiar to pregnant women. Hence the injustice to pregnant women in refusing such treatments is limited. As these treatments increase in popularity and the technologies advance, this distinction will become increasingly important. A woman who wants the eye colour of her foetus changed, or the hair colour, height, cosmetic appearance or sex could legally and ethically be denied the opportunity. Already the problems with embryology have given rise to many an ethical dilemma[4] and there are cases of foetal surgery that also give rise to concern.[5] This chapter aims to guide the complex ethical situation in as simple a way as possible attempting to respect autonomy but more importantly, to conform to the societal goal of health for both foetus and pregnant woman.

What is the Status of the Foetus?

A charged debate surrounds the moral status of the foetus and no attempt will be made to give a grand definition that ignores the obvious divergences in societal

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[4]. Such as the recent case of the woman pregnant with eight foetuses.

[5]. See page 80.

opinion, for this is not the purpose of the law. Instead some of the arguments are eliminated and others are praised in an attempt to compromise.

Of the political commentators, there are two main camps; the conservative and liberal. The conservative view is often theological and based on the importance of the soul, which the foetus is said to have from conception. Hence abortion (and screening with a view to abortion), are considered morally wrong due to the 'murder' that is intended to result. Similarly, surgery and treatment that would be considered too risky for the born child would be equally wrong in the case of a foetus. Because the importation of the soul occurs at conception, the foetus is said to deserve protection from that point as a full human being.

On the opposing side, the liberal view tends to put the well-being of the foetus in the hands of the pregnant woman. The foetus is said to be a part of the woman and therefore hers to expel or keep as she wishes. Though not necessarily looking from a viewpoint on medical treatment, this group tend to concentrate on the woman's right to equal freedom. In other words, they are keen to ensure that the woman is not prejudiced in any way by her pregnancy. Hence they do not have much to say about her right to demand treatment, except that she should have the same rights as other women. Even if she should demand abortion, there would be reason to comply so as to put her in the same position as other women; but if she should demand foetal surgery to save the life of the foetus, the liberal perspective have little to say in her defence, because there is no corresponding right for unpregnant woman.[6] Hence this group give little guidance in the field with which this chapter is concerned.

Other groups concentrate on moral rather than political or theological grounds. They claim that the foetus deserves protection because it is a person, or because it has potential or because it is derived from humanity.

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[6]. For a full appraisal of the conservative and liberal viewpoints, see L.W. Sumner and Princeton, Abortion and Moral Theory (New Jersey, USA: Princeton University Press, 1981).

a) The Human Foetus Argument

In this section the view that the foetus deserves protection because it is a human, or a person is examined and rejected. We, as humans expect certain rights, and it is possible to argue that the foetus has certain attributes in common with us and that it therefore deserves equal protection.[7] Criticism of this view is possible because the label of human can be considered empty, in that what matters is when life is morally important rather than when it physically begins.[8] When life becomes morally important is a subjective ethical argument and depends on answers to the questions in the following sections, such as when potentiality plays a role in conferring status to an organism. However, for now the argument is considered that the foetus is human and deserves protection on this ground alone.

If the law conferred human status on the foetus, and made no distinction between 'foetal humans' and 'born humans' then despite its lack of autonomy; its lack of the ability or desire to self-govern, it would have rights merely by virtue of the fact that it is a human-being. The European Convention of Human Rights would apply to the foetus, and our own legislature would demand its rigorous protection.[9] However, from an ethical perspective even if the foetus is human, who is to say that its weakness makes it the candidate for preferential treatment? Could it not be said with equal conviction that the woman's right to autonomy is more important than the foetus' life by virtue of the fact that the foetus does not yet care for its life? What value is the 'human foetus' argument if, instead of using it to argue for equality for *all* humans, one goes to great lengths asserting that the foetus is a human only then to demand that its rights as

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[7]. See J.R. Lieberman, M. Mazor, W. Chaim and A. Cohen 'After Office Hours; The Fetal Right to Live' Obstetrics and Gynaecology, 53 (1979), 515. Also see Baruch Brody Abortion and the Sanctity of Human Life: A Philosophical View (Mass, USA; MIT Press, 1976), chapter 2.

[8]. See John Harris The Value of Life: and Introduction to Medical Ethics (London and Boston: Routledge and Kegan Paul, 1985), 14.

[9]. The European Convention treats humans thus because of a respect for the sanctity of human life. See Jonathon Glover Causing Death and Saving Lives (London: Penguin Books, 1977), chapter 3.

a human are different from the pregnant woman's rights as a human? In saying that woman and foetus are human and concluding that the foetus is the weaker human (and therefore deserved of better protection), the proponents of the argument leave themselves defenceless against the argument that the woman should get the greatest protection by virtue of being stronger!

Hence one argument against the 'human foetus' argument is that it affords no firm conclusions if human and foetus are then said to be unequal, for the question of how to treat the foetus once it is accorded human status depends on the perspective from which it is viewed. Utilitarians follow the course that creates the most good, natural rights theorist advocate minimum state intervention, liberal theorists prevent overzealous paternalism and deontologists follow what they believe is the 'right' course irrespective of outcome. Hence, even if it is said to be human, the possible corollaries that flow from the assumption are endless. This makes the argument legally inapplicable.[10]

The final criticism is that if foetus and woman are equal, the infringement of autonomy that the woman will suffer for the sake of the foetus is out of proportion with the infringement of autonomy that she will suffer for the sake of other human beings (by virtue of the fact that the foetus is a part of her). Though Brody says that there is no duty to *save* the human, he believes that there is a duty not to *harm* him. On this view, all the acts in-between harm and killing, (such a abuse, bodily harm and addiction) would become illegal. This would mean that the woman, who is also a human, could not possibly expect to have *her* human rights respected if the foetus is also labelled a human. If her human rights are to suffer, then why should the foetal human rights not suffer to a similar degree, and hence we arrive back at the first criticism of the human foetus debate; that if both woman and foetus cannot claim full and equal human rights, then there is little point in the label human. In short, legal human right are simply inapplicable to the foetus.

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[10]. Note, however, that rejection of this argument does not prevent protection of the foetus, for it can be protected on grounds other than humanhood. See Leanord Glantz 'Is the Foetus a Human? A Lawyers View' in Bondeson, Engelhardt, Spicker and Winship Abortion and the Status of the Fetus (New York: Reidel, 1983) 107.

If the foetus is to be protected, it must be on the grounds that follow; that they are derived from humans and are potentially human. That they are something apart that have no desires, no feelings, but must be protected for what they may become and, of equal importance, what they *are* to society.[11]

b) The Argument form Potential

The potential of the foetus to become human is a valid ground on which to base the protection of the foetus. However, within the argument there are two possible camps, both of which offer some guidance in the protection owed to the foetus, though the latter camp offers the more concrete grounds.

Of the two camps, the first involves the claim that from some point in the production of the child, the foetus suddenly becomes worthy of protection by virtue of its potential to become human. Though this view usually concerns a particular point in gestation, Lord Immanuel Jakovits (speaking from the Jewish perspective) believes that though full human status does not occur until birth, the potential for being human should be respected even before conception. Hence the seed must not be wasted because the sole purpose of procreation is the production of children. As the potential grows (as gestation continues) so the respect owed to the foetus is increased.[12]

Most claim that the specific point in gestation from which potentiality becomes important, is conception. As a *child* is given protection and valued highly, they argue, so too the foetal potential for becoming this child should be valued. However, the problem with this argument lies in determining the degree of protection that the foetus deserves by virtue of its potential human status. For it is not a human but merely a potential human, so surely protection should not

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[11]. See J. Eekelaar 'Does a Mother have Legal Duties to her Unborn Child?' in Peter Byrne (ed.) Health, Rights and Resources: King's College Studies 1987-8 (London: Oxford University Press, 1988), 55. Eekelaar advocates that trying to solve moral issues by recourse to definitions in this way are best avoided: "Definitions are descriptions of factual phenomena; their applicability in the present context is, as a matter of language, uncertain. They cannot in themselves resolve the moral issues of how people should behave." at 58.

[12]. 'Respect for Life: Embryonic Considerations' in D.R. Bromham, M.E. Dalton, J.C. Jackson and P.J. Millican Ethics in Reproductive Medicine (London: Springer-Verlag Ltd., 1992), 47.

be as great as the protection owed to a fully fledged human. For example Tristram Engelhardt says:

> "If 'X' has potential 'Y', it follows that 'X' is not 'Y' and does not have the properties of 'Y' ... If 'X' has potential to be President, he does not have all the Presidential rights."[13]

John Harris agrees that just because a creature can become something else does not necessitate treating it as such prematurely.[14] He points out that we will all die one day, but do not want to be treated as dead. Raanan Gillon is equally critical of this form of the argument from potential saying:

> "The crucial moral question remains: at which phases of human development should individuals within those phases be accorded the intrinsic right to life that we all agree must be accorded to individuals who are in the person phase of human development? And alas the argument from potential, in whatever version, does not ... give us an answer to that question..."[15]

Some commentators within this camp believe that the argument from potential runs from the viability[16] of the foetus. This is because the foetus can often survive outside the woman from this point and is therefore not dependant upon her to such an extent. Patricia King believes that the foetus at viability has such great potential to become human that full human protection should run from this point.[17] However, there are problems of legal certainty here, because as

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[13]. Tristram Engelhardt 'Viability and the Use of the Fetus' in Bondeson, Engelhardt, Spicker and Winship, Abortion and the Status of the Fetus: Philosophy and Medicine Volume 13, A Collection of Essays (New York: Reidel, 1983), 184.

[14]. John Harris op. cit., 10.

[15]. 'Human Embryos and the Argument form potential' Journal of Medical Ethics 17 (1991), 59, at 61.

[16]. Viability is a term given to the stage when the foetus is developed enough to survive outside the pregnant woman. (Usually taken to mean 26 weeks gestation, though foetus' have survived from 24 weeks).

[17]. Patricia King 'The Judicial Status of the Foetus: a Proposal for the Legal Protection of the Unborn' (1979) 77(22) Michigan Law Review 1647.

technology advances, the point when a foetus becomes viable changes. Birth is the most logical and certain point in gestation to separate foetus from child, though this is not to say that protection cannot gradually increase throughout gestation as the foetus nears childhood.

The foetus is a potential human, but the argument from potential fails to provide any concrete method by which to afford the foetus protection and for this reason it is criticised. However, it will be seen in the next section that the symbolic significance of the foetus to society *is* an important consideration and that as the foetus ages in gestation (and its potential for life comes closer to being realised) its symbolic significance increases. This is because the foetus becomes more like a baby which we recognise as deserving of human rights. It is for this reason that the foetus is given more protection as it nears term; not directly because it has potential to be human (because it would be impossible to say where in that potential to begin protecting the foetus, and to what degree), but because as the foetus grows, so does the symbolic significance society holds for it. In this way, the potentiality argument fails because no particular point in potentiality is more important than another. The same criticism does not exist for symbolic significance.

The second camp in the argument from potential are of the view that only the future child has enough potential to warrant protection. This group can be sub-divided into those who look prospectively and those who look retrospectively at the foetus. The former group believe that the foetus has no significant human potential as long as there exists the woman's right to abort. Hence Janet Radcliffe Richards proclaims that once the mother decides not to abort the child, the mother's autonomy can be overridden because the foetus is now a definite future child.[18] However, criticism of this view is conceivable because it is impossible to say that a foetus is a definite future child, firstly because the decision of whether to abort is ongoing and secondly because there

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[18]. 'Maternal-Fetal Conflict' in S. Bewley and R. Humphrey Ward (ed.), Ethics in Obstetrics and Gynaecology, (London: RCOG Press, 1994), 34.

is always a possibility of miscarriage. Even in the Re S[19] situation, it could not be said with certainty that the foetus would survive the caesarean section operation.

The latter group within this camp, however, propose that the future child (foetus) deserves protection from a retrospective stance. In other words, rather than looking from the perspective of the foetus, the situation must be viewed from the perspective of the child. Hence it is the baby that has retrospective rights once it is born and has become a person.[20] As Engelhardt contends:

> "Potential persons have no actual rights, however the actual persons they become will have strong rights and claims. Therefore, actions harming future persons are immoral due to a casual chain that is part of the gestational history of the body of that person."[21]

Because these rights are retrospective, third parties are unable to tell if the foetus will later become a future person, and hence some protection is offered to all foetus'.[22] This is especially important in the case of foetal surgery and treatment where the effects of the such treatment on a future child will always have to be considered in case the foetus survives (and survival is the primary objective). It is this final view that will be supported (in conjunction with other perspectives outlined below) for the purposes of this chapter, because it does not make unrealistic and legally inapplicable distinctions between the various gestational stages of the foetus. However, the claim that the symbolic importance of the foetus grows as gestation continues will also be recognised.

c) Symbolism

The foetus is therefore protected retrospectively (by the Congenital Disabilities (Civil Liabilities) Act 1976, for example) out of a concern for the well-being of

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[19]. Re S (adult: refusal of medical treatment) [1992] 3 W.L.R. 806.

[20]. See Congenital Disabilities (Civil Liabilities) Act 1976 s. 1(1). Also see Raanan Gillon 'Pregnancy, Obstetrics and the Moral Status of the Fetus' Journal of Medical Ethics 14 (1988), 3.

[21]. Tristram Engelhardt op. cit., 186.

[22]. Note that there are also laws that protect the foetus regardless of its potential such as the Abortion Act 1967.

the future child. However, it is also protected prospectively (by the Abortion Act 1967, for example) because the foetus has special significance to us because it is human derived. Ian Kennedy recognises the flaws in the 'human-foetus' debate, but believes that the foetus is special, not because of its humanhood but because of its 'humanness'. [23] He believes that the foetus is sufficiently human-like to deserve special status and protection. It has the potential to become human but, he claims, more than this is needed. That extra factor is provided by virtue of the fact that there is something special, something that commands moral respect in human products. [24]

The belief that human products are special is undoubtedly correct. What should be done as a result of that belief and how to best respect that product, however, is a matter of conjecture. To what degree must the foetus be protected in view of its humanness? For Kennedy, the symbolism is an important issue; if physicians experiment on the foetus then a bad example will be set to the rest of society. Here the concern does not lie with issues of the embryo and experimentation, but Kennedy's concept can be applied to the foetus-pregnant woman scenario. The foetus should be protected, but its protection does not take precedence in all cases. Surely it would prove adequate, if the foetus is not a human but is merely potentially so (with that added 'humanness' factor), that the foetus is protected by controlling the woman's right to demand treatment so leaving her right to refuse it uncurbed. For protection must be given to the foetus, but that protection need not equal the rights of an actual human. Further, as the foetus becomes more human-like, protection is increased out of a recognition that the symbolic significance of the foetus as it grows. Hence the Abortion Act 1967 prevents unlimited abortions

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[23]. See Ian Kennedy, Treat me Right: Essays in Medical Law and Ethics, (Oxford: Clarendon Press, 1988), 125.

[24]. See J.E. Myers 'Abuse and Neglect of the Unborn: Can the State Intervene?' (1984) 24 Duquesne Law Review 1. See also Bonnie Steinbeck op. cit., 40. Also see the Meeker, Annas debate; W. Meeker 'Protecting the Liberty of Pregnant Patients' New England Journal of Medicine 317 (1987), 1224 (letter) and G.J. Annas 'Letter to the Editor' New England Journal of Medicine 317 (1987), 1224 (letter). Also see S.L. Barron 'The Galton Lecture for 1992: The Changing Status of the Foetus' S.L. Barron and D.F. Roberts (eds.) Issues in Fetal Medicine, Proceedings of the 29th Annual Symposium of the Galton Institute 1992 (London and New York: Macmillan Press Ltd., 1995), pp. 1-24 for the increasing symbolic significance of the foetus.

partly out of a concern for the symbolic affect on society caused by the killing of a humanly derived organism, and as the foetus nears term, protection is increased. However limited abortions are legalised in order to protect the autonomy of the woman and prevent back-street abortions.

Therefore three arguments for the protection of the foetus have been accepted based on; the retrospective value of the future child; the prospective value of the foetus which is human derived and special to us; and the symbolic effect on society of treatment or lack of treatment of the foetus.

What Protection do the Foetus and the Pregnant Woman Deserve?

A framework now exists whereby the woman can refuse intervention, but cannot necessarily demand it, and whereas her interest is of primary concern in the former case, the state interest is of primary concern in the latter. Defining the state interest involves devolving the best possible goal for the greatest number of people; a broad utilitarian concept. Though the 'best possible goal' is impossible to accurately define, it is here advocated that a possible goal in this case is 'health'. Hence, though individual autonomy is of primary importance in the refusal of treatment, when defining what an individual can demand, the best possible health of those involved in the scenario, is a worthy governmental goal. This will include a consideration of both the health of the foetus and the woman, for the governmental concern is paramount here (whereas with the right to refuse treatment the pregnant woman's concern is paramount) and so both foetus and pregnant woman will be of importance to the government.[25] The woman is important to the government because of her human status, and the foetus is important because of its potential to be human, its human origins and its symbolic significance.

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[25]. Note that just because the foetus' and pregnant woman's health are considered side-by-side here, does not make foetus and woman of equal status, for the pregnant woman enjoys far more protection by virtue of her right to refuse medical intervention. It will also be shown that as health is a value laden concept, the maternal health will include a degree of mental well-being which the foetus cannot possibly claim for it is not sentient.

This section firstly determines an acceptable definition of health, and secondly briefly examines the 'Four Principles' in order to clarify the wider meaning of health. Following this abortion, foetal surgery and screening are examined in an attempt to apply the principles. In conclusion three different types of treatment are differentiated and the corollaries that flow from each for woman and foetus are elucidated.

a) Is Health the Best Goal?

First, it is important to define health. Following this the value of the goal is considered. Good health may refer to physical well-being, to mental well-being, social well-being or to all three. Edwards and Graber consider the definition of 'health' (and the often opposing definition of 'disease'), and propose that one possible definition of health is 'the normal, natural functioning of the body and or the mind'.[26] However, Edwards and Graber oppose this, for the mere fact that statistically few exemplify a trait (for example beauty or extreme height) does not necessarily make them ill. They also point out that if an illness were to become common, it would not make it healthy. In fact, though the concepts of health and disease have a descriptive content they are also value laden:

> "... the general concepts of disease requires descriptive differentiating criteria and that all particular disease concepts incorporate descriptive clinical causes, conditions, signs, and / or symptoms. Medical education pays almost exclusive attention to the empirical dimensions of disease and tend to ignore or forget the disvalues."[27]

On this definition both the pregnant woman and the foetus can suffer illhealth depending on the prevalent societal values.

Hence it can be seen that health is value laden; it is subjective and moveable, but is laced with a descriptive content. Edwards and Graber provide some of the 'disvalues' of disease which gives the concept a content. Using these they limit the term disease to areas in which the physician has province. This seems the correct solution, for though the potency of social problems is

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[26]. Edwards and Graber Bioethics (San Diego: Harcourt Brace Jovanovich, Publishers, 1988), 246. (As exemplified by Christopher Boorse, Leon Lass and Thomas Szasz).

[27]. Edwards and Graber op. cit., 248.

recognisable, placing them in the 'disease' bracket merely confuses the roles of physicians. The terms they use to give content to 'disease' are dysfunction, distress, deformities and premature death.[28] However, health involves more than the mere absence of diseases; it involves a wider sense of well-being. For this reason it will take more to accomplish the health of the pregnant woman than it will to accomplish the health of the foetus. This is because the foetus is likely to be construed as unhealthy or diseased only where there is medical evidence of disease, for it is unable to have, recognise or communicate feelings of mental distress.

It is in the interest of the pregnant woman's health to allow certain concessions in her right to demand treatment, for health is not merely the absence of disease, but a more general well-being. This includes both treatment that may harm the foetus (though her access to this must be limited) and treatment that will benefit the foetus, for the latter is usually her desire. However, the value of health to the *foetus* will depend on the rationale from which it is viewed that the foetus deserves protection. For example the proponents of the argument from potential who recognised that the foetus must be retrospectively protected would presumably care little about the health of the foetus provided that it is born alive and healthy. Those who wish to give the foetus prospective protection, on the other hand, would be keen to see that no pain is suffered by the foetus during the gestational period. Those who argue that the foetus is human-derived and deserves protection because of the symbolic significance on society would presumably wish for foetal health both prospectively and retrospectively. Since the value of all three perspectives has been acknowledged, it seems acceptable to say that the value in foetal health exists both prospectively and retrospectively. However, the health of the foetus in the womb is limited by its lack of sentience (and often its lack of sensitivity to pain), therefore its health once born will usually be the primary consideration.

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[28]. 'Dysfunction' refers to an under or over presence of a desirable mental or physical capacity. They give examples of blindness, deafness, and heart failure. Medical help is called for here. 'Distress' refers to physical or mental distress or pain. Examples given are cancer, appendicitis, depression and paranoia. Again, it is appropriate to seek medical advice and help here. 'Deformities' *may* be disvales. Hence if alopecia, or dwarfism cause mental distress then they are within the province of the physician. 'Premature death' *may* be a disvalue, for we use advice and treatment from the physician in order to try to prevent it.

All that remains is to balance the value of foetal health with the value of the pregnant woman's health. One possible aid to equilibrium is the 'Four Principles'.

Because health is partly descriptive, but also value-laden, it is important to uncover the basis of the values. Boyd, with this purpose in mind, refers to the famous 'Four Principles'. [29] These include beneficence, non-maleficence, respect for autonomy and justice. 'Beneficence' and 'non-meleficence' require the physician to consider the clinical aspects of the case; to assess the physical and mental requirements and suggest any alternatives to the patients preferred course. 'Respect for autonomy' means that the doctor must have good reason for refusing to allow the patient's self-determination. Justice is the final principle which is all encompassing, involving the balancing of considerations in the individual case.[30]

Hence autonomy of the pregnant woman is still an important issue even when considering her right to demand treatment, however it must exist alongside the societal interest in foetal health. The justice consideration is also important to ensure that the pregnant woman is not disadvantaged by virtue of her pregnancy. Any treatment that a normal woman would be given should not be withheld from the pregnant woman, though she should be warned of the risks of any treatment that is harmful to the foetus. Though at present this leaves little scope for governmental refusal of the pregnant woman's requests on behalf of the foetus, two important factors must be noted. The first is that the foetal and maternal health rarely come into opposition at present. The second is that the likelihood of opposition will increase as the recent technological advances become common place. When this happens, the principles revealed in the thesis will prove extremely useful, for the woman's rights to alter her foetus (be it a

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[29]. in Raanan Gillon, op. cit., 814.

[30]. The Four Principles are criticised by K. Danner Clouser and Bernard Gert 'Morality vs. Principalism' in Raanan Gillon op. cit., 251, at 261. They prefer instead rules of morality, by which they include: Do not kill; do not cause pain; do not disable, do not deprive of freedom; and do not deprive of pleasure. Morality also comprises the following five rules which cause harm if ignored; do not deceive; do not break your promise; do not cheat; do not break the law; and do not neglect your duty.

change in it's cosmetic appearance, sex or intellect for example) can be legitimately limited in the interests of the future child, the foetus and the society for whom the foetus has such symbolic significance. Further, though the principle offers some legal certainty, it is sufficiently liquid to alter with technological advances.

b) The Effect on Medical Procedures

It is useful at this stage to examine the effect that this interpretation of the status of the foetus has on the medical procedures (specifically abortion, screening and foetal surgery) open to the pregnant woman.

The Maternity Services Government Response to the Second Report from the Health Committee, Session 1991-1992 on Maternity Services, affirms the importance of health in the wider sense in which it has been proposed, saying: " ... The key factor is the outcome: a well baby and a healthy, happy mother."[31]

It has been noted that the woman's right to demand treatment (including abortion) can, and must, be limited. It is suggested that the present abortion laws largely accord to this principle,[32] so by affording a measure of protection to the foetus, but preserving the woman's autonomy by occasionally allowing her to rid of an unwanted child. It also protects other aspects of the woman's well-being, reducing the incidence of back-street abortions and giving precedence to the pregnant woman's life over that of the foetus. However, if this seems too much of a concession to the pregnant woman (in view of the fact that this is the

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[31]. London HMSO Cm. 2018, Part 1, Par. 1.4..

[32]. Though Ruth Hubbard, 'Eugenics: New Tools, Old Ideas', in Hoffman Baruch, A. D'Adamo, J. Seager (eds.) Embryos, Ethics and Women's Rights (New York and London: Harrington Park Press, 1988), 225 (Hereafter Hoffman Baruch) legitimately argues that due to the symbolic importance of the foetus, abortion on the grounds of handicap alone (s.1(1)(d)) is unacceptable because of its eugenic connotations. In this thesis a distinction has been made between treatments which the woman refuses (which she is able to refuse absolutely) and treatments which the woman demands (which should take into consideration factors other than the woman's autonomy though not completely ignoring that factor). Abortion comes under the latter category and therefore the woman's autonomy must be considered alongside the welfare of the foetus. It has been noted that refusing abortion altogether would create an undesirable situation of back-street abortions, however it would be possible to omit the eugenic aspect of the Abortion Act leaving the woman able to abort should her health suffer as a result of continued pregnancy, even if her health suffers directly as a result of the handicap of the child. In effect her freedom would be altered minimally, but the bad symbolic effect of the eugenic section would be reduced.

main source of foetal protection), then John Eekelaar's views show the wisdom of the concessions to the pregnant woman.[33] Eekelaar starts from the premise that the foetus is no morally different to a child, and though this does not necessarily accord with the views represented in this thesis it illustrates how abortion can be justified even when the foetus is elevated to the position of human.

Eekelaar contends that, from a moral objective, there is no distinction between the foetus and the child. Therefore, as the child cannot expect its mother to put herself in a life-threatening position (or even at risk of serious psychological disturbance) for his sake, neither should the foetus (nor the state on behalf of the foetus). Abortion is permissible only due to the physical inseparability of the mother and foetus: "Only by abortion can the mother be protected from undergoing conditions a parent would not be expected to tolerate. Nature, not social ordering, has made it so."[34] In this way it can be seen that limited abortion rights for the pregnant woman are justifiable.

Foetal screening has multiple purposes:[35] It can be used to diagnose illness in a foetus with a view to its treatment, or alternately with a view to its termination: It can be used to determine the sex or other characteristics of the foetus, either with a view to parental preparation for the child, or with a view to its termination should it fail to reach the standards set by the parents, or possibly with a view to correction of the defect by foetal surgery.[36] Therefore, though the

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[33]. Eekelaar op. cit., 55-76. "... no single stage of embryonic evolution, after its commencement at fertilisation, seems in itself capable of generating a moral conclusion. I feel compelled to adopt the position that, if a fetus has rights, it always has them; if it has not I am not convinced how or at what point they are acquired." at 57.

[34] Eekelaar, op. cit., 61. Note that Eekelaar does not use this model to justify any abortion; only to justify conditions that a parent would not be expected to tolerate: there must be commensurability between the act and the threat to the woman.

[35]. See generally A. Sutton Prenatal Diagnosis: Confronting the Ethical Issues (London; The Linacre Centre for the Study of the Ethics of Health Care, 1990) and more specifically M. Richards and J. Green 'Screening for Foetal and Genetic Disease: Some Social and Psychological Consequences' in Ian Robinson (ed.) Life and Death Under High Technology Medicine (London: Manchester University Press, 1994), p36-48.

[36]. For the specific techniques involved see A. Sutton op. cit., 19 and Caroline Whitbeck 'Fetal Imaging and Fetal Monitoring: Finding the Issues' in E. Hoffman Baruch op. cit., 47.

woman has the opportunity of ultrasound screening, the more complicated screening techniques, such as amniocentesis and chorionic villus sampling are reserved for cases with a higher risk of abnormality largely because the risks to the foetus are considered too great to justify the procedure.[37] It should also be noted that though screening is often aimed at detection of abnormalities with a view to termination, it can conversely prevent unnecessary abortions where the risk of handicap is great but proves to have been avoided in a particular case.

Foetal surgery[38] is a recent technique that is not yet technologically advanced enough to become commonplace. It is prudent, however to ensure firstly that when it does so, the law is sufficiently advanced to protect women from forced surgery and secondly to limit women's recourse to it on the grounds that the risks to the foetus is occasionally unacceptable. On 14th February 1995, BBC2's 'Horizon' episode 'Twice Born' researched the recent advances in foetal surgery around the world. They reported the wonderful ways in which the technique can be used to save or treat the foetus and the way in which scarring can be eliminated. However, there are few laws or properly researched ethical codes governing foetal surgery and there are areas of concern. Though Michael Harrison and his pioneering team at California University were said to operate only if the foetus could not survive without the operation, others such as Doctor Monenterro of the University of Mexico were said to have operated on less dire cases, for cosmetic effect. Horizon quoted the case of a lady who visited Doctor Monenterro for the correction of the foetus' cleft lip (with the benefits of healing without scar tissue). This particular lady considered the cleft lip to constitute

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[37]. David Heyd in 'Prenatal Diagnosis; Whose Right?' Journal of Medical Ethics, 21 (1995), 292 says that of the four possible groups towards which prenatal screening should be aimed (the parents, the child, society or no one), a balance between the parents needs and society's needs is called for.

[38]. For techniques and justifications of foetal surgery see D.K. Nakayama 'Foetal Surgery' and M.J. White 'Foetal Surgery' in S.L. Barron and D.F. Roberts (eds.) op. cit., 94, 105. See also W.R. Barcley, R.A. McCormick, J.B. Sidbury, M. Michejda and G.D. Hodgen 'The Ethics of In Utero Surgery' Journal of American Medical Association, 246 (1981), 1550 and Francois Luks 'Foetal Surgery: New Techniques Have Given Surgeons a Second Chance' British Medical Journal, 311 (Dec. 1995), 1449.

such a handicap, that she would have aborted the foetus had the technique not been available. There is concern as to whether the precedent set by such an operation which is both expensive and extremely risky to the foetus, is acceptable. While the technique is uncertain it would be prudent to reserve foetal surgery for cases where the foetus would otherwise miscarry. This would accord with the conclusions that have been drawn concerning the protection deserved by the foetus, and it would also alleviate a possibly damaging symbolic effect on society. Further, it would represent the best chance for the foetus to attain health (both in the womb and, more importantly, once born).

As the technique advances, it will prove necessary to review the degree of intervention granted to the pregnant woman, but this must be done under the guiding principle that the foetus is deserved of protection by virtue of its potentiality, its value to society and the symbolic effect any treatment or lack of treatment will have on society. One possible solution, as Alexander Capron suggests, is the setting up of a national commission on medical ethics to deliberate the issues as the technologies advance.[39]

Hence the balance between woman as foetal container and foetus as mere appendage can realistically be appreciated on the basis of allowing the woman complete autonomy to refuse intervention with her body, but curbing her rights to demand such treatment.

Conclusion

Hence, the law must protect the foetus for the sake of the pregnant woman and her well-being; for the sake of the future child; for the sake of the foetus itself; and for the sake of society whose views on the subject must not go unheeded. When defining how far to heed a pregnant woman's demand for treatment, her autonomy must be recognised as valuable and worth protecting, especially if her

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[39]. 'A National Commission on Medical Ethics?' in P. Byrne (ed.) op. cit., 177. Capron describes the work of the American President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research and concludes that a similar Commission would be useful in Britain.

'health' will suffer as a result of non-compliance and especially if the foetal health will not be harmed as a result of her action.

In effect a distinction has been made between various types of treatment. It is concluded that treatment that is entirely separate from the pregnancy must be forthcoming to the pregnant woman in the same way as every other citizen can expect the treatment. This is because justice is one of the components of health which was viewed a valuable goal. Hence a pregnant woman who suffers from cancer should not be refused treatment on the grounds that her foetus would suffer or die.

The second category concerns treatment of the foetus, such as screening and foetal surgery. Here the components of the pregnant woman's health must be considered; her autonomy and the justice principle still have bearing, but the foetal interest in health must also be considered. Hence foetal surgery, for example, must be available to the woman (provided that resources are available) but must be limited to occasions when the benefit to the foetus is likely to outweigh the traumas of the surgery.

The third category concerns treatment relating to the pregnancy that is designed to help the pregnant woman. The most obvious example here is abortion. Here the interests of foetus and pregnant woman must again be balanced. The woman has some interest in equality with other women (in other words in being free to rid of the foetus is she so desires) but the prospective value of the foetus and its symbolic importance (that increases with gestation) necessitates limitation of abortion as is evidenced in the law as it stands.

With the aid of a medical ethics committee to review criteria as technology advances, it is hoped that the conclusions outlined in this thesis could prevent the trampling of the pregnant woman's rights, and offer protection to the foetus in an ordered and logical manner.

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