Maternal Liability for Prenatal Harm

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Catherine E Bowden

Department of Law

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LIST OF ABBREVIATIONS

CDCLA	Congenital Disabilities (Civil Liability) Act 1976
CICA	Criminal Injuries Compensation Authority
CMOs	UK Chief Medical Officers
CRPD	UN Convention on the Rights of Persons with Disabilities
DOH	Department of Health
ECHR	European Convention on Human Rights
FASD	Foetal Alcohol Spectrum Disorder
GMC	General Medical Council
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ILPA	Infant Life (Preservation) Act 1929
IVF	In Vitro Fertilisation
MCA	Mental Capacity Act 2005
NHS	National Health Service
NICE	National Institute of Health and Care Excellence
NIPT	Non-invasive prenatal testing
OAPA	Offences Against the Person Act 1861
PHE	Public Health England
SIDS	Sudden Infant Death Syndrome
SIGN	Scottish Intercollegiate Guidelines Network
UDHR	Universal Declaration of Human Rights
UK	United Kingdom
US / USA	United States of America

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ABSTRACT

Catherine E Bowden, The University of Manchester
PhD in Bioethics and Medical Jurisprudence
Maternal liability for prenatal harm
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Could women be held responsible for prenatal harm due to their conduct during pregnancy and would this be justified?

It is tempting to assume that women's rights are secure from the interference that legal liability for unintentionally causing harm to their future children through their behaviour during pregnancy would represent. After all, women have not faced criminal liability for such harm in the almost three decades since the House of Lords ruling in *Attorney-General's Reference (No 3 of 1994)* [1997] 3 WLR 421, which suggested that such liability might be possible, and in light of the more recent case of *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation)* [2014] EWCA Civ 1554 in which the Court of Appeal expressed a reluctance for the law to interfere with the behaviour of pregnant women.

In this thesis I consider whether we are right to assume that there is no prospect of women facing such liability and conclude that we are not. Further, I argue that such liability would not be justified. I take a fresh approach to the question of maternal liability for prenatal harm by considering how the behaviour of pregnant women is currently being policed in public health measures aimed at reducing prenatal harm and asking whether this could translate into legal liability.

In Papers One and Two, I consider how women are currently held responsible for prenatal harm in public health, with a focus on the policy to routinely screen all women for behaviours such as smoking and drinking during pregnancy. This is followed in Paper Three by an analysis of the reasoning in *Attorney General's Reference (No 3 of 1994)* and *CP* to determine whether criminal liability remains a possibility for women whose behaviour during pregnancy results in harm to their future child. I argue that the moral judgment of pregnant women who drink or smoke during pregnancy, reflected in public health policies, could be used to support calls for criminal liability, exploiting the opportunity left open by the focus on the status of the victim in these cases. Finally, in Paper Four, I consider whether the unequal treatment of mothers and fathers in the Congenital Disabilities (Civil Liability) Act 1976 is justified and argue that reform is needed to bring the civil law up to date with changes in society, the criminal law, and medical science. Without such reform, the exclusion of maternal liability in the civil law is open to legal challenge, threatening women's hard-won rights.

Together, these papers demonstrate that if we want to improve outcomes for future children and protect women from liability for prenatal harm and the threat to their autonomy this would represent, it is time for a shift in the view of pregnancy taken by the law and in public health. Far from being in conflict, in the case of wanted pregnancies that women intend to bring to birth, the interests of pregnant women and future children are closely aligned and any attempt to impose a legal duty on pregnant women to act in the interests of their future children is likely to be unwarranted and counterproductive.

DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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I began this PhD because I found the topic of health care ethics and law so fascinating, it felt like pleasure rather than work to study it. I remember reading Mason and McCall Smith's textbook during my training contract in commercial law and thinking 'wow, imagine being lucky enough to study that'. But it is because of the people who have supported me along the way that I have finished it.

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***

THE AUTHOR

Catherine Bowden graduated from the University of Cambridge in 2002 with a 2:1 in natural sciences. She went on to study law at Guildford College of Law gaining distinctions in both the Graduate Diploma in Law, and the Legal Practice Course before completing her training contract in the City of London, qualifying as a solicitor in 2007. She went on to practice law in Manchester, handling a mixture of clinical negligence, fitness to practice hearings, access to healthcare in prisons, and employer's liability claims. After a short career break while having her three children, she completed her MA in Health Care Ethics and Law at the University of Manchester, achieving a merit, and was awarded the Centre for Social Ethics and Policy Chair's Prize in 2013. During her PhD, Catherine has worked as a Teaching Assistant for the University of Manchester in the Department of Law and Leadership in Action course, as well as acting as an external examiner in Advanced Tort Law for the University of London. She is also a board member for Healthwatch in Cheshire East and Cheshire West. She is currently a Research Associate in the Department of Law at the University of Manchester for a Data Trusts Initiative funded project, 'General Practice Data Trust'.

CHAPTER 1 - INTRODUCTION

The impact of the prenatal environment on the health of future children is well established. Everything from what a pregnant woman[1] eats, to how much stress she experiences can have negative consequences for her future child. This has led to a catalogue of anxiety inducing advice and instructions directed to pregnant women and indeed, all women 'of child bearing age'.[2] At the start of the twentieth century, very few pregnant women in Western Europe had any contact with healthcare professionals before they gave birth.[3] By the end of that century, the experience of pregnancy had changed dramatically with the hospitalisation of childbirth, the advent of assisted reproductive technologies, and the development of obstetric ultrasound and prenatal diagnostic tests.[4] Now, it is usual for a pregnant woman to attend antenatal appointments 8 times during a 40 week pregnancy (11 times if it is her first pregnancy) where she will have her abdominal growth measured, her urine dipped, the foetal heartbeat listened to, and be asked numerous questions about her health and behaviour.[5] Screening commonly includes screening for infectious diseases such as Human Immunodeficiency Virus (HIV), Syphilis, and Hepatitis B; as well as conditions such as pre-eclampsia, gestational diabetes, and rhesus D incompatibility.[6] In recent years, screening for genetic conditions such as foetal

[1] In this thesis I refer to 'pregnant women' but I acknowledge that not all pregnant people will identify with this term. There are strong arguments in favour of additive language but for the purposes of this work I feel that this is the most appropriate terminology as the law and public health policies considered are directed at pregnant women, mothers as gestators, and fathers as sperm donors.
[2] The emergence of advice to 'women of childbearing age' is the subject of a current study, Alana Cattapan, 'Perpetually, Potentially, Pregnant' <https://www.perpetuallypotentiallypregnant.com> accessed 11 July 2022.
[3] Salim Al-Gailani, and Angela Davis, 'Introduction to "Transforming pregnancy since 1900"' (2014) 47 Stud Hist Philos Biol Biomed Sci 229.
[4] ibid.
[5] NHS, 'Your antenatal appointments' (2019) <https://www.nhs.uk/pregnancy/your-pregnancy-care/your-antenatal-appointments/> accessed 24 May 2022.
[6] National Institute for Health and Care Excellence (NICE), *Antenatal Care* (NG201, 2021) <https://www.nice.org.uk/guidance/ng201> accessed 11 July 2022.

aneuploidy (e.g. Downs' Syndrome) through non-invasive prenatal testing (NIPT) has also become a part of routine antenatal care.[7]

Whereas once the exposure to stress, quality of nutrition, smoking and alcohol consumption, often associated with poverty would have been considered 'environmental factors' they are increasingly viewed as problems of maternal behaviour.[8] This can be seen as part of a broader trend which sees health as a matter of individual behaviour and responsibility with moral judgments frequently attached to those who fall short of the healthy ideal.[9] However, this moral judgment is magnified in the case of pregnancy where the pregnant woman is not only viewed as responsible for her own health and the valuable National Health Service (NHS) resources she takes up, but also for the health of her future child and the state resources required in the care of that child. Consequently, pregnant women are frequently singled out for coercive public health interventions in a way that non-pregnant individuals are not.

This construction of prenatal harm as a matter of individual responsibility has been internalised by many women and has transformed the experience of pregnancy. As Rebecca Kukla writes, we now 'treat pregnancy as something that is and ought to be *designed*, and designed in accordance with public, social standards.'[10] Part of the role of the 'good pregnant

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[7] NHS England, *Screening tests for you and your baby* (NHS Guidance, 2019) <https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby> accessed 11 July 2022. It has been argued that routine prenatal testing is coercive and irreconcilable with women's choice and empowerment; Rebecca Bennett, 'Antenatal genetic testing and the right to remain in ignorance' (2001) 22(5) Theor Med Bioeth 461; Panagiota Nakou, 'Is routine prenatal screening and testing fundamentally incompatible with a commitment to reproductive choice? Learning from the historical context' (2021) 24(1) Med Health Care Philos 73.

[8] For a thorough and insightful analysis of this change see Sarah Richardson, *Maternal Imprint: The Contested Science of Maternal-Fetal Effects* (University of Chicago Press 2021).

[9] Rebecca C H Brown, 'Resisting Moralisation in Health Promotion' (2018) 21 *Ethic Theory Moral Prac* 997.

[10] Rebecca Kukla, *Mass Hysteria: Medicine, Culture, and Mothers' Bodies* (Rowman & Littlefield Publishers 2005), 127.

woman' is now to research and consume the endless sources of advice, documenting the number of kicks and urinations, submit to measurements of weight, blood sugar level, and fundal height.[11] As a consequence of this social conditioning, research into the impact of maternal behaviour during pregnancy is likely to be received less critically, and have more of an impact on women's lifestyle choices than in the past.[12]

This has implications for the law as the notion of the 'good' pregnant woman and the moral policing that comes with it has the potential to be used to support calls for legal liability for women whose behaviour during pregnancy causes harm to their future children. If physical harm to an individual is caused by the morally blameworthy conduct of another, strong arguments would be needed to resist calls for retribution under the law. Indeed, women have already faced legal liability for their conduct during pregnancy that is thought to have caused harm to their future children in other jurisdictions, most notably in the United States (US).[13] In the US, 38 out of 50 states have extended laws designed to protect children against abuse and endangerment to the prenatal stage,[14] and the Unborn Victims of Violence Act 2004 (US) recognises a foetus in utero as a legal victim if it is killed or harmed during the commission of over sixty federal crimes.[15] The research associated with a public health approach that views the mother as responsible for the developmental environment of the future child is frequently cited by advocates of these foetal protection laws as evidence that the foetus is in

[11] ibid.
[12] Richardson (n 8) 14-16.
[13] For a detailed and disturbing account of the criminalisation of conduct during pregnancy in the United States, see Michele Goodwin, *Policing the womb: Invisible women and the criminalization of motherhood*. (Cambridge University Press 2020). Foetal harm is also criminalised in other jurisdictions such as El Savador, see Jocelyn Viterna and Jose Santos Guardado Bautista, 'Pregnancy and the 40-year prison sentence: how "abortion is murder" became institutionalized in the Salvadoran judicial system' (2017) 19 Health Hum Rights 81.
[14] Editorial, 'A woman's rights: parts 1-7' *New York Times* (New York, 28 December 2018) <https://www.nytimes.com/interactive/2018/12/28/opinion/pregnancy-women-pro-life-abortion.html> accessed 16 June 2022.
[15] Goodwin (n 13) 15.

need of legal protection.[16] Therefore, if we do not want to see women facing legal penalties for their behaviour during pregnancy, we should be concerned by the trend in public health for viewing prenatal harm as a problem of women's behaviour. Worryingly, it seems likely that the surveillance and criminalisation of women in America will only increase following the recent Supreme Court ruling overturning of the constitutional right to abortion established in *Roe v Wade*.[17]

It could be argued that there is no prospect of maternal liability for causing prenatal harm to their future children in English law. After all, women have not faced criminal liability for such harm in the almost three decades since the House of Lords ruling in *Attorney-General's Reference (No 3 of 1994)*[18] which suggested that such liability might be possible, and in light of the more recent case of *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation)*[19] in which the Court of Appeal expressed a reluctance for the law to interfere with the behaviour of pregnant women. However, there is no room for complacency when the hard-won rights of women are at stake. This thesis will examine the potential for maternal legal liability for prenatal harm and demonstrate that this remains a possibility. Further, it will show that legal sanctions are more than a technical possibility; there is good to reason to believe that this opportunity could be exploited. The law already concerns itself with the conduct of pregnant women, not least through abortion law,[20] but also in care

[16] ibid; Lynn M Paltrow and Jeanne Flavin, 'Arrests of and forced interventions on pregnant women in the United States, 1973–2005: Implications for women's legal status and public health' (2013) 38 J Health Polit Policy Law 299.
[17] 410 US 113, 163-64 (1973); *Dobbs v Jackson Women's Health Organization* 597 US (2022)
[18] [1997] 3 WLR 421
[19] [2014] EWCA Civ 1554, [2015] 2 FLR 1163 (CA)
[20] For details of women currently being prosecuted in the UK for accessing abortion see Rachel Moss, 'Two women in UK are facing criminal charges for abortion. Here's why' (*Huffington Post*, 18 July 2022) <https://www.huffingtonpost.co.uk/entry/why-women-in-uk-face-criminal-charges-for-abortion_uk_62d5689ee4b0116f21be6fe1> accessed 23 July 2022; Hannah Al-Othman and Laith Al-Khalaf, 'Women still on trial over abortions' *Sunday Times* (London, 17 July 2022).

proceedings and prosecutions for concealment of birth.[21] In addition, women's behaviour during pregnancy is being increasingly policed via public health interventions seeking to reduce prenatal harm. This indicates a desire to hold women responsible for prenatal harm due to their conduct during pregnancy which could drive calls for legal liability. If such calls are to be resisted, reform of the law on prenatal harm is required.

[21] Emma Milne, 'Putting the fetus first – legal regulation, motherhood, and pregnancy' (2020) 27 Mich J Gender 149.

CHAPTER 2 - ETHICAL AND LEGAL BACKGROUND

Pregnancy poses a unique set of challenges for moral and legal theory. The desire to respect and protect the pregnant woman, the uncertain rights and interests of fathers-to-be along with the intuition that the foetus, or unborn child, is particularly vulnerable and thus requires a special level of protection, often leads to impassioned and intractable debate. The debate raises questions of the moral status of the foetus and the autonomy and bodily integrity of the pregnant woman, as well as the interests of women in general and the role of men in reproduction. Given the complex moral nature of pregnancy, it is perhaps unsurprising that the law has struggled to find a consistent and appropriate approach to the legal issues raised.

In this section I will consider the legal statuses of the foetus and of the pregnant woman and how this is connected to their moral statuses. In so doing, I will demonstrate that English law adopts a situational approach to the status of the foetus; treating it differently in different situations, and that this requires a clear exposition of the terms of such an approach including any moral principles the law is seeking to reflect.

2.1 The Legal Status of the Foetus

It is an established principle under English law that it is live birth which confers legal personality. [22] Therefore, a foetus is not a legal person. Further, in *Re F (in utero)*[23] the court

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[22] This principle can be traced back to Coke who stated in his discussion of murder that a human being 'is accounted a reasonable creature *in rerum natura* when it is born alive.' Edward Coke, *The third part of the Institutes of the laws of England: concerning high treason, and other pleas of the crown, and criminal causes*, vol 1 (W. Clarke and Sons 1809) 50. This has been confirmed in case law. See for example, *Paton v Trustees of the British Pregnancy Advisory Service* [1979] 2 All ER 987.

[23] *Re F (In Utero)* [1988] Fam 122.

held that a foetus could not be made a ward of court under the court's inherent jurisdiction and in *Vo v France*[24] the European Court of Human Rights held that foetuses are not directly protected by the European Convention of Human Rights. However, it is not the case that the foetus is without protection under the law.

For example, it is an offence under s. 58 Offences Against the Person Act, 1861 (OAPA) for a woman to procure her own abortion. Abortion is only permitted in prescribed circumstances, with the approval of two doctors as set out in the Abortion Act 1967.[25] Further, the Infant Life (Preservation) Act 1929 confers protection on the 'child capable of being born alive' by creating the offence of 'child destruction'.[26] This offence is committed when 'any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother'.[27] A foetus of twenty-eight weeks gestation or more is considered *prima facie* to be 'a child capable of being born alive' by virtue of s. 1(2). Thus, this section characterises the foetus as 'other' to the pregnant woman; a separate being with distinct interests. In s. 58 OAPA the subject of the offence of procuring a miscarriage is the pregnant woman; it is an offence to cause her to miscarry her pregnancy. Thus, the woman is the victim (as well as a potential perpetrator) of the offence. However, the subject of the offence of child destruction is 'a child … before it has an existence independent of its mother.'[28,29] The concept of the 'child capable of being born alive' requires the law to consider the foetus as separate from the pregnant woman, as analogous to an existing child, with its unborn status a matter of mere geography.

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[24] *Vo v France* [2004] 2 FCR 577.
[25] As amended by the Human Fertilisation and Embryology Act 1990.
[26] section 1(1), Infant Life (Preservation) Act 1929.
[27] ibid.
[28] ibid.
[29] Kristin Savell, 'The Mother of the Legal Person', in Susan James and Stephanie Palmer (eds), *Visible Women: Essays on Feminist Legal Theory and Political Philosophy* (Hart Publishing 2002) 42.

The foetus is further protected under criminal law following the case of *Attorney-General's Reference (No. 3 of 1994)*.[30] In that case the Court of Appeal and then the House of Lords considered the extent of criminal liability for the death of a child born alive where the death was due to injuries inflicted prior to the child's birth. The case concerned a man who stabbed his pregnant girlfriend, causing injuries to the foetus. The baby girl was born alive prematurely, but later died. The House of Lords ruled that in this case a charge of murder was not established as there had been no intention to kill or harm the foetus or the child it would become, but a charge of unlawful act type manslaughter was established.[31] The father had committed a dangerous and unlawful act likely to cause harm to the future child, which resulted in her death. Applying the offence of manslaughter to actions that occur during the foetal stage which cause the death of a child later born alive, has come to be known as the born alive rule.[32] In finding that a third party could be liable in manslaughter in these circumstances, and further holding that the pregnant woman and foetus are '…two distinct organisms living symbiotically, not a single organism with two aspects',[33] the House of Lords took a step towards personalising the foetus, despite rejecting the possibility that the foetus could be a separate legal personality.

Underlying the legal status of the foetus is the assumption that while the state has a duty to protect the rights of women, it also has an interest, or perhaps even a duty, to protect foetuses, not only from harm by third parties because of their value to their parents, but also from harm *by* their parents because they have their own intrinsic value. I will now consider the moral justification for this assumption.

[30] *Attorney-General's Reference (No. 3 of 1994)* [1998] AC 245 (HL).
[31] ibid.
[32] Emma Cave, *Mother of All Crimes* (Routledge 2018) 56.
[33] ibid 255, per Lord Mustill.

2.2 The moral status of the foetus

2.2.1 What is moral status?

When we talk about the moral status of the foetus, what we are really talking about is what weight should be given to the interests of the foetus compared to that of the pregnant woman. Are beings at all stages of human development to be treated equally or do we have a reason for giving priority to some over others?

If the pregnant woman and foetus are of equal moral status, their rights and interests must be weighed against each other as equals. In this case abortion would be morally wrong unless the pregnancy posed a serious risk to the woman's life. Further, assisted reproduction techniques which involve the destruction of some embryos as well as research on human embryos would be impermissible. However, if we want to argue in favour of such practices and the hard-earned rights of women, we need to be able to say why treating embryos and foetuses in this way, permitting their destruction, is permissible when similar treatment of adult human individuals is not.

The question is therefore, 'what makes human life valuable and, in particular, what makes it more valuable than other forms of life?'[34] The approach we take to this question can then be used to determine which beings have this special value and correspondingly, which beings we have a special duty to protect the lives and interests of.

[34] John Harris, *The value of life: an introduction to medical ethics* (Routledge & Kegan Paul 1985) 7.

2.2.2 What is the moral status of the foetus?

The moral status of the foetus is a complex issue where there are a myriad of views and little consensus. At one end of the spectrum there are those who argue that the embryo has full moral status and thus a right to protection from conception.[35] This position is usually argued from either an idea of ensoulment at conception, [36] or based on an idea of potential, so we should protect this human entity at this early stage because of the potential it has to become a conscious and complex human being. At the other end of the spectrum there are those who argue that it is only attributes like consciousness, rationality, and agency, that convey moral status to a human being.[37] On this view moral status is not gained until sometime after birth.

Any conservative view that takes the position that the embryo and foetus has moral status at an early stage is not compatible with respect for the autonomy of women of childbearing age; there is no room for two sets of full and equal rights in one body. [38] It is also not compatible with practices such as abortion or even In Vitro Fertilisation (IVF), which inevitably involve the destruction of these entities. If this is the position to be taken, then the ethical and legal issues would be comparable to issues arising in other circumstances that require the balancing of the rights and interests of capacitous adult humans, albeit with the unique bodily connection of pregnancy.[39] But there are a number of weaknesses to these more conservative positions.

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[35] Alastair V. Campbell, 'Viability and the moral status of the fetus' in *Abortion: Medical Progress and Social Implications* (Pitman 2009) 228.

[36] John T. Noonan Jr, 'Abortion and the Catholic Church: A Summary History' Nat LF (1967) 12.

[37] This view was originally set out in Mary Anne Warren, 'On the moral and legal status of abortion' (1973) Monist 43.

[38] Mary Anne Warren, 'The Moral Significance of Birth' in Helen Bequaert Holmes and Laura M Purdy (eds), *Feminist Perspectives in Medical Ethics* (Indiana University Press 1992) 213.

[39] See Judith Jarvis-Thomson's thought experiment in Judith Jarvis-Thomson, 'A Defense of Abortion' (1971) 1 Philos Public Aff 47.

In general terms, the argument from potential states that foetuses ought to be treated as if they were persons because they have the potential to develop into persons if they are allowed to grow and develop.[40] There are two problems with this argument. Firstly, the fact that something has the potential to become something else does not require us to treat it as if it were already that something else. As Harris states, the fact that I will one day be dead does not mean that you should treat me as if I am already dead.[41] Secondly, the argument from potential does not justify what level of potential attracts the kind of moral status associated with personhood. A fertilised human embryo has the potential to develop into a person if it is successfully implanted, nurtured and safely delivered but a sperm or an unfertilised egg also has the potential to develop into a person if the additional step of fertilisation takes place.[42] Therefore, should gametes also be included in normative personhood? There are variations of the argument from potential which require a unique genetic identity or some other developmental milestone but the ethical relevance of such milestones is often poorly justified, if at all.[43]

An alternative approach commonly adopted by those who wish to support a woman's right to abortion is a gradualist approach. This view of moral status accepts that there is no milestone during foetal development which signifies the start of normative personhood but that there is a sliding scale, a gradual increase in moral status, as pregnancy progresses. As Steinbock claims:

> as the fetus develops, it gets closer to becoming an individual that will have moral claims on us. It seems reasonable that the considerations offered to justify

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[40] Warren (n 38).
[41] Harris (n 34) 11.
[42] ibid 11-12.
[43] John T. Noonan, Jr, 'An almost absolute value in history' in *The Morality of Abortion: Legal and Historical Perspectives* John T. Noonan Jr. (ed) (Harvard University Press 2013); John Finnis, 'The Rights and Wrongs of Abortion: A reply to Judith Thomson' (1973) 2(2) Philos Public Aff 117; See Rosamund Scott, *Rights, duties and the body: law and ethics of the maternal-fetal conflict* (Hart Publishing 2002), 38-41.

terminating a pregnancy should be stronger at the end of pregnancy than at the beginning.[44]

Some, such as Mackenzie argue that physical development is the significant feature that warrants greater intrinsic moral value.[45]

> …the moral value of a being's potential personhood is related to the physical or biological basis of the potentiality, in particular it is grounded in the degree of complexity and development of this physical basis.[46]
>
> At the early stages its moral standing is defined in relational terms, because it is a being with moral significance for the woman in whose body it develops and who acts as its moral guardian. As the foetus develops physically however its intrinsic moral significance increases. Its moral standing is less and less dependent on its relational properties with the woman in whose body it develops and more and more tied to its own intrinsic value.[47]

The problem is that it is not clear *why* increased physical development or closeness to personhood should be considered morally significant.[48] Proponents of the gradualist account of foetal moral value are therefore left with the argument that a gradualist account is nevertheless useful in tackling anti-abortion arguments based on the symbolic value of advanced foetuses.[49] The argument is that as foetuses develop to greater resemble human persons, to treat them as having equivalent intrinsic moral value to non-human sentient animals such as fish, would negatively impact on respect for actual human life. In other

[44] Bonnie Steinbock, *Life Before Birth – The Moral and Legal Status of Embryos and Fetuses* (Oxford University Press 1992) ch 2, 36-107, 62.
[45] Catriona Mackenzie, 'Abortion and embodiment' (1992) 70 Australas J Philos 136, 145.
[46] ibid.
[47] ibid 146.
[48] Scott (n 43) 31-32.
[49] ibid 45.

words, the potential personhood, coupled with the human-like developed state of a late term foetus, has symbolic significance, and this can be seen as a reason against killing it.[50] However, whilst the impact on respect for actual persons because of the symbolic importance of the late term foetus, is worthy of consideration, it does not seem to be an argument for claiming that killing the foetus would necessarily be a moral wrong, particularly when not killing the foetus would be interfering with the right of a capacitous adult person to control their own body.

Although no position on moral status is unproblematic, in this thesis I take a position based on a personhood approach, which recognises that what distinguishes beings which have an intrinsic right to protection from other beings is the ability to have a sense of their own life, their own plans and consciousness. I take this position because I find this approach the most defensible as it asserts a morally significant characteristic as the basis for valuing the lives of adult humans. If we want to argue that killing an adult human would be a different kind of moral wrong than killing an animal, we need an account of moral status based on what sets humans apart from animals and explains why ending that life is particularly problematic. In my view, the personhood approach provides this. The ability to have a sense of one's own life and hopes and plans for the future, is at the core of what sets human life apart from other sorts of life and it seems logical that ending the life of a being that has an expectation of a future is morally different to ending the life of a being that does not; the former would take away a future that was valued by that being, the other would not. This position is not without its problems in that it would not assign moral status to newborn human infants.[51] However, not assigning moral status is not the same as allowing these entities to be treated badly. There may be many other extrinsic reasons why we should, in most circumstances, protect

[50] ibid 45-46. See also Joel Feinberg, *Freedom and Fulfillment* (Princeton University Press 1994) 55.
[51] Scott (n 43) 32-33.

the newborn human being, not least because of its value to its parents.[52] This position is consistent with the law in this area and with practices such as abortion and assisted reproduction.

Having now set out the legal and moral status of the foetus that informs the work in this thesis, I will now consider the legal and moral status of the pregnant woman.

2.3 The legal status of the pregnant woman

The rights of the pregnant woman under English law have changed greatly over the last century. From the Infant Life (Preservation) Act 1929 which, for the first time permitted the killing of a viable foetus to save the life of a pregnant woman, to the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990 and Human Fertilisation and Embryology Act 2008, Parliament has to some degree, sought to favour the rights of the mother over those of the foetus.[53] However, despite the lack of legal personhood of the foetus, there are some ways in which pregnant women are treated differently by the law by virtue of their pregnant status.

2.3.1 Refusal of treatment cases

As medical science has advanced it has become necessary for the law to address the question of whether a pregnant woman is able to refuse medical treatment that would benefit, or even

[52] Warren 'The Moral Significance of Birth' (n 38) 285.
[53] Sara Fovargue and José Miola, 'Policing pregnancy: implications of the Attorney-General's Reference (No. 3 of 1994)' (1998) 6 MLR 265, 273.

prevent the death of a foetus. The possibility that a competent adult's right to refuse treatment might be overridden in the interests of a viable foetus was left open by the cases of *Re T (Adult: Refusal of Treatment)*[54] and *Re S (Adult: Refusal of Treatment),* [55] but later closed by the Court of Appeal in *Re MB (an adult: medical treatment)*.[56] In her judgment in this case, Lady Justice Butler-Sloss stated:

> …a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reason at all, choose not to have medical intervention, even though… the consequences may be the death or serious handicap of the child she bears or her own death… The fetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarean section operation. The court does not have the jurisdiction to declare that such medical intervention is lawful to protect the interests of the unborn child even at the point of birth.[57]

This welcome declaration that pregnant women have the same right to refuse medical treatment as any other competent adult reflects the fact that even if the law has a role in protecting the interests of future children, enforcing those interests against a pregnant woman refusing medical treatment would be the worse of two evils. This is evident in the case of *St George's Healthcare NHS Trust v S; R v Collins and others, ex parte S*.[58] In this case Judge LJ drew upon the reasoning in *AG's Ref (No. 3 of 1994)* that a foetus is 'not nothing'[59] and stated that 'the interests of the foetus cannot be disregarded on the basis that in refusing treatment which would benefit the foetus, a mother is simply refusing treatment for herself.'[60]

[54] [1992] 4 All ER 649.
[55] [1992] 4 All ER 671.
[56] [1997] 8 Med LR 217.
[57] ibid 227.
[58] [1998] 3 ALL ER 673.
[59] *AG's Ref (No. 3 of 1994)* 687.
[60] *St George's Healthcare* 688.

Despite this the Court of Appeal upheld the right of the pregnant woman to refuse treatment on the basis that the foetus was not a legal person and that protection of the foetus would require interference with the woman's right to self-determination and to permit this would be a step towards an unacceptable erosion of personal liberty.[61] In support of this Judge LJ cites the decision of the Supreme Court of Canada in *Winnipeg Child and Family Services (Northwest Area) v G*,[62] which followed the principle in the report of the Canadian Royal Commission that 'stressed that judicial intervention to protect an unborn child against its mother "ignores the basic components of women's fundamental rights – the right to bodily integrity, and the right to equality, privacy and dignity"….'[63] Judicial intervention in the treatment decisions of pregnant women clearly threatens multiple fundamental rights of the pregnant woman and as there is no other legal personality to protect, any such interference must be resisted.[64]

It is worth noting that the decision in *St George's* came after the event; the woman had been detained under the Mental Health Act 1983 and a caesarean section carried out against her will. Therefore, the Court of Appeal was not making a decision which could directly lead to the death of a viable foetus. It is possible that the court would have been more reluctant to uphold the pregnant woman's right to refuse treatment at a time when lives were in the balance.

In other jurisdictions courts have been willing to uphold a woman's right to refuse treatment at a time when the medical evidence indicates that the lives of the foetus and pregnant

[61] ibid 686-688.
[62] *Winnipeg Child and Family Services (Northwest Area) v G* [1997] 152 DLR (4th) 193, 210.
[63] Scott (n 43) 167.
[64] ibid.

woman are at risk. For example, in the American case of *In re Baby Boy Doe,*[65] the Illinois Court of Appeal stated that:

> …a woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant…[66]

However, even in this case, the court left open the possibility that a pregnant woman could be compelled to undergo a blood transfusion for the sake of her foetus, distinguishing this from a caesarean section on the grounds that it is 'relatively non-invasive and risk-free.'[67] Given the court's reasoning that an individual could not be compelled to undergo medical procedures for the sake of another even where the risk was minimal and the benefit to the other great,[68] it is difficult to see how this distinction could be justified. Indeed, the Illinois Court of Appeal[69] later held that a pregnant woman did have the right to refuse a blood transfusion rejecting the claim that a blood transfusion is non-invasive and risk-free. [70]

As stated in *Re MB,* in England and Wales pregnant women have the right to refuse any treatment, no matter how risk-free. This includes the administration of blood products. The only requirement being that they have capacity to make that decision as the Court of

[65] [1994] 632 NE2d 326 (Ill. App. Ct.).
[66] ibid 332.
[67] ibid 333.
[68] ibid 333-334.
[69] *In re Fetus Brown* [1997] 689 NE2d 397 (Ill App Ct), although in this case the blood transfusion was forcibly given following the granting of the court order but on appeal the order was overturned.
[70] Joelyn Knopf Levy, 'Jehovah's witnesses, pregnancy, and blood transfusions: a paradigm for the autonomy rights of all pregnant women' 27 JL Med & Ethics 171, 174. For an example of a recent case in the Court of Protection considering whether a pregnant woman had capacity to refuse blood products see Celia Kitzinger, 'Refusing blood products during pregnancy and labour' (*Open Justice Court of Protection Project*, 21 September 2021) <https://openjusticecourtofprotection.org/2021/09/21/refusing-blood-products-during-pregnancy-and-labour/?fbclid=IwAR2a2vlBesq6aPlgJXpNiB5Y_rHd-PnJGQKjnFU4YzjPtQKBWGeF7pHEvRY> accessed 22 September 2021.

Protection lacks jurisdiction to make treatment decisions for a capacitous adult.[71] As Lady Hale put it in *Montgomery v Lanarkshire*; 'gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.'[72] I will now consider whether this is the case in practice.

2.3.2 Pregnant women as incompetent adults

The Mental Capacity Act 2005 (MCA) sets out a two-stage test to determine a person's capacity to make a decision: the functional test and the diagnostic test. The functional test contained in s. 3(1) MCA states that a person lacks capacity if at the material times she is unable to understand, retain, use or weigh the information relevant to the decision, or to communicate her decision. The diagnostic test in s. 2 MCA requires that the lack of capacity has to be due to an impairment of, or a disturbance in the functioning of, the mind or brain.[73] If a patient is found to lack capacity on the basis of these two tests, treatment will only be lawful if it is in the 'best interests' of the patient.[74]

The case of *Re MB*[75] concerned a woman who, despite consenting to the need for her baby to be delivered by caesarean section, refused consent for the necessary anaesthesia due to her severe needle phobia. The court found that Miss MB lacked capacity to refuse treatment due to her phobia and thus ordered the caesarean section. Similarly, in *L (an adult: non-*

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[71] ibid.
[72] *Montgomery v Lanarkshire* [2015] UKSC 11, [116].
[73] Note that changes have been proposed to the Code of Practice for the MCA 2005, reversing the order of the two-stage test, HM Government, *Mental Capacity Act 2005 Code of Practice* (Draft) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080137/draft-mental-capacity-act-code-of-practice.pdf> accessed 16 August 2022. See n 91 below.
[74] S.1(5) MCA 2005.
[75] *Re MB (an adult: medical treatment)* 217.

consensual treatment)[76] it was held that the woman lacked capacity to refuse a caesarean section because she was incapable of weighing up the relevant information due to her needle phobia.[77]

Rosamund Scott defends the decisions in the 'needle phobia' cases by reference to the reasoning of Lady Justice Butler-Sloss in *Re MB*.[78] Butler-Sloss LJ held that Miss MB was unable to weigh the relevant information because her needle phobia meant that she was unable to consider anything else and therefore incapable of making a decision at all: '[s]he was at that moment suffering an impairment of her mental functioning which disabled her. She was temporarily incompetent.'[79] The court was clearly influenced by the fact that Miss MB had consented to the operation on five occasions, only refusing when it came to having the necessary blood tests and analgesia. It may be that a person is unable to weigh the information relevant to a decision because of a phobia, but it does not follow that phobias will always have this effect. In weighing up a treatment decision a person's phobia might make her attach a particular weight to the fact that the treatment will involve needles, but it does not necessarily follow that she is unable to weigh the information as required by s.2 MCA. As Fovargue and Miola note, it seems perverse that a pregnant woman should be entitled to refuse a caesarean section for 'no reason at all,'[80] which appears to require very little in the way of weighing information, but not because she has a phobia of needles.[81]

The trend for finding pregnant women to lack capacity in regard to refusals of caesarean sections reached what is perhaps its most extreme example in *Rochdale Healthcare (NHS)*

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[76] *L (an adult: non-consensual treatment)* [1997] 1 FCR 609.
[77] The test for capacity used in this case was that set out in *Re C (adult: refusal of treatment)* [1994] 1 All ER 819 is that the individual must be able to understand and retain the necessary information and weigh up the risks and benefits to arrive at a decision, which is now reflected in the MCA 2005.
[78] Scott (n 43) 155-158.
[79] *Re MB (an adult: medical treatment)* 224.
[80] ibid 227, per Lady Justice Butler Sloss.
[81] Fovargue and Miola 'Policing pregnancy' (n 53) 284.

Trust v C.[82] Mrs C refused a caesarean section because of her previous experience of the procedure, stating that she would 'rather die' than have another caesarean section. It was the consultant obstetrician's judgment that Mrs C was competent to make the decision. However, the court ruled that Mrs C was unable to weigh the relevant information due to being 'in the throes of labour with all that is involved in terms of pain and emotional stress.'[83] Presumably, all women in labour would therefore be incapable of refusing treatment, making a mockery of the autonomy of pregnant women.[84]

In *Bolton Hospitals NHS Trust v O*,[85] the court was asked (supported by the woman in question) to sanction a forced caesarean section on a woman who was thirty-nine weeks pregnant who had consented to the operation but then refused on four separate occasions when she got to the operating theatre due to fear and panic. Butler-Sloss LJ recognised that a woman has the right to refuse treatment even if that decision outrageously defies logic or moral standards. However, drawing parallels with her own judgment in *Re MB* she went on to say:

> But there is a point at which that refusal and irrationality, as others might see it, tips the usually competent person over into a situation where the person, for however long or short a period, is actually unable to see through the consequences of the act, because that capacity to see through the consequences is inhibited by the panic situation in which the patient finds…herself.[86]

An additional requirement appears to have been added to the assessment of capacity; that the individual is consistent in her decision and reasoning. If the individual's state of mind

[82] [1997] 1 FCR 274.
[83] ibid.
[84] Fovargue and Miola 'Policing pregnancy' (n 53) 287.
[85] [2003] 1 FLR 824.
[86] ibid 827.

changes in reaction to a change in circumstances, her decision can be seen to not be a product of her true will, but of a temporary overpowering of her mind. It is the temporary nature of the refusal which seems to have influenced Butler-Sloss LJ. Indeed, she seems to be greatly reassured by the fact that Miss MB was pleased with the court order compelling her treatment and consented to go to the operating theatre (although presumably not the administering of the anaesthetic injection) and was delivered of a healthy child.[87]

Similarly, in a recent case an agoraphobic pregnant woman was found to lack capacity to make the decision about where to give birth.[88] The woman wanted to have a home birth but it was held that her agoraphobia would make her unable to consent to a transfer to hospital if an emergency arose. Despite there being no increased risk of such an emergency transfer being necessary, the court authorised the hospital trust to remove the woman from her home and transfer her to hospital against her will prior to going into labour in order to be induced to avoid the small chance of an emergency transfer. In determining whether the pregnant woman lacked capacity to make the decision about where to give birth, Holman J prioritised the diagnostic test over the functional one. The diagnosis of agoraphobia was taken as the starting point with this entailing that the pregnant woman was unable to 'weigh matters in the balance if the activity in point entails her leaving home'[89] and therefore she failed the functional test of capacity. The woman's reasons for not wanting to leave home were not explored to determine if she had understood and weighed the relevant information. As Ruth Fletcher has noted, applying the tests in this order goes against the cardinal principles of the application of the MCA which require that the starting point should be the functional test in order that diagnosis is not prioritised over social functions when assessing capacity and to

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[87] ibid.
[88] *NHS Foundation Trust v An Expectant Mother* [2021] EWCOP 33.
[89] ibid [8].

avoid any assumption of incapacity on the basis of the person's condition.[90] This is something that has been reflected in the new draft code of practice for the MCA, which changes the order in which the test of capacity assessment is set out, so that the question of whether the person is able to make the decision is considered before the question of whether this is due to an impairment or disturbance of the functioning of the mind.[91]

These cases raise the question: would an individual who is *not* pregnant be judged to lack capacity to refuse treatment if he/she is suffering from a phobia causing fear and panic? Further, how temporary does a state of mind have to be for it to indicate incapacity? I am not aware of any cases concerning individuals who are not pregnant in which the individual has been deemed to lack capacity to refuse treatment because of a phobia. In the case of *DH NHS Foundation Trust v PS (By her litigation friend, the Official Solicitor)*, [92] the court sanctioned the sedation and forced removal of a woman from her own home and the performance of a hysterectomy for the treatment of her endometrial cancer against her will. The woman suffered from learning disabilities and a phobia of needles and hospitals. In this case, although the woman's phobias were considered relevant in determining how best to treat her, the assessment of her capacity to refuse treatment was entirely based on her learning disabilities. It is possible that had she not had learning disabilities, her phobias would have been of greater relevance in deciding her capacity.

A similar prioritisation of the diagnostic test can be seen in the cases involving forced treatment of women suffering from anorexia nervosa. Where the court has been asked to

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[90] Ruth Fletcher, 'On care, coercion, and childbirth in the Court of Protection.' (*Open Justice Court of Protection Project,* 5 July 2021) <https://openjusticecourtofprotection.org/2021/07/05/on-care-coercion-and-childbirth-in-the-court-of-protection/> accessed 21 September 2021.

[91] HM Government, *Consultation on proposes changes to the Mental Capacity Act 2005 Code of Practice and Implementation of the Liberty Protection Safeguards* <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1084096/changes-to-the-MCA-code-and-implementation-of-the-LPS-consultation-document-extension.pdf> accessed 16 August 2022, Para 1.3.

[92] *DH NHS Foundation Trust v PS (By her litigation friend, the Official Solicitor)* [2010] EWHC 1217 (Fam).

authorise treatment such as direct feeding against the wishes of the patient suffering from anorexia, it seems that the patient will always be found to lack capacity to refuse such treatment. This was described in *A Local Authority v E and Others*[93] as a Catch-22 situation because the patient proves their lack of capacity to decide on nutrition by refusing to eat. Rendering the functional test redundant by permitting a diagnosis to determine capacity in this way has been criticised as incompatible with the UN Convention on the Rights of Persons with Disabilities (CRPD) as discrimination on the basis of disability.[94] A person's condition should not determine their capacity; the question of capacity must be answered on a functional basis.

A similar criticism could be made of a presumption that pregnant women suffering from phobias lack capacity to make decisions regarding their treatment. This would deny pregnant women suffering from phobias the right to make autonomous decisions regarding their treatment that other capacitous adults enjoy. It is therefore vital that the functional test be given priority in such cases.

2.3.3 Further cases on incapacity

The inconsistent treatment of pregnant women in refusal of treatment cases is further illustrated by two cases on court ordered caesarean sections from 2012 and 2014.

In the case of *Re AA*,[95] Ms Alessandra Pacchieri had been detained on 13 June 2012 under s.23 *Mental Health Act 1983*[96] for treatment of her bipolar disorder after she had stopped

[93] [2012] EWCOP 1639.
[94] Daniel Wei L. Wang, 'Mental Capacity Act, Anorexia, and the Choice Between Life-Prolonging Treatment and Palliative Care: A NHS Foundation Trust v Ms X' (2015) 78(5) Mod L Rev 871, 881.
[95] [2012] EWHC 4378 (COP).
[96] As amended by the Mental Health Act 2007.

taking her medication. An application was made some two months later on 23 August 2012 for an order authorising the hospital to perform a caesarean section on her despite her refusal to consent to the procedure. Whether or not Ms Pacchieri had capacity to refuse the caesarean section was dealt with extremely briefly in the judgment with Mr Justice Mostyn merely noting that '…there is evidence here that demonstrates that this is the case.'[97] Perhaps this would have been dealt with more thoroughly had Ms Pacchieri's litigation friend not accepted that she lacked capacity.[98] The court appears to have considered that the medical evidence was determinative of what was in Ms Pacchieri's best interests, and therefore that a caesarean section was required despite the fact that the 'significant risk of a ruptured womb' if she delivered vaginally was only 'perhaps as much as 1%'.[99] The procedure was also deemed to be in her 'mental health best interests' that 'her child should be born alive and healthy and that such result should be, if possible achieved, and such risks attendant should be avoided.'[100] There is no mention of what reasons Ms Pacchieri had given for her refusal nor were any alternatives such as a trial of labour considered. Further, no consideration was given to the effects on her mental health of being compelled to submit to major surgery against her will. Perhaps the most troubling aspect of the judgment is the lack of Ms Pacchieri's voice.[101] It appears that this judgment could apply equally to any pregnant woman detained under the MCA who had previously undergone two caesarean sections.

A very different approach can be seen in the case of *Great Western Hospitals NHS Foundation Trust v AA*.[102] In this case, Hayden J gave a detailed explanation of his finding

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[97] *Re AA*, para *2*.
[98] ibid.
[99] ibid [4].
[100] ibid [5].
[101] Sarah Fovargue and José Miola, 'Are we still policing pregnancy?' in Catherine Stanton, Sarah Devaney, Anne-Marie Farrell, and Alexander Mullock (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015) 249.
[102] [2014] EWHC 132 (Fam).

that AA lacked capacity.[103] Other alternatives such as induction of labour were considered.[104] A ‘broader survey of the available material’ rather than just her medical best interests, was carried out to ascertain what was in AA’s best interests.[105] The judgment in this case is an example of best practice in such decisions; AA’s views and those of her family were taken into account and thus a very personalised decision was reached.[106] However, as Fovargue and Miola note, it would be interesting to know how the judgment would have differed if AA’s family had not been in agreement with medical opinion.[107]

Unfortunately, the example of *Great Western* was not followed in the case of *NHS Trust 1, NHS Trust 2 v FG*.[108] This case followed an application by a local authority not to disclose a care plan providing for the removal of a child immediately after birth from a woman detained under the Mental Health Act 1983.[109] An application was then made by the treating Trusts for orders authorising the use of restraint and deprivation of liberty for her care. The court took the opportunity to set out detailed guidelines for applications when there are concerns that a pregnant woman may lack capacity to make decisions about her care. Unfortunately, the guidelines do very little to involve the patient in the process, merely stating that her ‘…past and present wishes and feelings and beliefs and values…’ ‘may be contained in the witness statements from the consultant psychiatrist and obstetrician.’[110] The orders were granted although a caesarean section was not required in the end as FG cooperated in a successful vaginal delivery. It appears that Keehan J granted the orders on the basis of medical evidence alone. The ‘broad survey of available material’ seen in *Great Western*

[103] ibid [19-20].
[104] ibid [10].
[105] ibid [16].
[106] Fovargue and Miola, ‘Are we still policing pregnancy?’ (n 101) 252.
[107] ibid 252-253.
[108] [2014] EWCOP 30.
[109] *X County Council v M and Othrs* [2014] EWHC 2262 (Fam).
[110] *NHS Trust 1, NHS Trust 2 v FG, 23 (f), annex.*

Hospitals NHS Foundation Trust v AA, is missing, with a distinct lack of input from others connected to FG.[111]

A further troubling development is the apparent trend that is emerging for using anticipatory or contingent declarations to manage the care of currently capacitous pregnant women not yet in labour, where there are concerns that they might lose capacity later in their treatment. In two cases, *United Lincolnshire NHS Hospitals Trust v CD*[112] and *Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R,*[113] anticipatory declarations were made in relation to the obstetric care of two women detained under the Mental Health Act 1983. And, in the recent case of *North Middlesex University Hospital v SR*[114] a similar declaration was made in relation to a currently capacitous pregnant woman who was not detained under the MHA, where there was no evidence of any increased foetal risk. This has led to commentators questioning whether pregnant women are more likely to be subject to such declarations, and what the parameters of anticipatory declarations are?[115] As Sara Fovargue puts it:

> …the possibility is left open that an application for anticipatory declarations can be made in relation to, at the very least, any capacitous pregnant woman. But why stop there? As these declarations appear to be seen to be required to cover the event that a patient who currently has capacity might, at some point during their course of treatment, no longer have the capacity to make decisions for themselves, then why

[111] Fovargue and Miola, 'Are we still policing pregnancy?' (n 101) 253.
[112] [2019] EWCOP 24.
[113] [2020] EWCOP 4.
[114] [2021] EWCOP 58.
[115] Sara Fovargue, 'Anticipating Issues with Capacitous Pregnant Women: *United Lincolnshire NHS Hospitals Trust v CD* [2019] EWCOP 24 and *Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R* [2020] EWCOP 4' (2020) 28(4) MLR 781; and Aimee V. Hulme, 'An Emerging Pattern? A Further Case of Anticipated Capacity Loss in Pregnancy: North Middlesex University Hospital NHS Trust V SR [2021] EWCOP 58' (2022) MLR <https://academic.oup.com/medlaw/advance-article-abstract/doi/10.1093/medlaw/fwac021/6617970?login=false> accessed 24 July 2022.

could they not be applied for in relation to any one of us? Or are anticipatory declarations only suitable for pregnant women, and/or pregnant women who are detained under the MHA?[116]

While cases such as *Great Western Hospitals NHS Foundation Trust v AA* provide hope that the law can treat pregnant women respectfully in deciding refusal of treatment cases, the courts still appear to find it difficult to accept the principle that pregnant women have the same rights to refuse treatment as individuals who are not pregnant, and that failure to comply with the opinion of healthcare professionals in the management of labour, does not justify a finding of incapacity. The courts have no role to play in protecting the foetus in such scenarios. However, as I will now demonstrate, other aspects of the law are concerned with protecting the interests of future children against pregnant women.

2.3.4 Criminal Liability

One way in which the law protects the interests of future children against pregnant women is through the criminal law. Although the case of *Attorney-General's Reference (No. 3 of 1994)*[117]*,* discussed in Chapter 2.1 above, did not directly concern *maternal* liability for harm caused to a foetus later born alive, it left open the possibility of such liability. The personalisation of the foetus as the potential victim of a crime of violence along with the objectification of the pregnant woman as the ‘maternal environment of the foetus’[118] reflects

[116] ibid Fovargue 793.
[117] [1997] 3 WLR 421.
[118] ibid AG’s Ref 437, per Lord Mustill.

a separation of mother and foetus to an extent which raises the possibility of maternal criminal liability. As Lord Mustill commented:

> the unlawful and dangerous act of B *changed the maternal environment of the foetus* in such a way that when born the child died when she would otherwise have lived. [119] (emphasis added)

This conception of the pregnant woman as the 'maternal environment' presents the foetus as almost external to the pregnant woman; it is developing in an environment governed by the pregnant woman, but the fact that that environment *is* the pregnant woman is lost. Therefore, the pregnant woman who 'changes the maternal environment' through her conduct towards her own body, is presented as equivalent to a third party who changes that environment, such as a man who stabs his pregnant partner.

This raises the possibility that such liability may be extended to the woman's failure to maintain that environment to the standard acceptable to the law.[120] For example, it is possible that a pregnant woman could face a charge of gross negligence manslaughter for taking illicit drugs which caused harm to her foetus leading to its death after being born alive.[121] Following *Attorney-General's Reference (No. 3 of 1994)*, it is also possible that a woman could face criminal liability for otherwise legal conduct (such as drinking excessive amounts of alcohol) which later caused the death of her child following its birth, under a charge of gross negligence manslaughter. Given the standard of health promotion in the UK it is possible that such risks would be considered 'obvious' and so the woman might be guilty

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[119] ibid.
[120] Savell (n 29) 46.
[121] Emma Cave and Catherine Stanton, 'Maternal responsibility to the child not yet born' in Catherine Stanton, Sarah Devaney, Anne-Marie Farrell, and Alexander Mullock (ed), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015) 290. In *R v Senior* [(1832) 1 Mood CC 346, 168 ER 1298, a midwife who caused the death of a child born alive by injuring it before it was fully born (injuring the foetus with a knife), was convicted of gross negligence manslaughter.

of manslaughter even if she did not actually know of the risk. This is troubling particularly for women whose addictions or education means that these risks are not 'obvious' to them.[122] However, this is something that the jury would be able to take into account when considering criminality.[123] The question of whether such behaviour warrants criminal liability is considered in detail in Chapter 8.

In addition, the case leaves open the possibility of criminal liability for harm short of death suffered by a child born alive as a result of actions which occurred prenatally.[124] Therefore, a woman could face criminal liability for disabilities suffered by her child as a result of her conduct during pregnancy.[125] However, as I will now explain, following the case of *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation)*,[126] it seems unlikely that the courts will be willing to extend the law to impose criminal liability for maternal actions except where Parliament has already set out such liability.

2.3.5 CP (a child) v First-Tier Tribunal (Criminal Injuries Compensation)

Following the case of *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation)*,[127] it seems that the courts would be reluctant to extend criminal liability to maternal conduct.

> …the policy reasons underlying the state's view that a child should not be able to claim compensation from her mother for what is done (or not done) during pregnancy

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[122] ibid 62.
[123] *Attorney-General's Reference (No. 2 of 1999)* [2000] Crim LR 475..
[124] *AG's Ref (No. 3 of 1994)* 254, per Lord Mustill.
[125] Margaret Brazier, 'Liberty, Responsibility, Maternity' (1999)' 52 Curr Leg Probl 359, 382.
[126] *CP (A Child) v First-Tier Tribunal (Criminal Injuries Compensation)* [2014] EWCA Civ 1554, [2015] 2 FLR 1163 (CA)
[127] ibid.

> should rationally also lead to the conclusion that, save in the exceptional circumstances expressly recognised by Parliament, there should be no criminal liability for what a mother does (or does not do) during pregnancy.[128]

In this case an attempt was made by a local authority on behalf of a seven year old girl in its care, to claim compensation from the Criminal Injuries Compensation Authority (CICA) for her Foetal Alcohol Spectrum Disorder (FASD) connected to her mother's alcohol abuse during pregnancy. In the past, compensation had been awarded to claimants suffering from FASD, however, CICA's policy at the time was to reject such claims.[129] In this case at first instance, compensation was rejected but the First-Tier Tribunal granted the appeal on the basis that the girl's FASD amounted to an injury which was directly attributable to a crime of violence, namely administering poison or other destructive or noxious thing to 'any other person' contrary to s.23 Offences Against the Person Act, 1861 (OAPA).[130] This was overturned by judicial review on the ground that a foetus was not capable of being 'any other person' within the meaning of s.23 and so the mother's drinking during pregnancy could not be considered a criminal act.[131] The child appealed to the Court of Appeal where it was submitted that the reasoning in *Attorney-General's Reference (No. 3 of 1994)*[132] should be extended to cover maternal liability for *harm* caused to a child born alive.[133] The appeal was dismissed on the grounds that the *actus reus* of s.23 had not been established as a foetus could not be considered 'any other person'.[134] The born alive rule[135] was not appropriate as in this case the relevant harm occurred whilst the child was a foetus which differed from the circumstances of the case of *Attorney-General's Reference (No. 3 of 1994)* in which the

[128] ibid 1178-1179 para [67].
[129] ibid para [3].
[130] ibid para [5].
[131] ibid 1163.
[132] *AG's Ref (No. 3 of 1994).*
[133] *CP* 1163.
[134] ibid 1172 paras [38] and [39].
[135] See Chapter 2.1 above.

relevant harm was the death of the child which occurred after it had been born alive.[136] Further, the Master of the Rolls, Lord Dyson, reaffirmed the settled proposition that a pregnant woman does not owe a legal duty of care to her unborn child.[137]

> The law would be incoherent if a child were unable to claim compensation from her mother for breach of a duty of care owed during pregnancy, but the mother was criminally liable for causing harm which gave rise to damage and a right to compensation under the Criminal Injuries Compensation Act 1995.[138]
>
> It makes no sense to say that a child who has been harmed by her mother's conduct during pregnancy can claim compensation from the CICA, but cannot claim compensation from the person who caused the harm.[139]

In light of the comments in *CP*, it seems unlikely that a mother would be found criminally liable for harm suffered by her child whilst *in utero* as a result of the mother's drinking during pregnancy, such as FASD. However, the situation relating to behaviour during pregnancy that causes harm after the child is born alive still remains unclear (as discussed in Chapter 8). The possibility remains that a woman could face criminal liability for manslaughter if, for example, she uses heroin during pregnancy and her child is born alive but later dies from Sudden Infant Death Syndrome (SIDS). However, this is unlikely as a prosecution would have to be in the public interest and it would have to be proved beyond reasonable doubt that the mother's heroin use was the cause of death.[140] It might also be possible for a woman to be held criminally liable for *harm* caused to her child as a result of her illegal drug use during pregnancy, if that harm can be said to occur after the child is born.

[136] ibid paras [36], [37], [41] and [42].
[137] *CP (A Child)* [2014] All ER (D) 48 (Dec).
[138] *CP* 1178 para [66].
[139] ibid 1179 para [67].
[140] Cave and Stanton (n 121) 290.

For example, if the heroin remained in the child's blood stream after birth and caused damage to the child's brain, it could then be argued that the noxious substance had been administered to the child once born even if the mother took the heroin prior to the birth. However, causation would be extremely difficult to prove in such cases and the effects on newborn babies of heroin use during pregnancy can normally be managed with an opiate withdrawal programme,[141] meaning that if such care was not provided where it could be reasonably expected to have been provided, the failure could be considered to have caused the harm.

Therefore, while it may not be likely that women will face criminal liability for their conduct during pregnancy under the current law, it remains a possibility. I will now consider the position under the civil law.

2.3.6 Civil Liability

The question of civil liability for harm suffered by a child as a result of acts which took place prior to or during the child's birth is currently dominated by the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA). This Act provides for compensation for a child born alive suffering disabilities as a result of an occurrence prior to conception which affected either parent's ability to have a healthy child, an occurrence affecting the mother during pregnancy, or affecting the mother or child during its birth.[142] Liability under the CDCLA is dependent on a breach of legal duty to the parent.[143] Therefore, although the claim is brought by the

[141] Nina Ebner and others, 'Management of neonatal abstinence syndrome in neonates born to opioid maintained women' (2007) 87(2-3) Drug Alcohol Depend 131.
[142] Congenital Disabilities (Civil Liability) Act 1976 s.1(2).
[143] ibid s.1(3).

child, it is in effect reflecting liability for harm done to the parent's ability to have a healthy child.

Crucially, the CDCLA provides an exemption for harm due to the actions of the child's mother, other than for injuries caused by negligent driving.[144] Therefore, a child cannot sue its mother for harm suffered as a result of her conduct during pregnancy including drinking or drug abuse.

The CDCLA provides a basis for reflecting some level of maternal liability in that, in a case where a child is suing a third party such as the mother's doctor in relation to an injury suffered prenatally, the child's damages may be reduced if the mother contributed to the disability.[145] As Brazier and Cave note, this provision envisages cases where a pregnant mother contributes to the child's disability by smoking, drinking or failing to take precautions, against medical advice.[146] The justification for reducing the child's damages on this basis is that there are circumstances in which it would be unjust, for example, for the woman's employer to be found liable in full for harm suffered by her child as a result of her unsafe working environment during pregnancy, if the woman contributed to the harm by failing to heed medical warnings regarding the risks of working in that environment. While this provision does not impose a legal duty of care on the pregnant woman, it does acknowledge that the conduct of a woman during pregnancy can be a legitimate concern of the law. As discussed below, this is also reflected in the family law context.

Fovargue and Miola argue that the civil law, with its exemption for maternal liability could provide a model for reform of the criminal law which would provide a better balance between

[144] ibid s.2.
[145] ibid s.1(7).
[146] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law* (6th edn, Manchester University Press 2020) para 11.16.

protecting the foetus and protecting the rights of pregnant women.[147] As noted above, it appears from the case of *CP* that the position in civil law is strongly influencing that in criminal law, at least for now. However, as I will now explain, family law provides another example of how the law does not entirely refrain from judging the conduct of pregnant women.

2.3.7 Family Law

In the case of *D v Berkshire County Council*,[148] the House of Lords ruled that in deciding whether a care order should be made under s. 1(2)(a) Children and Young Persons Act 1969[149] in respect of a baby, the mother's conduct during pregnancy, specifically her use of illegal drugs, could be taken into account. With regard to the primary ground in s.1(2)(a) that 'his proper development *is being* avoidably prevented or neglected or his health *is being* avoidably impaired or neglected or he *is being* ill-treated,'[150] (emphasis added) it was held that the phrase 'is being' referred to a continuing situation and there was no reason why the court could not look back at circumstances prior to the child's birth for evidence of this.[151] Therefore, the court found that the ground in s.1(2)(a) was met despite the fact that the child had never been in the care of either parent, as the child had been taken into care immediately following his/her birth. Although, this does not amount to the court acting to protect a foetus, as Cave points out, it '… demonstrates a willingness of the courts at the highest level to condemn maternal treatment of the unborn child and to (inappropriately) redress past wrongs

[147] Fovargue and Miola 'Policing pregnancy' (n 53) 292.
[148] [1987] 1 All ER 20 (Div Court); 27 (CA); and 33 (HL).
[149] Superseded by the Children Act 1989.
[150] s. 1(2)(a) Children and Young Persons Act 1969, emphasis added.
[151] *D v Berkshire C C,* 436.

through a care order.'[152] As Lord Brandon of Oakbrook commented: 'each situation could have been avoided if the mother had not persisted in taking excessive narcotic drugs throughout her pregnancy.'[153] The court was not only considering what care the child was likely to receive in the future, but what it considered to be the care the child had received prior to its birth. It is notable that Lord Goff held that care proceedings were only justified in such circumstances where the court was satisfied that '…there is an existing likelihood that the state of affairs revealed by those past events will continue into the future…'[154] However, there remains the possibility that care proceedings could be used as a threat or punishment against pregnant women.[155] As the Children and Young Persons Act 1969 has been replaced with the Children Act 1989 it is possible that future cases could be distinguished from *D v Berkshire County Council*.[156]

Having now considered the legal status of the pregnant woman, I will now turn to the moral status of the pregnant woman and the importance of this in the question of maternal liability for prenatal harm.

2.4 The moral status of the pregnant woman

Underlying the refusal of treatment cases, the criminal law as stated in *CP* and the exclusion of mothers from civil liability for prenatal harm, are two principles regarding the moral status of the pregnant woman; her right to bodily integrity and respect for autonomy. Although these two principles are connected, as I will show, the distinction between them is an

[152] Emma Cave, *Mother of All Crimes* (Routledge 2018) 71.
[153] *D v Berkshire C C,* 436
[154] ibid 439.
[155] Jane E. S. Fortin, 'Legal Protection for the Unborn Child' (1988) Mod L Rev 54, 82.
[156] Cave (n 152) 72.

important one. First, I will explain what is meant by autonomy and bodily integrity and why they are considered worthy of protection.

2.4.1 Autonomy

Autonomy literally means 'self-rule' and was originally used in relation to Greek city states that were not controlled by a conquering power, in which the citizens made their own laws.[157] However, its meaning for individuals is complex and much debated (see Chapter 4.3) Generally speaking, autonomy is the ability to control one's own life by the exercise of one's own faculties.[158] It is this ability to make decisions about one's own life that makes morality possible. Decisions can only be considered morally right or wrong because they are based on that person's own thinking and a freedom to enact those decisions.[159] It would not make sense to judge the morality of an action which the individual had no choice whether to carry out or not. In reality, full autonomy is an ideal rather than a standard, that is rarely, if ever achieved.[160] An individual's autonomy can be diminished by many factors including defects in control due to mental illness or an addiction to drugs; defects in his reasoning due to blind prejudice or illogical inferences or; defects in information, for example, where others deliberately mislead him or where he has not understood the information provided.[161] However, this does not make autonomy any less valuable, but means that we should be seeking to maximise autonomy rather than only protecting it in its ideal form.[162]

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[157] Gerald Dworkin, *The theory and practice of autonomy* (Cambridge University Press 1991) 12-13.
[158] Harris (n 34) 195.
[159] Raanan Gillon, 'Ethics needs principles—four can encompass the rest—and respect for autonomy should be "first among equals"' (2003) 29 J Med Ethics 307, 310.
[160] Joseph Raz, 'Liberalism, Autonomy, and the Politics of Neutral Concern' (1982) 7 Midwest Stud Philos 89, 111-12; Harris, (n 32) 195.
[161] Harris (n 34) 195-198.
[162] ibid 200.

The ability to control one's life is generally thought to be important because it is central to what makes us human; without respect for autonomy individuals would be unprotected from coercion and being subjected to the will of others, thus preventing them from being individuals by reducing them to means to someone else's ends.[163] From the state's perspective, the principle of respect for autonomy is associated with the concept that moral persons are free and equal. What makes a life good or valuable varies from person to person. Therefore, if the state is to treat its citizens as free and equal beings, it must not, as far as possible, give preference to a particular view of what constitutes a good or valuable life; it must instead leave its citizens free to make decisions about their lives according to their own beliefs and values.[164] Of course, the state must protect the interests of all its citizens and so it is not possible to uphold the autonomy of all citizens as there will be times when the autonomous choices of one impairs the autonomy of another. For example, an individual could autonomously choose to interfere with another's rights, for example, by falsely imprisoning them. Therefore, respect for autonomy does not require that the state can never interfere with its citizens' autonomous choices, but that it can only do so when such interference is necessary for the protection of others.[165]

It is the connection with what makes life valuable that underlies the importance given to the principle of respect for autonomy in the law, as explained by DJ Eldergill in *Westminster City Council v Manuela Sykes*:

> This desire to determine one's own interests is common to almost all human beings. Society is made up of individuals, and each individual wills certain ends for themselves and their loved ones, and not others, and has distinctive feelings, personal

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[163] Immanuel Kant, *Groundwork for the Metaphysic of Morals,* Mary Gregor and Jens Timmermann (eds), (Cambridge Texts in the History of Philosophy, revised edition, Cambridge University Press 2012), 66-7.
[164] Dworkin 'Theory and practice of autonomy' (n 157) 4.
[165] John Stuart Mill, *On Liberty* (Longman, Roberts and Green Co. 1859) ch 1.

goals, traits, habits and experiences. Because this is so, most individuals wish to determine and develop their own interests and course in life, and their happiness often depends on this. The existence of a private sphere of action, free from public coercion or restraint, is indispensable to that independence which everyone needs to develop their individuality, even where their individuality is diminished, but not extinguished, by illness. It is for this reason that people place such weight on their liberty and right to choose.[166]

In this thesis, I take the view that respect for autonomy is important for two reasons: (1) because of its connection with the notion of a valuable life and what it means to respect another's personhood; and (2) because the individual is best placed to know what is best for them, and so respecting autonomy generally leads to good outcomes. [167]

Respect for autonomy is a central principle in modern medical ethics. It is one of the four principles advanced by Beauchamp and Childress in their highly influential approach to medical ethics; (1) respect for autonomy, (2) nonmaleficence, (3) beneficence, and (4) justice.[168] Although Beauchamp and Childress intend for these principles to be given equal importance, Gillon, a leading proponent of the four principles approach, argues that autonomy should be prioritised.[169] He uses the example of a Jehovah's Witness refusing a lifesaving blood transfusion that will leave his wife and children who are dependent on his earnings, destitute and asks: why should respecting the man's autonomy be seen as more important than non-maleficence and justice towards his dependents, that would require that

[166] [2014] EWHC B9 (COP), §10.
[167] Ronald Dworkin, *Life's Dominion: An Argument about Abortion and Euthanasia* (HarperCollins 1993) 223. For a discussion of this reasoning see Craig Purshouse, 'Review: Against Autonomy: Justifying Coercive Paternalism by Sarah Conly' (2014) 89 Philos 367.
[168] Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019).
[169] Gillon (n 159). For a critique of this approach see Søren Holm, 'Not just autonomy - the principles of American biomedical ethics' (1995) 21(6) J Med Ethics 332.

his wishes be overridden? Gillon argues that we should act in accordance with the man's wishes because far more harm than good results from a social or moral system that permits, let alone requires, compulsory medical treatment in such cases.[170] In other words, the harm associated with a society in which autonomy is not respected outweighs the harm done by respecting the wishes of individuals in difficult circumstances.

The principle of respect for autonomy has also become central to medical law. The principle underlies the refusal of treatment cases discussed in Chapter 1.3 above, as well as the issue of informed consent. For example, in the case of *Chester v Afshar*[171] on informed consent, the ethical principle of respect for autonomy was considered at length by the House of Lords, with Lord Steyn quoting from the work of Ronald Dworkin.[172] In relation to informed consent, as Jonathan Herring states:

> the issue is not whether enough information was given to ensure consent to the procedure, but whether there was enough information given so that the doctor was not acting negligently and giving due protection to the patient's right of autonomy.[173]

However, as Miola notes, 'the only consistent factor in the law's treatment of medical ethics is its inconsistency.'[174] For example, on informed consent, in the seminal case of *Montgomery v Lanarkshire*,[175] the principle of respect for autonomy was central to the court's decision. However, in the earlier case of *Sidaway v Board of Governors of Bethlem Royal Hospital*,[176] the question of what information should be provided in the consent procedure was seen as no different to treatment and diagnosis decisions which are considered

[170] Gillon (n 159), 309.
[171] [2004] 4 All ER 587.
[172] Dworkin 'Life's Dominion' (n 167).
[173] Jonathan Herring, *Medical Law and Ethics* (4th edn, Oxford University Press 2012) 170.
[174] José Miola, 'The relationship between medical law and ethics' (2006) 1(1) Clin Ethics 22, 23.
[175] (n 72).
[176] [1985] 1 All ER 643.

a matter of professional judgment rather than as a matter of patient autonomy. In addition, there are reasons to question the appropriateness of the prominence given to respect for autonomy over other ethical principles in the law.[177] These arguments are beyond the scope of this thesis but they do not alter the fact that respect for autonomy plays a central role in medical law. If we wish to accept the principle of respect for autonomy as central to modern law and ethics then allowing pregnant women to choose how they lead their lives will be paramount unless it can be shown that the foetus has a stronger claim here.

2.4.2 Bodily integrity

If we were to take the view that a foetus is a normative person, or that its interests could take priority over the autonomous wishes of the pregnant woman, this would mean that not only could her autonomy be interfered with but also that her right to bodily integrity could be compromised. The foetus is within the pregnant woman's body, therefore, any enforcement of its interests against the wishes of the pregnant woman will involve an assertion of some level of control over what happens in and to her body. This is most stark in court ordered caesarean section cases, in which the pregnant woman is often physically restrained and forced to submit to major surgery in the interests of her foetus.[178]

The right to decide what happens in and to one's body is a particularly important aspect of respect for autonomy because the body is a central part of oneself.[179] This is reflected in the

[177] For analysis of this issue see Sheila McLean, *Autonomy, consent and the law* (Routledge, 2009); and Emily Jackson, 'Challenging the comparison in Montgomery between patients and 'consumers exercising choices'' (2021) 29(4) MLR 595.
[178] Perhaps the most famous of these horrifying cases was that of Angela Carder in the US who was dying of cancer and yet was forced to undergo a caesarean section despite the fact that there was little chance of the baby surviving. Indeed, the baby only lived for a few hours following the caesarean delivery and the mother died two days later. *Re AC* [1987] 533 A 2d 611 (DC App).
[179] Scott (n 43) 14.

law as there is no obligation for anyone to donate an organ or other bodily tissue for the benefit of another, even a parent to a child. If we think that respect for autonomy and relatedly, bodily integrity are important principles in our society and medicine in particular, and if we accept that the foetus does not have equal value to the pregnant woman, then we should resist any measures that seek to control the behaviour of pregnant women in the interests of the foetus. To interfere with such a fundamental right to control what happens to one's own body would require strong justification.

2.4.3 A contextual approach

The above analysis of the legal status of the foetus and pregnant woman indicates that the legal status of the pregnant woman and the foetus is inconsistent and often without a clear moral basis. As we have seen, the refusal of treatment cases set out the principle that pregnancy has no effect on a woman's rights of self-determination and bodily integrity, but this is not always the case in practice. Similarly, it would seem that the law on abortion in England does not reflect a woman's right to self-determination or bodily integrity, as whether she continues with a pregnancy is not solely a matter of her choice but of others' judgment of her choice. A woman does not have the legal right to an abortion. Procuring an abortion is a criminal offence with exceptions in certain circumstances, which require two doctors to agree to the abortion (see Chapter 1.1 above).[180] As Savell notes, in this way pregnant women do not enjoy the same rights as other legal persons:

[180] Abortion Act 1967.

> In contrast to the normative person whose boundaries are discrete and who receives law's assistance in protecting those boundaries from transgression, the pregnant woman's physical boundaries are policed against her.[181]

The reason for this appears to be that the English law has adopted what Seymour calls, a relational, or contextual, approach rather than a definitive approach to the maternal-foetal relationship:

> …the law's response to the fetus can be determined on the basis of the context in which the law is being invoked rather than on the basis of a definitive characterization of the nature of the fetus.[182]

He argues that '[a] legal system that acknowledges the distinctiveness of the fetus can in some circumstances confer benefits on the woman.'[183] For example, the foetus is viewed as separate to the pregnant woman in circumstances such as those in *Attorney-General's Reference (No. 3 of 1994)*, however, in terms of civil liability under the CDCLA, the foetus is viewed in some respects as part of the pregnant woman, with liability being dependent on a duty of care owed to the parent.[184] If a definitive approach was taken; defining the foetus as part of the pregnant woman, in cases such as *Attorney-General's Reference (No. 3 of 1994)*, the real nature of the harm caused would not be captured. Also, it would not be possible for a child to recover damages in respect of prenatal injury against anyone as the harm would be to a part of the woman in the same way as had her leg been injured, rather than to the child as an individual.[185] On the other hand, viewing the foetus as separate to the pregnant woman

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[181] Savell (n 29) 40.
[182] John Seymour, *Childbirth and the Law* (Oxford University Press, 2000) 193.
[183] ibid 194.
[184] The Law Commission Report on which the CDCLA is based states that 'The plaintiff has no legal existence at the time of his injury nor has he, prior to live birth, an existence separate from his mother. The fact of physical identification of mother and foetus is something which cannot be ignored and which gives rise to difficult questions.' Law Commission, *Injuries to Unborn Children* (Law Com. No. 60) 11, para 33.
[185] Seymour (n 182) 193.

could be problematic for those concerned with the primacy of the autonomy of pregnant women because a separate being has interests which could potentially be used to justify imposing limitations on such autonomy. However, it may be that the autonomy of pregnant women can be protected without the need for the foetus to be viewed as a part of the woman's body. As Seymour argues:

> To shackle the law by adhering to the body-part model is to pay an unnecessary price for the preservation of maternal autonomy. To adopt the analysis employed in *Gentry v Gilmore*, when a criminal attack on a pregnant woman has led to a miscarriage, the law can respond to the destruction of the foetus on the basis that the woman's interests and those of the foetus are congruent. Equally, it is in the woman's interests for a child negligently injured *in utero* to be able to sue for damages. In situations in which the claims of the woman and the foetus might be in conflict (such as when medical treatment is refused), a different approach can be adopted and the interests of the foetus given little or no weight. This does not make it any easier to decide whether the woman's interests should always prevail over those of the foetus in such a situation, but it leaves the question to be answered on its merits rather than determined on the basis of an artificial characterization of the nature of a foetus. If the foetus is acknowledged as having inchoate interests that the law can protect in some circumstances but not in others, the resolution of the problem posed by a possible conflict between those interests and the pregnant woman's autonomy interests will be explicitly addressed. If the fetus is dismissed as a body part, the problem will be ignored.[186]

[186] ibid 193-194.

This contextual approach was endorsed in *Burton v Islington Health Authority*[187] where Dillon LJ stated 'that an unborn child *(sic)* shall be deemed to be born whenever its interests require it.'[188]

Acknowledging that the foetus has interests the law can protect in some circumstances exposes the problem of a potential maternal-foetal conflict but does not address such conflict in itself, as it does not resolve the question of when, if ever, the interests of the foetus should prevail over the woman's interests, as Seymour acknowledges.[189] What is required to do this is a clear exposition of the terms of the contextual approach the law is adopting, including an explicit acknowledgement of the moral principles the law is seeking to reflect.

If we are to respect the right of pregnant women to refuse treatment we can do so either on the basis of respect for bodily integrity, or respect for autonomy, or both. Whilst arguments have frequently centred on bodily integrity, due to the focus on questions of abortion and refusal of treatment, I take the view that respect for autonomy in its wider sense remains key. If we focus on bodily integrity we leave open the possibility that women's conduct which does not invoke their bodily integrity in a significant way (such as their choice of workplace, what they eat, whether they submit to antenatal testing) could become the legitimate subject of state interference. There are already clear examples of this in employment law such as the compulsory period of maternity leave of two weeks,[190] and the prohibition of employing women 'of reproductive capacity' in certain roles involving toxic substances.[191] Whether a woman is 'of reproductive capacity' is to be determined by whether she has 'a medical or physical condition that would make it impossible for her to conceive, e.g. she is sterilized, or

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[187] [1993] QB 204.
[188] ibid 226.
[189] Seymour (n 182) 193-194.
[190] s.72(3)(a) Employment Rights Act 1996, and regulation 8, Maternity and Parental Leave etc. Regulations 1999.
[191] Control of Lead at Work Regulations 2002. For discussion of this see Jackson, 'Regulating Reproduction' (n 207) 152-155.

had a hysterectomy, or is clearly post-menopausal,'[192] regardless of whether her husband or partner is sterile[193] and presumably, as this is not even considered, regardless of any choice she has made not to have children or to accept the risk. Alternatively, if we focus the defence of women's rights on respect for autonomy more broadly, we can better protect women from this erosion of their freedom. Therefore, in this thesis, arguments against maternal liability for prenatal harm will focus on women's autonomy rather than on bodily integrity alone. Before I outline what these arguments will be, in the following section I provide a summary of the existing arguments against maternal liability for prenatal harm that provide the foundation for this thesis.

2.5 Resisting maternal liability for prenatal harm

Central to the arguments in this thesis is the contention that it is undesirable for the law to hold mothers liable for their behaviour during pregnancy which results in harm to their future children. Although this is not a universal position,[194] a number of strong arguments have been advanced to support it. I will consider six of these here; the personhood argument, implications for abortion, a threat to the autonomy of pregnant women, practical difficulties, ineffective, and inappropriateness.[195]

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[192] Control of Lead at Work Regulations 2002, paras 267-268.
[193] ibid para 268.
[194] Wilkinson and others, and Robertson argue that it may be appropriate in some circumstances: John Robertson, *Children of Choice: Freedom and the new reproductive technologies* (Princeton University Press 1994) 184-186; Dominic Wilkinson and others, 'Protecting future children from in-utero harm' (2016) 30(6) Bioethics 425.
[195] Wilkinson and others consider 4 classes of argument (personhood, abortion, autonomy, and self-defeat): Wilkinson and others (n 194).

2.5.1 Legal personhood

It could be argued that as a foetus is not a separate legal person, any harm the mother causes to it should not attract legal liability, or at least, that it should not be treated in the same way as harm done to a legal person. However, if a woman chooses to continue a pregnancy to birth, following the birth there will be a separate individual with the same fundamental human rights as you and I, including the right not to be exposed to avoidable suffering.[196] Should individuals, who are legal persons, not be protected from harm prior to their birth? As Brazier notes:

> Understanding that what you may choose to do may have harmful effects on another person, a person whom you will call into being, carries with it a responsibility to have regard to the interests of that person. The moral obligation to seek to avoid causing suffering to other people whom you should contemplate as affected by your own conduct underpins the common law. You must avoid harming your 'neighbour'. Future children are just as much 'neighbours' as strangers the law demands you protect in determining your own course of conduct.[197]

This suggests that liability for prenatal harm does not require that the foetus be considered a legal person, only that there can be liability to a legal person for harm done when he was a foetus. It is important to recognise that the object of a duty not to cause prenatal harm is the 'future child', meaning the child who will be, but *is not yet* born,[198] or what Robertson refers to as 'prenatal duties to expected offspring.'[199] An advantage of this terminology is that it

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[196] Margaret Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 Curr Leg Probl 359, 365.
[197] ibid 369.
[198] ibid.
[199] John A Robertson, Children of choice: Freedom and the new reproductive technologies (Princeton University Press 1994).

recognises the important fact that the child is not yet in existence *and* is within the woman's body. There is a danger if we were instead to take the subsequently born child as the object of the duty, that the importance of the context of pregnancy would be lost and the duty become one of parent to child. As I will argue in Chapter 8, this context is less important when considering the actions of a third party who harms a child subsequently born alive *in utero* because the location of the future child inside a woman's body at the time of the harm does not significantly alter the duty that third party owes it. However, when considering the duty of a pregnant woman towards her future child, the fact that the future child is currently located within her body is of critical importance. [200]

Therefore, any consideration of maternal liability for prenatal harm should be based on a duty to the future child rather than the foetus, which is not a legal person, and rather than a duty to the child who was a foetus at the time, as this would take insufficient account of the interconnected nature of pregnancy.

2.5.2 Abortion

A second reason for resisting maternal liability for prenatal harm is the potential impact of such liability on the legality of abortion. The Abortion Act 1967 (as amended) permits the destruction of a foetus up to 24 weeks gestation, where two medical practitioners agree that the continuation of the pregnancy would involve a greater risk to the life or health of the pregnant woman than if the pregnancy was terminated.[201] Where a termination is necessary

[200] Scott (n 43) 24. However, I do not agree with Scott's argument that maternal duties concerning "general conduct" are akin to those of the "detached" third party because they do not seriously invoke the woman's bodily integrity. The fact that the expected child is within the woman's body impacts upon all her duties towards it because she cannot separate herself from it - as I will argue more fully in Chapter 8.
[201] Abortion Act 1967, s.1(1)(a).

to prevent grave permanent injury to the pregnant woman, or there is a risk to her life, or a substantial risk that the child would suffer serious physical or mental abnormalities, a termination can be performed at any stage of pregnancy.[202] In practice, this has been implemented to permit abortion on demand in most cases, prior to 24 weeks gestation, as the continuation of any pregnancy is likely to be more risky to the health of the woman than a termination.[203] It could be argued that maternal liability for prenatal harm could conflict with abortion law; how could a woman be liable for causing harm to her foetus but not for destroying it? However, as Brazier notes, this is a perceived conflict rather than an actual one as it is possible that a woman could owe a duty of care to a future child that she intends to bring to birth, but be permitted to abort a foetus that she does not intend to bring to birth:

> Restrictions on women's freedom to end a pregnancy logically depend on according to the foetus a superior, or at least equal, right to life and health to that of its mother. Asserting that women have a right to do what they will to harm a foetus who will be born, who will become a child capable of suffering, demands that society accepts that a mother be allowed to injure her child. Such a claim involves a right to harm a person, a right impermissible against any other person but the unfortunate potential infant.[204]

Therefore, maternal liability for prenatal harm does not necessarily conflict with abortion law, but it is possible that the threat of liability for prenatal harm could act as an incentive for women to abort pregnancies. For example, a woman who discovers that she is pregnant at 10

[202] ibid s.1(1)(b)-(d).
[203] Brazier and Cave (n 146) para 13.4. Although, the accessibility of abortion services is not consistent throughout the UK, notably in Northern Ireland. Maya Oppenheim, 'Postcode lottery preventing women in Northern Ireland accessing abortion services' (*Independent,* 21 October 2020) <https://www.independent.co.uk/news/uk/home-news/northern-ireland-abortions-women-postcode-lottery-b1205000.html> accessed 24 July 2022.
[204] Brazier, M., 'Parental Responsibilities: Foetal Welfare and Children's Health' in Bridge C. (ed), *Family Law Towards the Millennium: Essays for P M Bromley* (Butterworth-Heinemann Ltd 1997) 270.

weeks and drank heavily before she knew she was pregnant, could decide to abort the pregnancy to avoid legal penalties in the event that the child is subsequently born suffering from FASD. This is not only of concern to those who oppose abortion,[205] but also to those who value the autonomy of pregnant women to make decisions about their own lives and bodies, free from coercion by the law, as explained below.

2.5.3 A threat to the autonomy of pregnant women

Legal liability for women whose actions during pregnancy result in harm to their future children would represent a substantial interference with the autonomy of pregnant women; they may in effect be prohibited from engaging activities that would be entirely lawful if they were not pregnant.[206] It could be argued that such interference would be justified because it would prevent harm to another person. However, even if we concede for the moment that the future child can be considered a person, this is unlikely to justify the level of surveillance of women's lives that would result. Everything from a woman's choices regarding medical treatment (including her consent or refusal of a caesarean section), to what she eats and drinks, and what employment she is engaged in, could all become subject to the scrutiny of the law.

The prospect of legal liability could also make women vulnerable to coercion by others.[207] Brazier illustrates this with two powerful examples:

[205] Wilkinson and others (n 194) 429.
[206] Brazier 'Parental Responsibilities' (n 204) 289.
[207] Brazier 'Liberty, Responsibility, Maternity' (n 196) 379.

(1) A woman with two children from a previous marriage forms a new relationship with a man anxious for a child of his own. She has a good but demanding job. He would prefer her not to work at all and would prefer it if her first husband had day-to-day care of his partner's existing children. Her blood pressure rises a little. Her partner, who monitors her diet, and has had the family cat put down, urges her to give up work telling her it is the law that baby must come first. The woman needs her income to support her children and doubts if this relationship will survive. Yet if they are unlucky and this child does suffer some prenatal harm who will control any claim against her in tort but the child's father?

(2) A woman luckier in her choice of mate has had two children from earlier pregnancies, one delivered naturally and one by Caesarean surgery. She suffered acute pain and months of postnatal depression after the Caesarean. She very much wants a normal delivery. However, her obstetrician says that the risk of the scar rupturing is such that she must have a repeat section. She reads that in cases like hers a trial of labour is often allowed. Her doctor warns her that if the child is born damaged she will be at fault and have acted 'illegally'.[208]

These examples demonstrate how the potential for her actions in pregnancy to attract legal liability could take away a woman's power to make responsible choices about her own life as well about her family, including her future child; she would no longer be able to make decisions based on what she considers best for her and her family, but would instead be constrained by the views of others, with legal penalties if she does not submit.

[208] ibid 380.

Further, as prenatal harm can be caused at the gamete stage, this surveillance could extend well beyond the nine-months of pregnancy. Imposing retrospective liability on women for their behaviour in pregnancy would in practice demand that all fertile, sexually active women of childbearing age should act at all times as if they were pregnant.[209] While to most this would seem quite obviously unacceptable and unrealistic, in recent years we have increasingly seen policy directed at the 'potentially pregnant woman' or 'woman of childbearing age'.[210] Perhaps the possibility of a woman facing liability for drinking cider, smoking, or eating pâté as a teenager is not as far-fetched as it appears.

Such significant impact on the autonomy of pregnant women and by extension, all women and girls, could only be justified if the benefit to the child's interests was compelling and there was no less problematic way to achieve the same benefit. This is something I consider in Chapter 6.

2.5.4 Practicalities

A further argument against maternal liability for prenatal harm is the problem of how a standard of reasonable behaviour in pregnancy would be set and how causation would be established.

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[209] Brazier 'Liberty, Responsibility, Maternity' (n 196) 380.

[210] Cattapan (n 2); The first draft of the World Health Organisation, Global alcohol action plan 2022-2030, published in June 2021 stated that 'appropriate attention should be given to prevention of [...] drinking among pregnant women and women of childbearing age'. This has since been amended to remove the reference to 'women of childbearing age'; World Health Organisation, *Global alcohol action plan 2022-2030,* (July 2021) 17 <https://cdn.who.int/media/docs/default-source/alcohol/alcohol-action-plan/first-draft/global_alcohol_acion_plan_first-draft_july_2021.pdf?sfvrsn=fcdab456_3&download=true> accessed 25 July 2022. See Full Fact 'The WHO hasn't said women should be banned from drinking' (*Full Fact*, 22 June 2021) <https://fullfact.org/health/who-alcohol-women/> accessed 3 August 2022.

As noted above, a plethora of advice is given to women during pregnancy. The advice frequently changes[211] and often takes little account of the difficulties in applying that advice to individual circumstances. While it may be possible to identify behaviour that flagrantly disregards the welfare of the future child, defining the precise point at which behaviour becomes unreasonable is far from straightforward.[212] Even where there is consensus within the medical profession on the advice given to pregnant women, if women were to be considered unreasonable for not following that advice, this would represent an unparalleled level of medical control.[213] Assessing reasonableness is further complicated by the reality that not all women will find it equally possible to avoid harmful behaviours. Circumstances can make it harder for women to attain the standard the law requires.[214]
As Brazier notes:

> The pregnant mother of four other small children subject to the stresses of poverty and inadequate housing may do her best [to stop smoking] but be defeated by circumstances. It would be all too easy to define how pregnant women should behave by reference to the reasonable *Guardian* reader.[215]

A further difficulty arises in establishing that the suffering of a child is, on the balance of probabilities, caused by his mother's behaviour during pregnancy, as a wide variety of factors can impact on the welfare of the future child. For example, the mother's poverty is a more statistically significant risk to the welfare of the future child than her failure to abstain from

[211] For example, the Department of Health changed its advice on alcohol in pregnancy from 'no more than 1 or 2 units of alcohol a week' to total abstinence. See Pat O'Brien, 'Is it all right for women to drink small amounts of alcohol in pregnancy? Yes' (2007) 335(7625) BMJ 856.
[212] Brazier 'Parental Responsibilities' (n 204) 272.
[213] ibid 272-274.
[214] ibid 274.
[215] Brazier 'Liberty, Responsibility, Maternity' (n 196) 379.

alcohol during pregnancy. FASD is closely associated with the socio-economic class of the pregnant woman and is relatively uncommon in children whose mothers drank heavily during pregnancy but had good nutrition and prenatal care.[216] It is difficult to see how causation could be established here when there is such a strong indication that factors other than the woman's drinking are at play.

It is possible to imagine some cases that would not face these difficulties, for example if a woman took a drug in the last trimester of her pregnancy with the sole purpose of causing her future child to be born disabled and the child, despite scans earlier in the pregnancy detecting no disabilities, was born disabled. However, these cases are rare if not non-existent, and liability in such cases would do nothing to address the vast majority of instances of prenatal harm. As the saying goes, hard cases make bad law.

2.5.5 Ineffective

It is not entirely clear what it is hoped retrospective maternal liability for prenatal harm would achieve but the likely consequences of such liability appear far from positive. Jackson has argued that using the law to protect foetuses against the women carrying them has been shown to be ineffective, illogical and counter-productive.[217] She advances four reasons for this. First, the foetus is most vulnerable at the early stages of gestation but criminal sanctions are usually focused on behaviour in the latter stages of pregnancy. This makes them ineffective at best. Second, legal liability would be a powerful deterrent to engagement with

[216] One study found an incidence of FASD of 4.5% in the children born to upper middle-class women who drank more than 3 units of alcohol a day, but an incidence of 70.9% in children born to poor women drinking identical amounts. Nesrin Bingol and others, 'The Influence of Socioeconomic Factors on the Occurrence of Fetal Alcohol Syndrome' (1987) 6(4) Adv Alcohol Subst Abuse 105.
[217] Jackson, E., *Regulating reproduction: Law, technology and autonomy* (Bloomsbury Publishing 2001) 149.

antenatal care,[218] something that is likely to reduce the welfare of future children (and women) rather than protect them. Third, imprisoning pregnant women is unlikely to benefit the future child. The availability of illicit drugs and the poor quality of antenatal care in prisons is likely to increase the threat to the welfare of the future child rather than reduce it. Fourth, legal liability is unlikely to deter women from using harmful, addictive, substances such as drugs and alcohol. A deterrent can only work if the choice of behaviour involves a cost-benefit analysis, something that plays a limited role in the decision making of any addict. Besides, the cost-benefit analysis is already heavily weighted in favour of avoiding these substances. If the potential legal penalties for possessing illicit drugs, the possible harm to the future child, and the health risks to herself are insufficient to motivate her to resist the addictive draw, then the addition of legal penalties for any harm caused to her future child is unlikely to shift the balance.[219] Therefore, if the aim of maternal liability is to confer a benefit on future children, it seems unlikely that this would be achieved. Jackson concludes that:

> …it is clear that the principal purpose of penalizing pregnant drug addicts is not the promotion of infant health, but rather the *punishment* of women whose behaviour transgresses certain widely shared moral norms. The particular rage directed at the pregnant drug user may derive from certain cultural assumptions about maternal self-sacrifice and women's natural nurturing instincts.[220]

If punishment for transgressing widely shared moral norms is the aim of maternal liability for prenatal harm (and I agree that it is), the question is why is there not an equal desire to punish the male partners of pregnant women for the prenatal harm caused by their behaviour such as

[218] Cynthia Daniels, 'Fathers, mothers and fetal harm' in Lynn M. Morgan and Meredith W. Michaels (eds) *Fetal subjects: Feminist positions* (Pennsylvania University Press 1999) 83, 95.
[219] Jackson 'Regulating reproduction' (n 217) 150.
[220] ibid.

smoking, drug use, or violence against their partners? All of these have a similar impact on the welfare of future children.[221] Why should the moral norms associated with women and motherhood be considered more significant than those attached to men and fatherhood? In any event, it would seem that the difficulties a woman whose child is born disabled as a result of her behaviour during pregnancy is likely to face in caring for that child or as a result of having that child removed from her care, mean that further punishment is unnecessary.[222]

2.5.6 Inappropriate

An argument that receives less attention in the debate surrounding maternal liability for prenatal harm is the argument that the pregnant woman's behaviour does not warrant legal sanction. While it would be relatively uncontroversial to say that the mother who deliberately takes a drug in the last trimester of her pregnancy with the sole purpose of causing her future child to be born disabled has caused harm in a morally blameworthy manner, the majority of maternal behaviours that result in prenatal harm are not so easily condemned. (It is this argument that forms the basis of Chapter 8).

Cave considers whether it would be appropriate to attach criminal penalties to maternal behaviour during pregnancy that results in prenatal harm, in the context of illicit drug taking. The only criterion that she suggests supports criminalising pregnant women for acts and omissions harming the future child, is that 'the conduct is prominent in most people's view of socially threatening behaviour, and is not condoned by any significant segment of society.'[223] While I agree with Cave that it is unlikely that a significant segment of society would condone a woman taking illicit drugs during pregnancy, or even drinking heavily, or

[221] ibid.
[222] Brazier 'Liberty, Responsibility, Maternity' (n 196) 384.
[223] Cave 'Mother of all crimes' (n 116) 84-85.

smoking, I would suggest that there could be a significant segment of society who would *not condemn* her for doing so either. Once the vicissitudes of life are taken into account, including the role of addiction in many of the harmful behaviours, it becomes less clear that we can say that the woman should be able to behave differently and therefore this behaviour is 'wrong'.

This is something Cave reflects in her argument that retribution is inappropriate in such circumstances. Not only is addiction a factor in drug and alcohol abuse, but the lack of availability of treatment programmes for addiction and the correlation between criminalization, race and poverty, all mean that retribution would be inappropriate.[224]

> This is not to say that other rationales for punishment are not applicable even where inequality thrives, but that the harsh value of retribution is reserved for those occasions where those individuals who share a set of values have strayed sufficiently to merit punishment. A measure of retribution is already achieved where the criminal law applies indiscriminately to punish illicit drug use. It therefore seems that in the case of extended criminalization, the goals of retribution and deterrence are not sufficiently poignant to override the autonomy of pregnant women.[225]

Although, Cave's focus is on extending existing criminal penalties for illicit drug use in the case of pregnancy, her argument that women who cannot beat their addictions during pregnancy have not strayed sufficiently to merit punishment, could equally be applied to substances such as nicotine and alcohol, as I consider in Chapter 8.

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[224] ibid 86.
[225] ibid 87.

These arguments provide the foundation for my thesis. Brazier, Jackson, Cave and others have made compelling arguments for why maternal liability for prenatal harm would be undesirable. What the research in this thesis considers is whether our current law is sufficiently robust to rule out such liability and the potential impact of the current public health approach to prenatal harm on the resistance of maternal liability in the law. As part of this, a comparison will be made between maternal and paternal liability in order to explore the significance of the maternal-future child relationship. The following section will outline the argument presented in this thesis and the research questions it addresses.

CHAPTER 3 - Outline of argument and research questions

This thesis considers the potential for women to be held responsible for prenatal harm due to their conduct during pregnancy and asks whether this would be justified.

It could be argued that women have not faced criminal liability for prenatal harm related to their behaviour during pregnancy in the almost three decades since the ruling in *AG's Ref (No 3 of 1994)* and the more recent case of *CP* stated a reluctance for the law to interfere with the behaviour of pregnant women, and therefore, there is no prospect of maternal liability under English law. However, the current resistance of maternal liability is not as sound as it might appear. Women's behaviour during pregnancy is being increasingly policed via public health interventions seeking to reduce prenatal harm. This indicates a desire to hold women responsible for prenatal harm due to their conduct during pregnancy which could drive calls for legal liability. As this work in this thesis shows, maternal liability for prenatal harm remains a possibility in the criminal law because of the law's focus on the status of the foetus rather than the conduct of the pregnant woman, and even the express exclusion of maternal liability in the civil law could be at risk if the unequal treatment of maternal and paternal liability under the CDCLA is no longer justified. If such calls are to be resisted, reform of the law on prenatal harm is required.

In order to demonstrate that the current public health approach to prenatal harm is problematic and could lead to women facing legal liability for their behaviour during pregnancy I will consider the following questions in my research:

- What are the ethical problems with singling out pregnant women for public health interventions aimed at reducing prenatal harm?
- Are we justified in singling pregnant women out in this way?
- Could this lead to maternal legal liability for prenatal harm?
- How could women be held liable for prenatal harm due to their behaviour during pregnancy under the current law in light of *CP* and the exclusion of civil liability under the CDCLA?
- Is the law governing prenatal harm consistent with its own principles of equality before the law, and the moral role of the criminal law?
- Could maternal liability for prenatal harm be more strongly resisted if the law was consistent with these principles?

These questions are explored in the four papers that form the body of this thesis in Chapters 6-9.

Before this, the following chapters explain the methodological and theoretical approach I have taken in this thesis: Chapters 4.2 and 4.3 explain my bioethical approach and the philosophical principles underpinning this work, and Chapter 4.4 explains the methodological approach I have taken to the legal questions in my research and the legal principles on which I base my critique of the law. Having established the foundation for this work, Chapter 5 then provides an overview of the four papers making up the main body of work.

CHAPTER 4 - APPROACH

4.1 Introduction

Establishing a link between the public health approach to prenatal harm and the potential for women to face legal liability for their behaviour during pregnancy requires an interdisciplinary approach to the questions outlined in the previous chapter. As explained below, I have applied a bioethical lens to examine the problematic nature of the public health approach to prenatal harm and a critical doctrinal lens to establish that maternal legal liability for prenatal harm remains a possibility due to the law being inconsistent with its principles of focusing on blameworthy conduct and no unjustified discrimination.

4.2 Ethical Approach

4.2.1 Bioethics

Bioethics is a relatively new interdisciplinary field of study evolving over the last 60 years or so as interest in ethical issues in healthcare grew, driven by advances in medical technology as well as concern over the power exercised by doctors and scientists[1] The etymology of the term lies in the combination of two Greek words: *bios* meaning 'life' and *ethikos* meaning 'showing moral character' and has come to refer to the interest in the ethical issues arising

[1] Helga Kuhse and Peter D. Singer, 'What is Bioethics? A historical introduction' in Helga Kuhse and Peter Singer (eds), *A Companion to Bioethics* (Wiley-Blackwell 1998) 3.

from health care and the biomedical sciences.[2] There is some debate about the role that philosophical theory should play in bioethics. Some view bioethics as the application of ethical theory to practical scenarios that arise in health care and biomedical science and therefore a branch of applied ethics. However, others see bioethics as ethical reflection independent of theoretical principles.[3] My own view of bioethics is somewhere between the two; an analysis of practical scenarios arising in health care and biomedical science through the application of ethical principles as well as asking more practical questions such as will an action achieve what it is supposed to achieve? It is in this sense that I adopt a bioethical lens in this thesis.

4.2.2 Speculative bioethics

Bioethics is commonly focused on practical scenarios, but the abstract also has a role to play. The use of thought experiments and 'what if?' scenarios, known as speculative reason, is a valuable part of a bioethical analysis, helping to deepen our moral understanding of a situation.[4] The most common form is the argument from analogy, in which the ethical responses to similar situations are compared to see whether our ethical judgment is consistent.[5] This can be done by comparing real or hypothetical situations, or a combination of the two. For example, the currently hypothetical example of ectogenesis in which a foetus gestates outside the human body in an artificial womb, provides a useful 'what if?' scenario for highlighting the significance of the bodily relationship of pregnancy (as considered in Chapter 8).

[2] ibid.
[3] John Arras, 'Theory and Bioethics' in Edward N. Zalta (ed), *The Stanford Encyclopedia of Philosophy* (Winter 2019 Edition) <https://plato.stanford.edu/archives/win2019/entries/theory-bioethics/> accessed 20 April 2022.
[4] John McMillan, *The Methods of Bioethics: An Essay in Meta-Bioethics* (Oxford University Press 2018) ch 8.
[5] ibid 128.

4.2.3 Empirical bioethics

As the field of bioethics has developed, there has been an increased interest in the use of empirical data to support empirical premises in argument.[6] This aim is not to replace ethical theorising and reduce bioethics to 'ethics by opinion poll', but to develop and articulate normative claims that are richly informed by the empirical world.[7] While I have not adopted an empirical bioethics methodology to my work in this thesis, I do share some of its aims. Establishing the problematic nature of the public health approach to prenatal harm requires a combination of the empirical and the normative; empirical data is necessary to evaluate the effectiveness of the public health approach which is balanced against the associated transgression of ethical norms. In this way, empirical data is used to support the ethical argument for what should be done.

4.3 THEORETICAL APPROACH

4.3.1 Autonomy

The ethical approach of this thesis centres on the principle of respect for autonomy. As discussed in Chapter 2.4, the principle of respect for autonomy is central to medical ethics and medical law. However, there are many different accounts of what autonomy is and what

[6] Pascal Borry, Paul Schotsmans, and Kris Dierickx, 'The birth of the empirical turn in bioethics' (2005) 19(1) Bioethics 49.

[7] Richard Huxtable and Jonathan Ives, 'Mapping, framing, shaping: a framework for empirical bioethics research projects' (2019) 20(86) BMC Med Ethics <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-019-0428-0.pdf> accessed 3 August 2022.

it means to respect it. This section sets out the approach I have taken to autonomy in this thesis and why.

The common theme of the various theories is that autonomy is the capacity for self-government, to make decisions in accordance with one's deeply held values and that this is important because it is a defining characteristic of free moral agents.[8] In other words, it is central to what makes us who we are and consequently to the respect we must show one another.

4.3.2 How the law views autonomy

As discussed in Chapter 2.4, the law employs an individualistic approach to autonomy. When judges talk about respecting the autonomy of individuals, they are concerned with respecting the choices of individuals on the basis that they are the result of a rational process. For example, the legal requirements for decision making capacity in medical treatment are set out in s.3 Mental Capacity Act 2005; that the individual can understand and retain the relevant information, use that information to come to a decision, and communicate that decision.[9] This clearly views the ability to make decisions as something an individual either has or does not have. The lack of attention paid by British courts to the role of external factors in influencing an individual's autonomy has been criticised by commentators such as Emily Jackson who states that:

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[8] Catriona Mackenzie and Natalie Stoljar, 'Introduction: autonomy refigured' in Catriona Mackenzie and Natalie Stoljar (ed), *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self* (Oxford University Press 2000) 5.
[9] Based on the test set out in *Re C (adult: refusal of treatment)* 1 All ER 819.

> This static conception of autonomy ignores both the future mutability of a diagnosis of incompetence, and the possibility that a woman's decision-making incapacity may in fact reflect a systemic failure to provide her with adequate support. Thus, by addressing the nature of the care that is and will be available to the mentally incapacitated woman, her ability to make autonomous reproductive decisions might be enhanced.[10]

A static, individualistic view of autonomy reflects the traditional liberal view of autonomy, but as discussed below, this is not the only account of autonomy the law could employ.

4.3.3 Criticism of the traditional liberal theory of autonomy

By focussing on the capacity for rational decision making, the traditional liberal view of autonomy presents us with an individual independent of his/her social context, who makes decisions on a wholly rational basis, with scant attention to other important motivations such as love and compassion. There are two problems with this view of autonomy. Firstly, that it fails to take into account the role that social context and oppression has in the development and exercise of autonomy including autonomy-related skills, attitudes and values.[11] Secondly, in the context of pregnancy, it ignores the unique physical and emotional relationship between a pregnant woman and her foetus.[12]

Feminist and communitarian scholars have criticised the traditional liberal view on the basis that it ignores the social nature of the self and the importance of social relationships to self-

[10] Emily Jackson, *Regulating reproduction: Law, technology and autonomy* (Bloomsbury Publishing 2001) 6.
[11] Erin Nelson, *Law, policy and reproductive autonomy* (Bloomsbury Publishing 2013) 47.
[12] Jackson 'Regulating reproduction' (n 10) 1-3.

identity.[13] For example, a woman is not an isolated rational being weighing up the pros and cons of her decisions in an abstract fashion, but a daughter, a mother, a wife, a friend, whose identity, beliefs and priorities are informed by her social relationships. If the purpose of the concept of autonomy is to protect the self-governance of individuals, such a concept should reflect the reality of such self-governance. Only by reflecting the true nature of our decision making can an account of autonomy provide guidance on what is required of us to show sufficient respect for autonomy.

In failing to acknowledge the role that one's social context has in autonomy it can be argued the traditional liberal account has subverted the claim that in order to promote and respect autonomy we must address the social conditions of individuals. Traditional accounts of respect for autonomy focus on the requirement of informed consent and freedom from coercion. In doing so they miss other important factors. For example, it is meaningless to say that a woman can make an autonomous choice to have an abortion because it is lawful in some circumstances, if at the same time she is unable to pay for the procedure or her caring responsibilities make travelling for the procedure impossible. Respecting autonomy requires meaningful choice and meaningful choice is heavily influenced by social factors.[14]

In the context of pregnancy, the traditional liberal account of autonomy is particularly problematic as it presents the ideal autonomous being as free from the influences of their circumstances. Therefore, the fact that a pregnant woman is making decisions on behalf of herself *and* her future child is seen as problematic. Such an account does not permit us to properly encapsulate the uniquely intertwined interests of the woman and future child and

[13] Nelson (n 11) 21.
[14] Jackson 'Regulating reproduction' (n 10) 4-9.

therefore contributes to the conflict view of pregnancy. This can be problematic for the rights of the pregnant woman as if her rights and interests are seen as conflicting with those of her future child, it could be assumed that protecting the future child requires the abrogation of the woman's interests.

4.3.4 Relational autonomy

In order to address the problems associated with the rational individualistic view of autonomy, the concept of relational autonomy has been developed, largely by feminist scholars to take its place.[15] The term 'relational autonomy' encompasses a range of theories that seek to address how the concept of autonomy should reflect the social nature of the self. Some aspects of these theories are to be welcomed, however, some are problematic.

A thorough explanation of the range of accounts of relational autonomy is beyond the scope of this thesis but I will attempt to set out the three main ways in which relational accounts seek to better reflect the social nature of individuals. In so doing, I will explain the strengths and weaknesses of each and argue that while there is much to be welcomed from relational accounts of autonomy, ultimately what is required is a reformulation of the traditional concept of autonomy rather than a whole scale replacement of it.

4.3.4.1 Relational conceptions of the self

Central to traditional concepts of autonomy is the idea that there is an 'inner citadel' or 'true self'; a central identity that autonomous decisions are made in accordance with, which is

[15] See Mackenzie and Stoljar 'Introduction: autonomy refigured' (n 8).

independent of social context.[16] In contrast, relational conceptions of the self claim that we are socially embedded beings entirely defined by our social context, and so there is no 'true self' independent from social factors.[17] In this way, autonomy is to be seen as a property of relationships, not of individuals.[18]

This is problematic because if we are constituted by the social relations and shared values that we find ourselves in to the extent that there is no 'self' able to reconsider our attachment to those relations and values, we are unable to argue that we choose our social relationships as part of how we choose to reflect and develop our identities.[19] If we are our social relations we can have no control over them. If the self is constituted by the relations one finds oneself in, social relations that are oppressive and unjust cannot be challenged on the basis that they are harmful as they are not *affecting* an individual; they *are* that individual. The feminist argument that we *choose* which communities to affiliate with as part of how we reflect and create our identities is a crucial part of challenging the traditional roles of women and not merely accepting the social relations women in particular find themselves in.[20]

Therefore, a relational conception of the self would not allow me to challenge the view of pregnant women as a risk to be managed on the basis that it interferes with women's autonomy. The social context of pregnancy, the meaning attached to that state, would define her, and would not be something she could align or detach herself from. She would be unable to decide what being pregnant means to her and thus others could legitimately impose their meanings, and therefore their expectations, upon her.

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[16] Marina Oshana, 'Personal autonomy and society' (1998) 29 J Soc Philos 81, 85.
[17] Marilyn Friedman, 'Feminism and modern friendship: Dislocating the community' (1989) 99 Ethics 275, 276. See Michael J Sandel, *Liberalism and the Limits of Justice* (Cambridge University Press 1998); and Alasdair MacIntyre, *After virtue* (A&C Black 2013).
[18] Mackenzie and Stoljar 'Introduction: autonomy refigured' (n 8).
[19] ibid.
[20] Friedman (n 17).

Therefore, I reject the argument that the solution to the problems associated with the rational individualism of traditional concepts of autonomy, lies in a relational concept of the self.

4.3.4.2 Constitutive relational autonomy

Constitutive relational accounts of autonomy claim that no matter what the self turns out to be, it is irrelevant to the concept of autonomy; autonomy is external to the self.[21] This is because regardless of one's internal state, one cannot be autonomous in an oppressive social environment. For example, while an internalist might claim that an individual who relinquishes money to a mugger is autonomous if he would have done so anyway of his own free will, an externalist might argue that autonomy is impossible in the absence of realistic alternatives.[22] Therefore, autonomy is not about the internal psychological state of individuals, but is fundamentally about social relations.[23]

Such a theory enables the argument to be made that in order to show respect for the autonomy of individuals we should be addressing the social relations which can be judged to be removing realistic alternatives from individuals. It is not sufficient to respect an individual's wishes; we must seek to ensure that social conditions meet the requirements for autonomous decision making.

However, if autonomy is seen as constituted by certain types of social relations it seems inevitable that those who are not in those social relations will not be considered to be autonomous.[24] This could then be used to argue for a diminished level of respect towards them and their decisions. Thus, a constitutive relational account of autonomy could increase

[21] Oshana (n 16).
[22] ibid.
[23] ibid.
[24] Nelson (n 11) 29.

the oppression of vulnerable groups, not reduce it. This could be particularly problematic in cases of pregnancy, as it would support the claim that during pregnancy a woman's autonomy is impaired due to the prevailing pronatalist views of society, or by her relationship with her foetus which is heavily influenced by societal pressures to act altruistically.[25] While such social factors can be seen as problematic, if they are taken as indicating that pregnant women cannot be autonomous by virtue of their pregnant state, more harm than good is likely to result for the status of pregnant women.

4.3.4.3 Causally relational autonomy

Causally relational accounts of autonomy seek to highlight the crucial causal role that social factors play in the development and exercise of autonomy.[26] Here, autonomy is a property of the individual but the impact of social factors on an individual's ability to develop and exercise autonomy is fundamental.

The strength of causally relational accounts is that they highlight the ways in which social factors can impact negatively and positively on an individual's autonomy. However, a relational account goes further than this; it claims that the right kind of social relations are *conceptually necessary* for autonomy rather than contributing factors.[27] Therefore, as Nelson notes

[25] ibid 21, 30.
[26] Mackenzie and Stoljar 'Introduction: autonomy refigured' (n 8).
[27] Nelson (n 11) 26-27.

> …they mistake the *possibility* that cultural norms (as opposed to autonomous reflection) have led to a particular decision being made for the *certainty* that this is the case.[28]

Further, if particular kinds of social relations are conceptually necessary for autonomy protecting the autonomy of individuals becomes protecting the relationships deemed worthy. Once again, this risks excluding those not in those relationships from autonomy.[29]

4.3.5 Social autonomy

In my view, the failure of the traditional liberal account of autonomy to sufficiently highlight the social nature of individuals and the impact social factors have on the development of autonomy can be addressed without abandoning traditional autonomy and replacing it with a relational account of autonomy.[30] Adopting a relational account of autonomy would carry the risk of supporting the claim that pregnant women are in some way lacking in autonomy.

There is room within the traditional notion of autonomy to recognise the impact of social factors without replacing and renaming it which risks contributing to the problem I am trying to address; the lack of respect shown to the autonomy of pregnant women. Acknowledging the social embeddedness of individuals does not prevent us from seeking to respect the choices of individuals; the fact that we are not in control of all the factors that influence who we are does not mean that our choices about what we do should not be respected.[31]

[28] ibid 29.
[29] ibid.
[30] As others have also argued including Nelson and Jackson. Nelson (n 11); Jackson 'Regulating reproduction' (n 10).
[31] Jackson 'Regulating reproduction' (n 10).

Some might argue that it is through asserting that the social relations associated with pregnancy diminish the autonomy of pregnant women that we can most forcefully argue for those social relations to be changed. However, change could equally be argued for on the basis that social relations associated with pregnancy *can potentially* diminish (as well as enhance) the autonomy of pregnant women. This would prevent pregnant women being automatically assumed to be lacking in autonomy because of their pregnant status and instead require that steps be taken to ensure that the impact of subversive social relations is minimised.[32]

Therefore, I prefer what Friedman and Nelson refer to as a socially sensitive account of autonomy.[33] A socially sensitive account of autonomy acknowledges that social contextual factors such as oppression can influence an individual's ability to exercise autonomy. It acknowledges that disadvantages faced by marginalised groups can cause them to make choices influenced by the wishes of those who dominate them and thus impair their autonomy. It also suggests that the way to address these issues is not to usurp the decision-making powers of such individuals but instead to address the conditions that lead to oppression.[34]

A further benefit of a socially sensitive concept of autonomy is that it avoids the problem inherent in traditional accounts of respect for autonomy of focussing on providing a range of options and instead focusses on whether there is meaningful choice. For example, the focus of traditional accounts of respect for autonomy on providing as many choices as possible can be seen as supporting, in the case of infertility treatment, to a neglect of research into the causes of infertility, such as pelvic inflammatory disease.[35] Focusing on the causes of

[32] Nelson (n 11) 26-29.
[33] ibid 30.
[34] ibid 31.
[35] Nelson (n 11) 51.

infertility does not add to the choices available to those who are *currently* infertile but by preventing infertility would add to the meaningful reproductive choices of those who otherwise would have become infertile.[36] A socially sensitive concept of autonomy would recognise that the availability (or lack of) of preventative treatments for infertility form part of the context in which individuals make reproductive decisions. Therefore, in order to respect autonomy by enabling meaningful choice, resources should be allocated to prevention as well as providing options for those who are currently infertile.

Adopting a socially sensitive concept of autonomy will provide me with an account of autonomy that is not diminished by pregnancy and takes account of how social factors such as poverty and the increasing social pressures on pregnant women can impact on their autonomy, and so addressing such social factors should form part of our respect for their autonomy. This shift away from the atomistic individuals pursuing their own self-interested ends enables attention to be focused on the laws, institutions, services and policies that enhance our capacity for meaningful choice in reproduction, taking into account the potential impact of social factors.[37]

The goal of relational autonomy is to recognise the social determinants of autonomy, which is to be applauded, but in order to achieve this without diminishing the respect for the autonomy of pregnant women, a socially sensitive conception of autonomy is to be preferred over a relational one.

[36] ibid.
[37] Jackson 'Regulating reproduction' (n 10) 6.

4.3.6 Application of a socially sensitive autonomy

A potential difficulty with a socially sensitive concept of autonomy is that it could be applied in such a way as to require us to say what kind of social factors positively influence autonomy and which have a negative effect. This could lead to problems similar to those relational accounts of autonomy face in that it could then be argued that those not in certain types of relationships cannot make decisions as autonomously as those who are. Nelson describes this as meaning that decisions will only be considered autonomous if they are in accord with what feminists think.[38] However, an important difference between a socially sensitive account of autonomy and a relational one is that a socially sensitive account recognises that social factors *are capable of* impacting on autonomy, whereas a relational account claims that they *always* impact on autonomy. Therefore, a socially sensitive account of autonomy can take into account the potential impact of social factors on autonomy without holding them to be determinative of autonomy.

A major advantage of a socially sensitive concept of autonomy is that once we acknowledge that an autonomous individual is an individual with a social context, we can see that far from the rights and interests of pregnant women being in conflict with those of her future child, they are uniquely intertwined. In the case of a wanted pregnancy, a pregnant woman is best placed to make decisions that take into account her own interests as well as those of her future child and it is in her future child's interests as well as her own for her autonomy to be respected.

As Jackson argues:

[38] Nelson (n 11) 30.

> …acknowledging the unparalleled intimacy of pregnancy does not necessarily render the concept of autonomy redundant or meaningless. On the contrary, I suggest that the uniqueness of the bond that exists between a pregnant woman and her fetus should alert us to her intrinsic interest in defining for herself the scope of her relationship with the fetus that is living inside her body. Thus, rather than ascribing some essential and separate moral status to the fetus, I argue that its interests can only be determined in conjunction with a consideration of the interests of the pregnant woman within whom it exists. Thus, we acknowledge the special bond of pregnancy precisely by treating the pregnant woman's moral agency with particular respect.[39]

This unique intertwining of interests that pregnancy represents means that a traditional atomistic account of autonomy is particularly insufficient for discussing the autonomy of pregnant women. As Jackson suggests, a more helpful configuration of autonomy would be one that is not based on an isolated, self-directed and self-sufficient, and I would add, self-motivated, subject.[40] In my view, a socially sensitive concept of autonomy can provide this.

4.3.7 Procreative liberty and reproductive conduct

If autonomy is important because of the value we place on being the authors of our own lives, of being able to control the things that we see as giving our lives value and defining ourselves as individuals, what does that tell us about the respect we should have for decisions regarding the conduct of pregnancy?

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[39] Jackson 'Regulating reproduction' (n 10) 3.
[40] ibid.

It could be that all autonomously made decisions are worthy of the same level of respect. They should not be interfered with unless such interference is necessary and proportionate for the good of others. However, we interfere with the autonomous decisions of individuals on a daily basis, our society would not function if we did not. For example, I want to drive at 35mph where there is a 30mph speed limit because I calculate the increased level of risk to be acceptable. Or, an individual who wants to go to watch a football match but does not want to pay to do so. These autonomous choices are interfered with for the sake of others and for the functioning of society. However, it seems that interfering with some autonomous decisions is easier to justify than others. It is one thing to limit the speed at which I may drive but quite another to require me to undergo an invasive medical procedure against my will. One explanation for this difference is the relative impact the decisions have on what the individual sees as giving his/her life value and defining who he/she is. Our body is the physical form we experience the world through and in and therefore it is unsurprising that decisions involving the right to control what happens to that body (bodily integrity) are of particular importance to us. Decisions regarding our relationships with others such as, if and when to get married and to whom would also seem to be closely tied to our sense of identity and satisfaction with our lives.

I will consider the argument that choices regarding whether or not to procreate ('procreative choices') are worthy of an enhanced level of respect because of the impact they have on what we consider to be a valuable life and argue that such enhanced level of respect should be extended to choices regarding the conduct of pregnancy.

Some commentators, most notably Robertson, have argued that procreative liberty belongs to a special class of rights that we should be especially reluctant to interfere with.

> Procreative liberty should enjoy presumptive primacy when conflicts about its exercise arise because control over whether one reproduces or not is central to personal identity, to dignity, and to the meaning of one's life. For example, deprivation of the ability to avoid reproduction determines one's self-definition in the most basic sense. It affects women's bodies in a direct and substantial way. It also centrally affects one's psychological and social identity and one's social and moral responsibilities.[41]

When Robertson talks about 'procreative liberty' he is referring to the choice of whether or not to reproduce and with whom.[42] He explicitly excludes choices regarding the conduct of a pregnancy from such elevated respect seeing these instead, as matters of 'personal autonomy'.[43]

Similarly, Jackson argues that 'reproductive freedom' is so significant to what an individual considers to be a satisfying life that it should be given the same status as what Ronald Dworkin refers to as 'critical interests'.[44] For Jackson, 'reproductive freedom' has a similar meaning to Robertson's 'procreative liberty', although she does seem also to include decisions invoking bodily integrity:

> Insofar as it is now possible for individuals to decide if, whether or when to reproduce, depriving them of this control significantly interferes with their capacity to

[41] John A Robertson, Children of choice: Freedom and the new reproductive technologies (Princeton University Press 1994) 24.
[42] ibid.
[43] ibid.
[44] Jackson 'Regulating reproduction' (n 10) 7; Ronald M Dworkin, Life's dominion: An argument about abortion, euthanasia, and individual freedom (Vintage 1993) 200.

> live their life according to their own beliefs and priorities. In relation to women, a lack of respect for their reproductive autonomy may even involve infringing their bodily integrity, as has happened when the courts have authorised non-consensual surgical intervention in childbirth.[45]

I agree that respecting an individual's control over whether he or she reproduces or not is central to the concept of respecting an individual as a person capable of determining his or her own life, and so is due particular respect. However, in my view, a similar argument can be made for including decisions regarding the conduct of pregnancy in this enhanced level of respect.

4.3.8 Expanding the enhanced respect given to procreative choices

Scott has sought to give special status to those decisions of pregnant women which invoke their bodily integrity because the body is a central part of oneself and one's sense of self.[46] Scott's is a powerful argument which provides a strong justification for respecting the decisions of pregnant women in the context of refusal of treatment. However, I do not agree that matters of more general conduct (such as taking pills or what one eats or drinks) during pregnancy are akin to the duty of a detached third party as Scott suggests.[47] This does not adequately reflect the relationship between a pregnant woman and her expected child.

Through her conduct during pregnancy, a woman is not only bringing a child into existence but also defining the relationship she has and will have with her expected child; she is

[45] Jackson 'Regulating reproduction' (n 10) 7.
[46] Rosamund Scott, *Rights, duties and the body: law and ethics of the maternal-fetal conflict* (Hart Publishing 2002).
[47] ibid.

making choices about one of the most significant features of her life. In other words, decisions regarding conduct during pregnancy should be afforded particular respect because they too are significant for the shape and meaning of one's life; they are the beginning of what type of parent one is, which is important to self-identity and fulfilment.

If, as some have argued,[48] what is important about procreative decisions is that they are decisions about whether or not to have an extremely significant type of relationship with another individual, i.e. whether we have parental responsibility for someone,[49] then it is arguable that one should similarly be able to make decisions which affect the fundamental nature of that relationship. As Jackson states, a pregnant woman has '…an intrinsic interest in defining for herself the scope of her relationship with the foetus that is living inside her body.'[50] Or, perhaps more accurately in this context, her relationship with her expected child. If this is the case, it is logical that it is not only decisions about if, whether or when to reproduce that should be afforded an enhanced level of respect, but also decisions about the conduct of a pregnancy that influence the scope and nature of the woman's relationship with her expected child.

Further, if this were not the case and the same presumption did not apply to choices regarding conduct, the freedom to make procreative decisions could be robbed of its value. If it is determining the shape and meaning of one's life that is important, what good would the freedom to choose to have a child be if, once that decision was made, the lives of every parent had to take the same shape and meaning?

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[48] Catriona Mackenzie, 'Abortion and embodiment' (1992) 70 Australasian journal of philosophy 136, 152.
[49] This would include the responsibility to decide whether to parent the child ourselves or to have the child adopted.
[50] Jackson 'Regulating reproduction' (n 10) 3.

Of course, while it may be relatively easy to accept that choices regarding whether one continues in employment, submits to medical tests, or follows a particular diet during pregnancy are closely connected to a sense of self-identity and the relationship a woman has with her expected child, it could be argued that other choices, such as drinking heavily or smoking or taking illegal drugs, do not share this connection. However, I would argue that even if such conduct does not share the same strong connection to self-identity and fulfilment, the difficulties inherent in determining which conduct during pregnancy does and does not have this connection from an objective viewpoint mean that it is preferable to include all conduct decisions in this enhanced level of respect. The factor that makes decisions regarding drinking and drugs during pregnancy more problematic, I would suggest, is the degree of harm they pose to the expected child compared with the benefit to the mother. The question is, what would this enhanced respect require?

4.3.9 What is the appropriate level of this 'enhanced respect'?

Of course, even critical interests or the right to bodily integrity could be justifiably overridden if necessary to protect others from serious, avoidable harm, as is the case with the power to restrain the liberty of those with certain highly communicable diseases such as tuberculosis or COVID-19.[51] If we accept that reproductive choices are worthy of a particular level of respect, when would we be justified in interfering with such choices?

Robertson argues that there should be a presumption in favour of procreative decisions (whether to have children or not), which could only be overridden when it has been shown

[51] Public Health (Control of Disease) Act 1984, for a discussion of this in relation to COVID-19 see Jonathan Pugh, 'The United Kingdom's Coronavirus Act, deprivations of liberty, and the right to liberty and security of the person' (2020) 7(1) J Law Biosci <https://academic.oup.com/jlb/article/7/1/lsaa011/5826792> accessed 3 August 2022.

that the choice would result in a level of substantial harm that justifies such interference.[52] It seems that interference with procreative decisions could therefore, only be justified when the harm to the resulting child is such that it can be presumed that the child would prefer never to have been born.[53] Any lesser degree of suffering would not be a harm to that child as the alternative is never having been born.[54] Brazier argues that such a bar is too high for interfering with procreative choices because expected children should enjoy the same protection of the basic interests which constitute a decent life that every human being is entitled to, including freedom from degrading treatment, freedom from acute pain and suffering of mind or body.[55] Therefore, 'Potential parents, as much as actual parents, should aspire to provide for their children conditions of life which minimise the risk of children suffering significant harm.'[56] However, it seems to me that Brazier's argument could be interpreted as shifting the standard for what constitutes a life worth living rather than altering Robertson's test. An expected child should enjoy the protection of its future interests, but arguably this can only be the case once there is an expected child, not a choice between expected children. I am therefore, not going to take the view that Robertson's bar for interfering with procreative decisions is set too high. However, I will take the view, as Brazier does, that Robertson's bar for interfering with other reproductive choices is set too low.

For Robertson, other reproductive choices, particularly regarding the conduct of pregnancy are choices which invoke personal autonomy rather than procreative liberty.[57] Therefore,

[52] Robertson (n 41).
[53] Margaret Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 Curr Leg Probl 359, 365.
[54] Robertson (n 41).
[55] Brazier 'Liberty, Responsibility, Maternity' (n 53).
[56] ibid, 373.
[57] Robertson (n 41) 178

such choices are limited by the harm principle; the duty to avoid harming others.[58] Robertson's error is that in deciding whether reproductive conduct should be afforded the same respect as procreative choices, he constructs the question as '…whether the right to procreate includes the right to engage in any conduct during pregnancy regardless of the consequences for offspring?'[59] However, for Robertson, the right to procreate is not the right to procreate regardless of the consequences for offspring. In his view, procreative decisions should not be interfered with unless the consequences for the offspring justify that interference.

It is not clear why other reproductive decisions should have to meet this higher standard of justifying the disregard of the consequences for the offspring. I would instead argue that interference with other reproductive decisions can only be justified when they result in substantial harm to others which is greater than the harm caused by such interference; the same standard for interfering with procreative decisions.

The reason that there should be a presumption in favour of respecting reproductive decisions in the same way as procreative decisions, is that choices regarding conduct during pregnancy are central to the woman's interests in defining the scope of her relationship with her expected child. Interfering with such choices could be justified in some circumstances if it were necessary to protect the expected child from serious harm but this is unlikely to be the case. While it may be that overriding an *individual* pregnant woman's choices would benefit her expected child, if we are interested in protecting one expected child, arguably we should be more concerned with protecting many expected children, and on a policy level, interfering with the autonomy of pregnant women *causes* harm to expected children, it does not reduce it.[60] Further, there is no evidence to suggest that pregnant women are making choices which

[58] ibid 173-174.
[59] ibid 178.
[60] I expand on this point in Chapter 6. It is supported by research such as Ulrike Boehmer and John B Williamson, 'The impact of women's status on infant mortality rate: A cross-national analysis' (1996) 37 Soc

harm their expected children intentionally or because they do not care enough about them, they are often simply trying to do their best to fulfil all of their obligations and balance the interests of those they care about.

Robertson's position reflects an atomistic, individual account of autonomy; the assumption is that pregnant women make choices regarding their conduct during pregnancy on the basis of their individual interests alone and so there should be no presumption in favour of these decisions. However, once a socially sensitive account of autonomy is adopted, it is clear that pregnant women can and do make decisions taking into account the interests of their future children, their other dependents, and their own interests. Therefore, extending the presumption and enhanced respect to reproductive conduct does not pose the risk to future children that Robertson assumes. The right to make choices regarding the conduct of reproduction is not the right to disregard the consequences for the expected child, but the right to be the one to assess what is in the interests of the expected child and balance those with one's own interests and those of others to whom we are connected.

In summary, it is my assertion that pregnancy, like parenting, is an important part of self-identity and so there should be a presumption of freedom to make decisions about the conduct of one's own pregnancy. Only when a compelling case in the interests of others is made should this be overridden. It is this approach to autonomy in reproductive conduct that informs my work in this thesis. In the following sections, I will look at two particular examples; the policy on alcohol in pregnancy and the increase in routine screening in pregnancy, in order to illustrate the need for this presumption.

Indic Res 333; Ramesh Adhikari and Yothin Sawangdee, 'Influence of women's autonomy on infant mortality in Nepal' (2011) 8 Reprod 1.

4.3.10 A note on the policy on alcohol in pregnancy and autonomy

While there is evidence that connects heavy alcohol consumption during pregnancy with problems such as low birthweight, premature birth, and developmental problems which come under the umbrella term of FASD,[61] the evidence that low level drinking during pregnancy poses a threat to the future child is uncertain.[62] On this basis the advice to pregnant women was that they could drink up to 1 to 2 units of alcohol no more than once or twice a week.[63] However, in 2007 the Department of Health (DoH) revised its position and advised that pregnant women or those trying to conceive should avoid alcohol completely but if they do choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk.[64]

This move to a recommendation of abstinence was acknowledged to not be the result of a change in the scientific evidence but rather it was felt necessary to make the advice easier to understand and follow.[65] In 2016, the UK Chief Medical Officers (CMOs) adopted a precautionary approach to low level drinking advising alcohol abstinence because of a lack of certainty that low level drinking is completely safe.[66] Similarly, an abstinence only approach was adopted in Scotland on the basis that:

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[61] Ron Gray and Jane Henderson, *Review of the fetal effects of prenatal alcohol exposure* (Report to the Department of Health, University of Oxford 2006); Elizabeth Welch-Carre, 'The neurodevelopmental consequences of prenatal alcohol exposure' (2005) 5 Adv Neonatal Care 217; Raja Gray, Michael Rutter, 'Alcohol consumption during pregnancy and its effects on neurodevelopment: What is known and what remains uncertain' (2009) 104(8) Addiction 1270.

[62] Pam K. Lowe and Ellie J. Lee 'Advocating alcohol abstinence to pregnant women: Some observations about British policy' (2010) 12(4) Health Risk Soc 301.

[63] Pat O'Brien, 'Is it all right for women to drink small amounts of alcohol in pregnancy? Yes' (2007) 335(7625) BMJ 856.

[64] Lowe and Lee (n 62).

[65] BBC News, 'No alcohol in pregnancy advised' (*BBC News online*, 25 May 2007) <http://news.bbc.co.uk/1/hi/health/6687761.stm> accessed 18 January 2022.

[66] UK Chief Medical Officers, *Low Risk Drinking Guidelines* (August 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf > accessed 27 October 2021, para 28.

> It is not possible to say that such drinking carries no risk of harm at all [and] it is plausible scientifically that alcohol, even at such low levels, could cause some harm.[67]

Since this guidance was issued the precautionary abstinence only approach has been accepted unquestioningly as the basis for all policy on alcohol in pregnancy.[68]

The underlying assumption here that there must be conclusive evidence as to safety before pregnant women are to be given the same choices as non-pregnant individuals, poses a significant threat to women's autonomy. Usually respect for autonomy requires that we have good reason to coerce someone into behaving a certain way, rather than requiring good reason not to. In this way the pregnant woman is removed from a position of an autonomous individual with the capacity to manage risk, to a risk to be managed in order to protect future children.[69] As Lee et al note this is reflected in a significant change in the language of the CMOs' guidance. The 2007 DoH guidance referred to women having a 'choice to drink', presenting the pregnant woman as a manager of risk. However, this reference to the choice of the pregnant woman is omitted from the 2016 CMOs' guidance and the guidance is no longer addressed to women, advising them on the risks they should consider when choosing how to conduct themselves during pregnancy, but is now addressed to health professionals, advising them on how to manage the risks presented by the woman's behaviour.[70] This leads Lee and others to conclude that:

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[67] Scottish Intercollegiate Guidelines Network, *Guideline 156: Children and Young People Exposed Prenatally to Alcohol* (SIGN 156, 2019) 10.
[68] National Institute of Clinical Excellence (NICE), *Draft Quality Standard for FASD* (initially published in March 2020 for public consultation); Public Health England (PHE), *Maternity High Impact Area* (December 2020); Department of Health and Social Care, *Fetal alcohol spectrum disorder: health needs assessment* (9 September 2021).
[69] Ellie Lee and others, 'Beyond 'the choice to drink' in a UK guideline on FASD: the precautionary principle, pregnancy surveillance, and the managed woman' (2022) 24(1-2) Health Risk Soc 17.
[70] ibid.

> …in policy construct, the case has been accepted that uncertainty regarding the safety of 'low level' drinking means there is no place for the idea that a woman might assess risk for herself and 'have a right' to make 'their own decision'; instead she should be advised to abstain.[71]

This lack of respect for the autonomy of pregnant women has serious implications for the relationship between pregnant women and healthcare professionals in several respects. First, there is a risk that if the public believes that the risks of alcohol in pregnancy are being exaggerated, the authority of public health messages could be weakened,[72] something that the current COVID-19 pandemic has highlighted the dangers of.[73] This authority could also be weakened by 'advice fatigue' resulting from the growing list of requirements for the behaviour of pregnant women.[74] The danger is that a long list of onerous dos and don'ts could cause women to switch off from medical advice and look to other, perhaps less reliable, sources for guidance. Further, in order to be effective the relationship between a patient and a healthcare professional should be based on trust, openness and good communication.[75] The General Medical Council's (GMC) guidance states that when there is uncertainty 'You must be clear about the limits of your knowledge and, if you can't answer a question, explain whether it is something you are uncertain of or something that is inherently uncertain.'[76] This is something that the precautionary approach of the current guidance fails to do. As

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[71] ibid.
[72] Colin Gavaghan, ' "You can't *handle* the truth"; medical paternalism and prenatal alcohol use' (2009) 35 J Med Eth 300, 302.
[73] Ariadne Neureiter and others, 'Trust in Science, Perceived Media Exaggeration About COVID-19, and Social Distancing Behavior' (2021) 9 Front Public Health article 670485 <https://www.frontiersin.org/articles/10.3389/fpubh.2021.670485/full> accessed 5 August 2022.
[74] Gavaghan, (n 72) 302-303.
[75] ibid.
[76] General Medical Council, *Decision making and consent* (2020) para 25 <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent> accessed 18 January 2022.

Gavaghan has argued, an honest and accurate response to the question of 'how much is it safe to drink during pregnancy?' is one that communicates the uncertainty in the evidence:

> A 'partnership based on openness, trust and good communication' does not involve substituting a true, complicated account of risk with a more simplistic, but less accurate, one.[77]

> The days when doctors routinely withheld information - about risks, alternative, side effects or prognoses – on the grounds that patients would become confused and make bad decisions are, supposedly, consigned to history. It is far from clear why a paternalistic exception is permitted in the case of pregnant women.[78]

One reason that might justify interfering with the autonomy of pregnant women is if such interference were shown to be necessary and proportionate to prevent harm to others, in this case future children. However, in this case this seems unlikely given the lack of certainty that low to moderate level drinking during pregnancy is harmful to the future child.

It could be argued that although coercing women to abstain from alcohol represents an interference with their autonomy, it does not do so in a significant way because it only interferes with a woman's interest in drinking alcohol. There are two problems with this argument. First, it assumes that the interest in consuming alcohol is insignificant. Drinking alcohol is a normal part of our society. It forms the basis of many social interactions and is seen as a stress reliever and one of life's pleasures by many. Conduct which enhances an

[77] Gavaghan, (n 72) 301.
[78] ibid.

individual's quality of life and does not result in harm to anyone else should not be dismissed as ethically irrelevant.[79] Second, the argument assumes that this is where the interference will end. If women's interest in drinking alcohol is to be overlooked then what about their interests in drinking coffee, taking part in sport, employment in potentially stressful or physically demanding jobs? Are these to be similarly discounted? At what point do her interests start to count against an unproven risk of harm to the future child, including her interests in defining her experience of such a significant stage in her life? Further, the interference is unlikely to be limited to the duration of pregnancy.[80] Women 'of child bearing age' are increasingly being advised to modify their behaviour to protect their hypothetical future children,[81] even if they do not want to become pregnant and are at no risk of becoming unintentionally pregnant because they are celibate, are lesbian or have fertility issues. Therefore, the interference with women's autonomy is far from insignificant.

4.3.11 Routine screening in pregnancy

Screening is a routine part of pregnancy. As noted in the introduction, a pregnant woman usually attends antenatal appointments 8 times during a 40 week pregnancy (11 times if it is her first pregnancy) and will have her abdominal growth measured, her urine dipped, the foetal heartbeat listened to, and be asked numerous questions about her health and behaviour.[82] Screening commonly includes screening for infectious diseases such as HIV, Syphilis, and Hepatitis B; screening for conditions such as pre-eclampsia, gestational diabetes, and rhesus D incompatibility. This monitoring enables potential problems to be

[79] ibid.
[80] ibid.
[81] ibid.
[82] NHS, *Your antenatal appointments* (2019) <https://www.nhs.uk/pregnancy/your-pregnancy-care/your-antenatal-appointments/> accessed 24 May 2022.

identified and, in many cases, treated, improving outcomes for women and future children.[83] In recent years, screening for genetic conditions such as foetal aneuploidy (e.g. Downs' Syndrome) through non-invasive prenatal testing (NIPT) has also become a part of routine antenatal care. As there is no cure or substantial treatment for these genetic conditions, screening cannot prevent harm to the future child.[84] The purpose of such screening is to enable future parents to make decisions about the children they want to bring to birth and feel able to parent.[85] In this sense at least, screening can be seen as enhancing reproductive autonomy.[86] However, as will be made clear in Chapters 6 and 7, screening for alcohol consumption or smoking cannot be justified on the basis of enhancing women's autonomy as such screening is designed to elicit information *about* women, not *for* women; women already know if they consume alcohol or smoke.

The routine nature of screening in pregnancy raises questions regarding the consent that is given to these medical interventions. Consent is a guiding principle in healthcare and is closely connected to the principle of respect for patient autonomy.[87] Routine screening is by its very nature coercive.[88] The very fact that it will be part of routine antenatal care and is intended to have a high uptake is incompatible with the principle of informed consent.[89] It raises concerns that women who take part in screening will not be making an informed choice because they are less likely to deliberate over a test that is seen as part of routine care and less

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[83] National Institute for Health and Care Excellence (NICE), *Antenatal care* (NG201,2021) <https://www.nice.org.uk/guidance/cg62>accessed 24 May 2022.
[84] Rebecca Bennett, 'Antenatal genetic testing and the right to remain in ignorance' (2001) 22(5) Theor Med Bioeth 461.
[85] Greg Stapleton, 'Qualifying choice: ethical reflection on the scope of prenatal screening' (2017) 20 Med Health Care Philos 195.
[86] However, as Panagiota Nakou has argued, this is not what lies behind the expansion of prenatal screening. Panagiota Nakou 'Is routine prenatal screening and testing fundamentally incompatible with a commitment to reproductive choice? Learning from the historical context' (2021) 24(1) Med Health Care Philos 73.
[87] See Chapter 2.3 and 2.4.
[88] Bennett, 'Antenatal genetic testing' (n 84).
[89] Rebecca Bennett, 'Routine antenatal HIV testing and informed consent: an unworkable marriage?' (2007) 33(8) J Med Ethics 446.

information might be provided by healthcare professionals regarding the risks and benefits of routine screening.[90] This is particularly likely where healthcare professionals are under pressure to meet high rates of women screened. Women might also feel pressurised to accept the screening because of a social pressure to conform to the social norm of having screening.[91] The screening is not mandatory, but the offer is one that is very difficult to refuse.[92]

This deviation from the normal standard of consent would only be justified if the screening is a necessary and proportionate intervention to prevent harm to others, in this case, future children. It is this question that I consider in Chapters 6 and 7.

Before I turn to considering these questions, the following section will set out my approach to the legal issues in this thesis.

4.4 Legal Approach

This section sets out the approach I have taken in this thesis to the legal aspects of the research questions outlined in Chapter 3. Although legal scholarship has traditionally resisted defining its methodology, an explanation of the types of questions asked and the parameters used to answer them, enhances the academic rigour of this body of work and positions it more clearly in relation to other work in the field.

[90] Adriana Kater-Kuipers and others, 'Ethics of routine: a critical analysis of the concept of 'routinisation' in prenatal screening (2018) 44 J Med Ethics 626.
[91] Sonia Mateu Suter, 'The Routinization of Prenatal Testing' (2002) 28 Am J Law Med 233.
[92] Dagmar Schmitz, Christian Netzer, and Wolfram Henn, 'An offer you can't refuse? Ethical implications of non-invasive prenatal diagnosis' (2009) 10 Nat Rev Genet 515.

4.4.1 Doctrinal Approach

The approach I have taken to the legal analysis in this thesis is largely a doctrinal one. A doctrinal approach can be defined as:

> …research that aims to give a systematic exposition of the principles, rules and concepts governing a particular legal field or institution and analyses the relationship between these principles, rules and concepts with a view to solving unclarities and gaps in the existing law.[93]

Smits identifies three key aspects to this approach.[94] First, unlike other disciplines, a doctrinal approach adopts an internal perspective; the legal system is the subject of enquiry as well as the normative framework on which the analysis is based. A doctrinal analysis does not need to draw on anything outside of the law. It asks questions such as whether the law is appropriate by applying the principles of the law itself rather than by drawing on external viewpoints. In this way, the methodology adopted is similar to that of the courts.[95]

Second, a doctrinal approach examines the law as a *system* rather than simply describing the existing legislation and case law.[96] Connections are made between the different elements of the law and how it is applied, and attempts are made to identify the underlying principles, rules and concepts against which the coherency of the law can be judged. In order to do this, the system of law under examination needs to be defined as there can be multiple 'coherent' systems such as; the law on offences against the person, the civil law, the criminal law, the

[93] Jan Smits, 'What Is Legal Doctrine?: On The Aims and Methods of Legal-Dogmatic Research' in Rob van Gestel, Hans Micklitz, and Edward Rubin (eds), *Rethinking Legal Scholarship: A Transatlantic Dialogue* (Cambridge University Press 2017); Terry Hutchinson, 'The Doctrinal Method: Incorporating Interdisciplinary Methods in Reforming the Law' (2015) 8 Erasmus L Rev 130.
[94] ibid.
[95] Susan Bartie, 'The lingering core of legal scholarship' (2010) 30 Legal Studies 345, 350.
[96] Smits (n 93).

law in England and Wales, European law. The choice of system will depend on the purpose of the analysis. In this thesis I examine the criminal law system in England and Wales for consistency with its own principles in Chapter 8, and in Chapter 9 I examine the coherency within the CDCLA and between it and the criminal law.

Thirdly, the doctrinal approach systematises the *present* law; systematising law that is not applicable, such as historic or foreign law would not be legal doctrine. However, historical law does a have role in demonstrating how the law has changed and developed. A key trait of the doctrinal approach is to analyse these changes and developments for deficiencies in legal principles, suggesting ways to improve or clarify the law.[97]

Although these traits of the doctrinal approach are likely to be recognised by all legal scholars, there is considerable debate about the aims and methods of this approach and how it can be combined with other methodologies.[98] Although a full account of these arguments is beyond the scope of this thesis, in my opinion, combining other methodologies with a doctrinal approach does not dilute the academic rigour of the analysis, but contributes to it. Searching for coherence and consistency with legal principles within the law alongside questions of what the social consequences of the law will be, how people experience the law, and what we can learn from the law in other jurisdictions, enhances the normative power of the analysis. After all, the legal system operates in a context and has real world consequences that impact on the lives of individuals. In my view there is much to be learned from examining how the law influences society and how society influences the law. For the purposes of this thesis I largely adopt the doctrinal methodology outlined above, however,

[97] Bartie (n 95).
[98] Smits (n 93); Fiona Cownie, *Legal Academics: Cultures and Identities* (Hart 2004) 97.

my central argument is a socio-legal one in that it examines the relationship between the law and the social situation demonstrated by the public health approach to prenatal harm.[99]

4.4.2 Legal principles

As explained above, the doctrinal approach I have taken in this thesis asks whether the law is consistent with its underlying principles. This section provides the groundwork for this task by setting out the legal principles I apply in my analysis.

4.4.2.1 Morality and the criminal law

Although there are no straightforward criteria determining which acts are rightly the concern of the criminal law, there are however, some general themes. The starting point for criminalisation is often taken to be the harm principle as formulated by John Stuart Mill:

> [T]he 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. His own good, either physical or moral, is not a sufficient warrant.[100]

Following this principle, the aim of criminal penalties can be viewed as the prevention of harmful conduct.[101] However, this is subject to the caveat that an individual should only be punished for harmful conduct that she is responsible for, in the sense that she has the capacity

[99] For a discussion on socio-legal theory see David N. Schiff, 'Socio-Legal Theory: Social Structure and Law' (1976) 39(3) Mod L Rev 287.
[100] John Stuart Mill, *On Liberty* (Longman, Roberts and Green Co. 1859) ch 1.
[101] Hyman Gross, *A Theory of Criminal Justice* (Oxford University Press 1979).

to act otherwise than she did.[102] This requires that the criminal law accurately reflect the nature of the harmful act in question, only then can the capacity to act otherwise be reflected in the punishment.[103]

Prevention of harm is only part of the function of the criminal law; it also serves to reflect the moral norms of society:[104]

> The wrongdoing which the criminal law seeks to punish is that which threatens the fundamental values upon which a society is founded. While it is harmful to the individual to be robbed or assaulted, it is also harmful to society as such behaviour threatens the security and well-being of that society. The criminal sanction operates then as a form of social control both punishing the offended and reasserting the mores of that society.[105]

Of course, not all transgressions of moral norms are crimes. For example, to many people adultery is immoral but there is no crime of adultery. Further, some crimes are morally neutral. Morality does not dictate that the speed limit in built-up areas is 30 miles per hour, or that persons under the age of 18 should not be served alcohol in licensed premises.[106] While these laws may be justified on the basis that they prevent harm to others, they do not reflect a common judgment of the morality of that behaviour. These laws represent the regulatory or utilitarian aspect of the criminal law; '…it prohibits things on grounds of public

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[102] Herbert L. A. Hart, 'Prolegomenon to the principles of punishment' in *Punishment and Responsibility: Essays in the Philosophy of Law* (2nd ed, Oxford University Press 2008) <https://oxford-universitypressscholarship-com.manchester.idm.oclc.org/view/10.1093/acprof:oso/9780199534777.001.0001/acprof-9780199534777-chapter-1> accessed 12 May 12 2022.
[103] As explained in Chapter 8.
[104] See for example, Baron Patrick Devlin, *The Enforcement of Morals* (Oxford University Press 1965).
[105] Michael Allen, *Textbook on Criminal Law* (13th ed, Oxford University Press 2015) 4.
[106] ibid 11.

health or safety, or for economic or political reasons, and sees the purpose of punishment as deterring that behaviour.'[107] It is clear that the criminal law is a combination of these moral and regulatory aspects. Deterrence is only one aim of the criminal law; as most would agree, those who commit murder or acts of violence should be subject to criminal penalties independent of the potential of those penalties to reduce future acts of violence.

This moral aspect of the criminal law is reflected in the retributive aim of the law; to punish offenders in a manner proportionate to their blame.[108] A key element of retribution is denunciation; to signal society's disapproval of the conduct and reaffirm the values of that society.[109] This is particularly true of crimes of violence or theft.[110] It is this function of the criminal law that has the potential to connect with the moralisation of conduct during pregnancy and lead to maternal criminal liability for prenatal harm; if prenatal harm is presented as a problem of morally condemnable individual behaviour, this strengthens the argument that the criminal law should signal society's disapproval of such behaviour by making it a crime.

However, not only does making an act a criminal offence *signal* society's disapproval, it can also contribute to the view that the act is morally wrong. In this way, the potential for women to face criminal sanctions for prenatal harm that results from their behaviour during pregnancy, could reinforce the 'policing of pregnancy' by non-legal means such as public health policies.

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[107] Celia Wells and Oliver Quick, *Reconstructing Criminal Law: Text and Materials* (4th edn, Cambridge University Press 2010) 6.
[108] Andrew Ashworth, *Sentencing and Criminal Justice* (2nd ed, Cambridge University Press 1995) ch 4; Tony Honoré, *Responsibility and Fault* (Bloomsbury 2002) 122-123.
[109] Ashworth (n 108) 5.
[110] Wells and Quick (n 107) 6.

4.4.2.2 Equality before the law

A fundamental principle of the rule of law and the system of precedent is equality before the law; like cases must be treated alike; everyone is subject to the same laws and must be treated equally by the courts.[111] This principle is embodied in UK and international law:

> Article 1 of the Universal Declaration of Human Rights (UDHR):
>
> All human beings are born free and equal in dignity and rights
>
> Article 7
>
> All are equal before the law and are entitled without any discrimination to the equal protection of the law
>
> Article 26 of the International Covenant on Civil and Political Rights (ICCPR)
>
> All people are equal before the law and are entitled without any discrimination to the equal protection of the law.

The UK is a party to both the UDHR and the ICCPR, but the UDHR is not a binding instrument and the ICCPR has not been turned into rights in UK law, unlike the European Convention on Human Rights (ECHR), parts of which were incorporated into UK law by the Human Rights Act 1998.

Article 14 ECHR provides:

> The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

[111] For an outline of some of the debate surrounding the nature of this principle see Alfonso Ruiz Miguel, 'Equality before the Law and Precedent' (1997) 10 Ratio Juris 372.

This includes the right to a fair trial under Article 6 ECHR and so any discrimination on the basis of sex in the determination of civil or criminal obligations could be in breach of Article 14 ECHR.[112] This would include the exclusion of a duty of care that serves as an immunity from civil liability as confirmed by the European Court of Human Rights in *Golder v UK*:[113]

> [t]he principle whereby a civil claim must be capable of being submitted to a judge ranks as one of the universally "recognised" fundamental principles of law; the same is true of the principle of international law which forbids the denial of justice. Article 6(1) must be read in the light of these principles.[114]

The Article 6 right is not absolute, but 'maybe subject to limitations' in national law.[115] However, any limitations must pursue a legitimate aim and must be proportionate to the policy aim pursued.[116]

This prohibition of discrimination of the grounds of sex in the provision of public services is also enshrined in the Equality Act 2010 under which, sex is a protected characteristic.[117] However, s.13 contains an exception to this:

> (1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.
>
> […]

[112] For a discussion on the interpretation and application of Article 14 see Rory O'Connell, 'A Dialogue on Discrimination and Equality: The UK Supreme Court and Article 14 ECHR' in Brice Dickson and Conor McCormick (eds), *The Judicial Mind: A Festschrift for Lord Kerr of Tonaghmore* (Hart Publishing 2022).
[113] [1975] 1 EHRR 524, 535-36
[114] ibid [35]
[115] *Fayed v UK* [1994] 18 EHRR 393, 429-30, [65].
[116] Rachel Mulheron, *Principles of Tort Law* (2nd edn, Cambridge University Press 2020) 70-71.
[117] Equality Act 2010, s.4.

> (6) If the characteristic is sex –
>
> […]
>
> (b) in a case where B is a man, no account is to be taken of special treatment afforded to a woman in connection with pregnancy or childbirth.

Therefore, a man can be treated less favourably than a woman is in connection with pregnancy or childbirth. However, it is significant for the discussion in Chapter 9, that the wording of this exception does not include treatment relating to conception or pre-conception.

My approach to the legal questions in this thesis is to ask whether the law is consistent with these principles of equality before the law and the moral aspect of the criminal law.

CHAPTER 5 - OUTLINE OF PAPERS

PAPER ONE: Are we justified in introducing carbon monoxide testing to encourage smoking cessation in pregnant women?

Smoking is frequently presented as being particularly problematic when the smoker is a pregnant woman because of the potential harm to the future child. This premise is used to justify targeting pregnant women with a unique approach to smoking cessation including policies such as the routine testing of all pregnant women for carbon monoxide at every antenatal appointment. This paper examines the evidence that such policies are justified by the aim of harm prevention and argues that targeting pregnant women in this way is likely to do more harm than good. Routine carbon monoxide testing is particularly problematic as it sends a message to pregnant women that they cannot be trusted either to truthfully answer questions as to whether or not they smoke, or to make decisions in the best interests of themselves and their future children in the way that non-pregnant individuals are. Further, if the aim is to reduce rates of prenatal harm, the evidence suggests that adopting a supportive and empowering approach to prenatal care is the most effective way to achieve this, something that the current policies aimed at pregnant women are in conflict with.

PAPER TWO: Can routine screening for alcohol consumption in pregnancy be ethically and legally justified? (Co-authored with Professor Rebecca Bennett)[1]

In the United Kingdom (UK) it has been proposed that alongside the current advice to abstain from alcohol completely in pregnancy there should be increased screening of pregnant women for alcohol consumption in order to prevent instances of Fetal Alcohol Spectrum Disorder. The Scottish Intercollegiate Guidelines Network (SIGN) published guidelines in 2019 recommending that standardised screening questionnaires and associated use of biomarkers should be considered to identify alcohol exposure in pregnancy. This was followed in 2020 by the National Institute for Health and Care Excellence (NICE) Draft Quality Standard which recommended that pregnant women should have information on their alcohol consumption recorded throughout their pregnancy and this information transferred to the child's health records. Most recently, Public Health England (PHE) have stated that the alcohol intake of all women should be recorded throughout pregnancy, not just at the initial booking appointment and that tools such as blood biomarkers and meconium testing should be researched in order to determine true prevalence rates of alcohol in pregnancy. We argue that this proposed enhanced screening undermines women's autonomy and their legal right to be sufficiently informed to consent to screening. We argue that there is no evidence that this kind of screening will result in a reduction of fetal harm and there is a danger that undermining the autonomy of women and the trust relationship between women and healthcare professionals may even increase harm to future children.

[1] This paper was written jointly with Professor Rebecca Bennett. The workload was approximately 50:50 with the original idea coming from myself. It was published as a feature article in the Journal of Medical Ethics. A jointly written blog post accompanies the article: Rebecca Bennett and Catherine Bowden, 'Why we must resist proposals for routine screening for alcohol in pregnancy' (Journal of Medical Ethics Blog, 28 March 2022) <https://blogs.bmj.com/medical-ethics/2022/03/28/why-we-must-resist-proposals-for-routine-screening-for-alcohol-in-pregnancy/> accessed 6 September 2022.

PAPER THREE: Is a relational approach required to close the door on criminal liability for maternal prenatal conduct?

Calls for women who drink heavily during pregnancy to face criminal liability for the subsequent harm to their future children are driven by notions of the 'bad mother' and the view that such behaviour represents a serious moral wrong, worthy of criminal penalties. If we are to avoid the erosion of women's autonomy and extensive scrutiny of women's lives such maternal criminal liability would precipitate, a new approach is needed in the criminal law. Until now, questions regarding criminal liability for conduct at the prenatal stage have focussed on the status of the victim at the relevant time; taking little account of whether the harm was caused by the pregnant woman or a third party. This has resulted in the woman who drinks heavily during pregnancy being presented as equally blameworthy as the man who stabs his pregnant partner. I argue that a relational approach; accurately reflecting the different nature of the relationship between a pregnant woman and her foetus, to that of a third party and a foetus, is vital for the law to capture the moral blameworthiness of conduct which unintentionally causes harm to future children. Only when the law is able to do this can arguments in favour of maternal criminal liability based on notions of the 'bad mother' be addressed and the door firmly closed on criminal liability for maternal prenatal conduct.

PAPER FOUR: Is the unequal treatment of maternal and paternal liability under the Congenital Disabilities (Civil Liability) Act 1976 justified?

Under the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) a child born disabled as a result of an occurrence prior to its birth can bring a claim against the individual responsible for that occurrence. Significantly, mothers are exempt from liability (except in relation to negligent driving) but fathers are not. Since the CDCLA came into force in 1976, there have been significant shifts in the landscape in which it operates: a more gender-neutral model of parenting; transmission of an infection to a sexual partner can be a criminal offence; and growing evidence regarding the impact of prenatal events. In addition, there is a trend for presenting prenatal harm as a problem of individual behaviour. This paper presents a timely consideration of the potential for parental liability under the CDCLA and asks whether restricting the exemption of parental liability to mothers but not fathers can be justified. It is argued that the reasons for unequal parental liability in relation to gestational harm are not sufficient to justify restricting the broad exemption to mothers but not fathers and a change in the law is required to bring the CDCLA up to date with advances in the criminal law, society and medical science.

CHAPTER 6 - PAPER ONE: Are we justified in introducing carbon monoxide testing to encourage smoking cessation in pregnant women?

6.1 Introduction

It is normally assumed that pregnant women not only want their future children to be born as healthy as possible, but that they are also under a moral obligation to protect those future children during their fetal stage if they are intending to bring them to birth.[1] This assumption underlies public health policies advocating interventions in pregnancy including those that aim to persuade women to limit their alcohol consumption, control their weight and stop smoking.[2] This paper focuses on a particular public health intervention, routinely testing pregnant women for carbon monoxide to encourage smoking cessation, and asks whether such measures are justified.

While there has been a great deal of discussion around what moral obligations pregnant women might have to their fetuses and the children their fetuses might become, and how this should affect law and policy in this area,[3] this paper seeks to explore a different but

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[1] Margaret Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 Curr Leg Probl 359; Rosamund Scott, *Rights, duties and the body: law and ethics of the maternal-fetal conflict* (Hart Publishing 2002).

[2] National Institute for Health and Clinical Excellence (NICE), *Weight management before, during and after pregnancy* (NICE Guideline PH27, 2010); National Institute for Health and Clinical Excellence (NICE), *Smoking: Stopping in pregnancy and after childbirth* (NICE Guideline PH26, 2010); UK Chief Medical Officers, *Low Risk Drinking Guidelines* (August 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf > accessed 27 October 2021.

[3] Susan Bewley, 'Restricting the freedom of pregnant women' (2002) Matern Fetal Med 131; Brazier 'Liberty, Responsibility, Maternity' (n 1); Rebecca Brione, 'To what extent does or should a woman's autonomy overrule the interests of her baby? A study of autonomy-related issues in the context of caesarean section' (2015) 21(1) New Bioeth 71; Erin Nelson, *Law, policy and reproductive autonomy* (Bloomsbury Publishing 2013); John Robertson, 'Procreative liberty and the control of conception, pregnancy, and childbirth' (1983) 69(3) VA Law Rev 405; Rosamund Scott, 'Maternal duties toward the unborn? Soundings from the law of tort' (2000) 8(1) MLR 1; Emma Cave and Catherine Stanton, 'Maternal responsibility to the child not yet born' in Stanton, C.,

equally important question. It seeks to avoid the intractable nature of the debate concerning what moral obligations pregnant women might have, by starting from the assumption that a convincing case has been made that pregnant women have a moral obligation to take reasonable steps to avoid causing their future children harm. By making this assumption, I am then able to focus on the fundamental question of whether the evidence suggests that public health measures such as routine carbon monoxide testing in pregnancy are likely to achieve their aim of preventing harm to future children. This question has received little attention despite its significance for policy making, as well as the ethical and legal issues it raises. Without strong evidence of harm prevention, such interventions and their implications for the lives of pregnant women cannot be justified.

6.2 Smoking Cessation Interventions in Pregnancy

Non-pregnant smokers are frequently offered support to quit, including nicotine replacement therapies, support groups and counseling.[4,5] However, in England it is only pregnant women who, irrespective of whether they say they are smokers or not, are now to be routinely screened and monitored using carbon monoxide tests at all prenatal care appointments.[6,7] As the majority of routine face-to-face antenatal care in the UK is

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Devaney, S., Farrell, A-M., and Mullock, A. (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015); Law Commission, *Injuries to Unborn Children* (Law Com. No. 60).

[4] NHS, *Smokefree* <https://www.nhs.uk/smokefree/help-and-advice> accessed 8 November 2017.

[5] Carbon monoxide tests have been used on non-pregnant smokers in Hertfordshire but this has so far been limited to individuals who say they are smokers and are required to quit before being permitted surgery on the NHS. While this is also problematic, it is not the same as testing all patients regardless of whether they say they smoke or not. See Haroon Siddique, 'Doctors to breathalyse smokers before allowing them NHS surgery' *The Guardian* (Wednesday 18 October 2017).

[6] Denis Campbell, 'Test all pregnant women for smoking, say NHS chiefs' *The Guardian* (Sunday 26 February 2017)

[7] Other measures include, the promotion of smoke free homes during pregnancy and beyond. Such measures could potentially avoid some of the problems associated with the policy of singling out pregnant women for routine carbon monoxide screening. Heather Morgan and others, 'An interview study of pregnant women who were provided with indoor air quality measurements of second hand smoke to help them quit smoking' (2016) 16(1) BMC Pregnancy Childbirth 305.

delivered by midwives, the task of performing the carbon monoxide tests falls to them, although some auxiliary staff have been involved where resources allow.[8] The implementation of this policy is therefore significant for the relationship between pregnant women and midwives. The policy was trialled in the North East of England in the Babyclear programme[9] and following the 2010 NICE Guidelines, 'Smoking: stopping in pregnancy and after childbirth' (the NICE Guidelines)[10] has been adopted by a number of NHS Trusts across England, Scotland and Wales.[11]. The test involves the midwife holding a doll connected to a model placenta, informing the pregnant woman that when you have a cigarette "…it is as if someone gets hold of your baby's cord and squeezes it really really hard and you can see that if that was held really tightly and squeezed really tightly, that stops the oxygen getting to your baby."[12] The woman is told that this will mean it will be a smaller, weaker baby, likely to need special care and she is likely to need a caesarean section.[13] The midwife then states that if it is alright with the woman she would like to do the test.[14] It is possible for a pregnant woman to refuse the test, but the fact that it is to be

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[8] Agnes McGowan and others, ''Breathe': The stop smoking service for pregnant women in Glasgow' (2010) 26(3) Midwifery e1–e13.

[9] Fresh NE, 'Major initiative to protect unborn babies from smoking in the North East' (2017) <http://www.freshne.com/in-the-news/pr/item/1974-major-initiative-to-protect-unborn-babies-from-smoking-in-the-north-east> accessed 8 November 2017.

[10] NICE 'Smoking' (n 2).

[11] There is currently no evidence regarding the extent to which NICE Guidelines on smoking cessation during pregnancy have been implemented nationally but the policy has been adopted by a number of NHS Trusts including South Tees NHS Foundation Trust (South Tees Hospitals NHS Foundation Trust, 'Major initiative to tackle smoking in pregnancy underway' (2013) <https://www.southtees.nhs.uk/news/health-improvement/major-initiative-tackle-smoking-pregnancy-underway/> accessed 15 November 2018); South Warwickshire NHS Foundation Trust (South Warwickshire NHS Foundation Trust, 'NHS Warwickshire Stop Smoking in Pregnancy Service' <https://www.swft.nhs.uk/our-services/adult-hospital-services/maternity/nhs-warwickshire-stop-smoking-pregnancy-service> accessed 15 November 2018); NHS Scotland (NHS Health Scotland, 'Ready Steady Baby! Tests and checks you may have' <http://www.ready steadybaby.org.uk/you-and-your-pregnancy/antenatal-care/tests-and-checks-you-may-have.aspx> accessed 15 November 2018) and NHS Wales (Public Health Wales NHS Trust, 'Models for access to maternal smoking cessation support' (2015) <http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20MAMSS%20Report%20E%2003.17.pdf> accessed 15 November 2018) among others.

[12] FreshSFNE, 'Smoking in pregnancy' (2017) <https://www.youtube.com/watch%3fv%3d0Icc3NwP-gU%26list%3dUU2lnzX6fEhIckkzI1amNs2Q%26index%3d9> accessed 8 November 2017

[13] ibid.

[14] ibid.

offered routinely at all antenatal appointments and given the emotive language used; presenting it as a test to see if someone is taking hold of the umbilical cord and squeezing it tightly, it seems inevitable that pregnant women will feel pressurised to take it. The pregnant woman then gives a breath sample connected to a computer screen displaying a picture of a fetus which changes from green to amber, to flashing red with an alarm sounding depending on the level of carbon monoxide in the woman's breath. If a high level of carbon monoxide is detected the woman is informed that her baby "…is in danger" and is struggling.[15]

This goes beyond the support to quit offered to non-pregnant smokers, with a lack of trust inherent in testing all pregnant women for carbon monoxide levels regardless of whether they say they smoke or not. It could be argued that the test detects the presence of carbon monoxide rather than whether the woman smokes, as some level of carbon monoxide could be present from other sources. However, the purpose of the test is to discover if a pregnant woman smokes or not, as stated in the NICE Guidelines.[16] If a carbon monoxide test is needed to determine whether a pregnant woman smokes rather than relying on whether she says she does, this indicates that a pregnant woman cannot be trusted to answer this question truthfully. It could be argued that targeting pregnant smokers is justified on the basis of preventing harm to the pregnant women themselves, utilising the window of opportunity that the close contact with health services provides.[17] However, this would only justify such measures if a similar approach was taken to other windows of opportunity, including the partners of pregnant women, parents of existing children and patients receiving treatment for other conditions. While these individuals may be offered smoking

[15] ibid.
[16] NICE 'Smoking' (n 2).
[17] Camilla Bille, and Anne-Marie Nybo Andersen, 'Preconception care' (2009) BMJ 338; Michele Bloch, and Mark Parascandola, 'Tobacco use in pregnancy: A window of opportunity for prevention' (2014) 2(9) Lancet Glob Health 489.

cessation services, they are not being routinely tested to determine if they smoke or not. Further, if this were the justification for targeting pregnant smokers the emotional presentation connected to the future child's wellbeing would not be justified. It is clear that pregnant women are being treated differently because of the potential health risks to their future children. Therefore, the question is, is singling pregnant women out for such pressurised interventions justified in order to prevent harm to future children[18]?

This paper suggests that for this to be the case four things would need to be established:

1. that smoking during pregnancy causes significant prenatal harm to future children;
2. that carbon monoxide testing reduces rates of smoking during pregnancy;
3. that such interventions do not cause more harm to future children than they prevent; *and*
4. that there is no alternative, less problematic way to reduce prenatal harm.

It argues that these things cannot be established and therefore carbon monoxide testing in pregnancy cannot be justified on the grounds of preventing harm to future children.

6.3 Does smoking during pregnancy cause significant prenatal harm to future children?

This condition must be satisfied if the potential harm to future children is to justify the uniquely pressurised approach to smoking cessation during pregnancy. After all, if smoking during pregnancy is no more harmful than at other times, there would be no reason to single

[18] As the policy under consideration is a public health measure, this paper assesses harm on the basis of rates of children born classified as being of low birthweight, stillborn or born preterm.

out pregnant women for these measures.

Although there is a significant amount of evidence linking smoking during pregnancy to low birthweight, stillbirth and premature delivery, this is not the only factor linked to such harms[19] and the issue of causation beyond correlation remains unclear.[20] Significantly, the majority of studies linking smoking during pregnancy to these harms have not looked in depth at the role of social factors such as education and poverty. The evidence suggests that such harms could be reduced in a number of ways including reducing inequality,[21] improving nutrition,[22] increasing education,[23] encouraging men not to smoke,[24] or encouraging pregnant women not to smoke.[25] Therefore, the choice to view these harms as primarily a problem of individual behaviour during pregnancy requires justification.

The assertions about the health risks of smoking during pregnancy contained in the NICE

[19] Judith Lumley and others, 'Interventions for promoting smoking cessation during pregnancy' (2009) 8(3) Cochrane Database of Syst Rev: CD001055; Kate E. Pickett and Richard G. Wilkinson, 'Income inequality and health: A causal review' (2015) 128 Soc Sci Med 316.

[20] This weakness in supporting evidence can similarly be seen for the causal link between alcohol consumption during pregnancy and Fetal Alcohol Syndrome. One study found that "women who consumed at least three alcoholic drinks a day but ate balanced diets experienced a rate of Fetal Alcohol Syndrome (FAS) of only 4.5 percent, while women who drank the same amount and were malnourished had an FAS rate of 71 percent (Nesrin Bingol and others, 'The influence of socioeconomic factors on the occurrence of fetal alcohol syndrome' (1987) 6(4) Adv Alcohol Subst Abuse 105). It was also found that the rate of FAS in children born to chronic alcoholic mothers in lower socioeconomic classes (defined as labourers and unskilled workers) was 70.9% compared to 4.5% in those born to mothers in higher socioeconomic classes such as clerical and sales workers (Bingol) See also Ernest L. Abel, 'An update on incidence of FAS: FAS is not an equal opportunity birth defect' (1995) 17(4)
Neurotoxicol Teratol 437.

[21] Pickett and Wilkinson (n 19).

[22] Kathleen Abu-Saad and Drora Fraser, 'Maternal nutrition and birth outcomes' (2010) 32(1) Epidemiol Rev 5.

[23] Emma Tominey, 'Maternal smoking during pregnancy and early child outcomes' (2007) CEP Discussion Paper No 828: Centre for Economic Performance, London School of Economics.

[24] Peter S. Blair and others, 'Smoking and the sudden infant death syndrome: Results from 1993–5 case-control study for confidential inquiry into stillbirths and deaths in infancy. Confidential enquiry into stillbirths and deaths regional coordinators and researchers' (1996) 313(7051) BMJ 195; Jonathan Day and others, 'Influence of paternal preconception exposures on their offspring: Through epigenetics to phenotype' (2016) 5(1) Am J Stem Cells 11; David A Savitz, and others, 'Influence of paternal age, smoking, and alcohol consumption on congenital anomalies' (1991) 44(4) Teratology 429.

[25] Catherine Chamberlain and others, 'Psychosocial interventions for supporting women to stop smoking in pregnancy' (2017) 2(2) Cochrane Database Syst Rev CD001055.

Guidelines are based on a 1992 report of the Royal College of Physicians[26] and a claim in The Department of Health's 'Review of the health inequalities infant mortality PSA target' (the DOH Review),[27] that smoking during pregnancy increases the risk of infant mortality by an estimated 40%.[28] The DOH Review states that babies born to women who smoke are more likely to be born prematurely, are twice as likely to have a low birthweight and are up to 3 times more likely to die from sudden infant death syndrome (SIDS).[29] This is based on research which states that the causal mechanisms by which smoking and other risk factors influence the likelihood of preterm birth remain unknown and highlights the fact that many factors are associated with an increased risk of preterm birth.[30] Further, it states that infections are implicated in at least 40% of preterm births and as much as 70% for births prior to 32 weeks gestation.[31] The claim in the DOH Review that the likelihood of infant mortality is increased by about 40% is a finding of correlation as a result of a statistical analysis.[32] Similarly, the 1992 report of the Royal College of Physicians establishes a correlation between smoking during pregnancy and outcomes such as low birthweight but not a direct causal link.[33] One Swedish study has attempted to isolate the effects of smoking during pregnancy from other maternal characteristics by comparing the birthweights of siblings born to mothers who smoked in one pregnancy but not another.[34] This study found that maternal smoking during pregnancy did reduce birthweight but not by as much as was predicted by conventional analysis. Further, as its authors acknowledge this study still does

[26] Margaret Turner-Warwick, 'Smoking and the young: A report of a working party of the Royal College of Physicians' (1992) 1(3) Tob Control 231.
[27] Department of Health, *Review of the Health Inequalities Infant Mortality PSA Target* (London 2007).
[28] NICE 'Smoking' (n 2).
[29] DOH Review (n 27).
[30] Nancy Green and others, 'Research agenda for preterm birth: Recommendations from the March of Dimes' (2005) 193(3) Am J Obstet Gynecol 626.
[31] ibid.
[32] Hamisu M. Salihu and others, 'Levels of excess infant deaths attributable to maternal smoking during pregnancy in the United States' (2003) 7(4) Matern Child Health J 219.
[33] Turner-Warwick (n 26).
[34] Sol Pía Juárez and Juan Merlo, 'Revisiting the effect of maternal smoking during pregnancy on offspring birthweight: A quasi-experimental sibling analysis in Sweden' (2013) 8(4) PLoS ONE e61734.

not establish a causal link as other factors linked to the change in the mother's smoking behaviour such as stress, relationship breakdown and nutrition have not been accounted for.[35]

Another study which sought to look beyond correlation is that conducted by Emma Tominey in 2007 which analysed data on the lives of 6500 children and their mothers, considering in detail the lifestyles of the mothers.[36] By controlling for variables including grandparent smoking habits during adolescence, maternal birthweight and paternal smoking habits, it was able to establish that the harm often attributed to smoking during pregnancy varies according to the education of the mother, and unobservable traits of the mother such as nutrition and knowledge of healthy behaviour. The study concluded that:

> …around one-third of the harm from smoking is explained by unobservable traits of the mother. Smoking tends to reduce birthweight by 1.7% but has no significant effect on the probability of having a low birthweight child, pre-term gestation or weeks of gestation.[37]

A further claim is made in the NICE Guidelines that "exposure to smoke in the womb is associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour."[38] However, the link between prenatal smoking and childhood behavioural problems has been questioned in a study which

[35] ibid.
[36] Tominey (n 23).
[37] ibid.
[38] NICE Smoking (n 2). Based on Tanya Maria May Button, Barabara Maughan, and Peter McGuffin, 'The relationship of maternal smoking to psychological problems in the offspring' (2007) 83(11) Early Hum Dev 727.

concluded that once compounding factors such as maternal antisocial behaviour were taken into account, prenatal smoking was no longer associated with antisocial behaviour in children.[39]

Establishing a causal link beyond correlation between smoking during pregnancy and harms such as low birthweight is problematic given the difficulties in isolating smoking from other potentially causal factors. However, a strong indication of a causal link would be if reducing smoking rates during pregnancy led to reduced rates of prenatal harm.

6.3.1 Does reducing smoking rates during pregnancy reduce prenatal harm?

Although most reviews of the effectiveness of smoking cessation interventions in pregnancy focus on their ability to reduce smoking rates rather than their ability to reduce harm to future children, there is evidence that smoking cessation interventions can reduce low birthweight and preterm birth.[40] However, the link between reducing smoking rates and prenatal harm is not a straightforward one.

This is illustrated by a study which considered the impact of declining rates of maternal smoking during pregnancy on the number of low birthweight babies in Massachusetts from 1989 to 2004.[41] During this period there was a significant yearly decline of at least 6% in maternal smoking prevalence during pregnancy. However, over the same period a significant *increase* of up to 1% in the prevalence of low birthweight babies occurred. The

[39] Brian B Boutwell and Kevin Beaver, 'Maternal cigarette smoking during pregnancy and offspring externalizing behavioral problems: A propensity score matching analysis' (2010) 7(1) Int J Environ Res Public Health 146.

[40] Felicity Allen and others, 'The effectiveness of interventions targeting major potentially modifiable risk factors for infant mortality: A user's guide to the systematic review evidence' (National Perinatal Epidemiology Unit: University of Oxford, 2009).

[41] Zubair Kabir and others, 'Declining maternal smoking prevalence did not change low birthweight prevalence in Massachusetts from 1989 to 2004' (2009) 19(1) Eur J Public Health 65.

report concluded that factors other than maternal smoking had reversed the potential gains attributable to reductions in maternal smoking. However, it seems equally possible that the link between smoking and low birthweight is one of correlation rather than causation and other factors such as poverty and low education which are aligned with smoking rates could be more significant causes of low birthweight. Similarly, it could be that at least some of the positive effects of smoking cessation interventions could be explained by side effects of the specific delivery of the interventions, such as increased contact with healthcare professionals or other simultaneous interventions regarding nutrition and lifestyle.

Particularly significant is the conclusion of Emma Tominey's study that only up to 13% of the babies classified as low birthweight, born to mothers who smoked during pregnancy could have been classified as being of healthy weight had their mothers not smoked.[42] Such a low prevention rate seems insufficient to justify presenting such prenatal harm as solely a problem of the individual behaviour of pregnant women. After all, in 87% of cases the prenatal harm associated with maternal smoking (low birthweight), would have occurred even if the mother did not smoke during pregnancy. Further, the impact of smoking is much greater for mothers of low education, even controlling for the quantity of cigarettes they smoke, clearly indicating that factors other than the woman's smoking are at play.[43] Therefore, while reducing smoking rates during pregnancy might lead to some reduction in prenatal harm, it is not clear that a more significant reduction could not be achieved by focussing on a different factor.

Assuming that condition 1 is fulfilled and reducing smoking rates during pregnancy has some beneficial impact on the rates of prenatal harm, for the policy of routine carbon monoxide

[42] Tominey (n 23).
[43] ibid.

testing in pregnancy to be justified, it must still be established that this specific smoking cessation measure is likely to be effective.

6.4 Does routine carbon monoxide testing reduce rates of smoking during pregnancy?

The NICE Guidelines, recommend that a carbon monoxide test be used to identify pregnant women who smoke as “some women find it difficult to say that they smoke because the pressure not to smoke during pregnancy is so intense.”[44] Targeting the behaviour of pregnant women with carbon monoxide testing is unlikely to alleviate this pressure, particularly as pregnant smokers might find it difficult to admit they smoke because they fear they will be judged and emotionally blamed for something they feel they have little control over. If pregnant women are treated with distrust by their midwives and emotional, coercive language is used, they are unlikely to be encouraged to engage with smoking cessation services and prenatal care more generally. An alternative would be to make pregnant women feel respected and trusted and support them in what they feel is best for them and their future children. Indeed, the NICE Guidelines state that because some pregnant women find it difficult to say that they smoke it is important to communicate in a sensitive, client centred manner.[45] It is difficult to see how the lack of trust displayed by the policy to routinely test pregnant women for carbon monoxide fulfils this requirement. Further, it is equally plausible that a non-pregnant smoker might not admit to smoking in order to avoid feelings of judgment and pressure to quit, yet it is only pregnant women who are to be routinely screened for carbon monoxide levels. This policy sends out a message

[44] NICE ‘Smoking’ (n 2).
[45] ibid.

to pregnant women that they cannot be trusted either to truthfully answer questions about whether or not they smoke, or to make the right decisions in the interests of themselves and their future children in the way non-pregnant individuals can. Not only does this raise ethical concerns because it involves unequal respect for the autonomy of pregnant women compared to individuals who are not pregnant, but it is also likely to have a negative impact on the health outcomes for pregnant women and their future children as research suggests that respecting the autonomy of pregnant women is linked to better outcomes for mother and babies.[46]

One problem with evaluating the effectiveness of routine carbon monoxide testing is that instead of asking whether the policy reduces rates of prenatal harm, the policy is frequently assessed on the percentage of pregnant smokers that it identifies. This not only fails to take account of the possibility that smokers identified in this way might be less likely to engage with smoking cessation measures and go on to quit, but it also ignores the possibility that such policies might lead to increased prenatal harm in other ways. For example, one study trialled the use of routine carbon monoxide testing as part of a smoking cessation programme targeting pregnant women across three maternity units serving Glasgow in Scotland.[47] While it suggested that utilising carbon monoxide testing alongside self-reporting could increase identification of pregnant smokers from 80 to 94%, it found that booking midwives found it difficult to approach all pregnant women to talk about smoking and this was not made easier by the requirement that all pregnant women should be tested

[46] Adhikari, R. and Sawangdee, Y., 'Influence of women's autonomy on infant mortality in Nepal' (2011) 8 Reprod 1; Arpana Sharma and Manzur Kader, 'Effect of women's decision-making autonomy on infant's birth weight in rural Bangladesh' (2013) ISRN Pediat 159542.
[47] McGowan (n 8).

for carbon monoxide at the initial booking appointment.[48]. This indicates that a policy of routine carbon monoxide testing might actually hinder midwives from raising smoking cessation with pregnant women and even decrease rates of pregnant women who successfully quit smoking. The CATCH programme also operated in Glasgow, employing a similar approach to smoking cessation using motivational interviews to engage pregnant smokers during telephone contact and withdrawal orientated therapy including nicotine replacement therapy.[49] However, it differed from the 'breathe' programme in that it delivered care in a home setting rather than a clinic; it operated a holistic approach, helping women to solve more pressing problems such as housing, before smoking; the referral model was opt-in rather than opt-out; and smokers were not initially identified by routine carbon monoxide testing. While no data was collected as to whether CATCH identified fewer smokers than 'breathe', the data suggests that CATCH achieved a better quit rate than 'breathe'.

While pregnant smokers need to be identified to be supported to quit, the goal of reducing prenatal harm to future children should not be reduced to identifying pregnant smokers. No information was collected as part of this study on the rates of low birth weight or premature delivery as a result of these interventions. Further, it does not support the claim that routine carbon monoxide testing itself leads to better rates of smoking cessation. It is possible, if not probable, that those smokers who would only be identified as smokers by carbon monoxide testing rather than self-reporting, would be less likely to be motivated to quit and

[48] This study also found that in one hospital where auxiliary nurses were responsible for performing the test, 89% of women provided a breath sample at the initial booking appointment, whereas in a hospital where midwives were responsible for carbon monoxide testing, only 35% of women provided a sample. This indicates that the policy is unlikely to achieve its potential of identifying 94% of pregnant smokers when the test is the responsibility of midwives, perhaps due to time constraints or other priorities for midwives delivering antenatal care. McGowan (n 8).

[49] Anne Bryce and others, 'CATCH: Development of a home-based midwifery intervention to support young pregnant smokers to quit' (2009) 25(5) Midwifery 473.

engage with smoking cessation measures. Treating them with distrust is unlikely to change this. Therefore, while the evidence indicates that carbon monoxide testing could increase the number of pregnant smokers identified, it does not allow the conclusion to be made that a policy of routine carbon monoxide testing of pregnant women would reduce rates of smoking during pregnancy and so condition 2 is not satisfied.

However, even if conditions 1 and 2 were met, the policy of singling out pregnant women for routine carbon monoxide testing would only be justified on the basis that it reduces prenatal harm to future children, if it could be shown that such measures do not cause more harm to future children than they prevent.

6.5 Do such interventions cause more harm to future children than they prevent?

It could be argued that even if smoking during pregnancy is not as harmful as other factors such as poverty, a lack of education, genetic factors, poor nutrition, or a lack of good quality prenatal care, smoking during pregnancy is harmful to some extent and therefore it is still a good thing to reduce smoking rates among pregnant women.

It is likely that it would be of some benefit to future children and to others, including the women themselves, if women did not smoke during pregnancy.[50] It is also possible that some pregnant smokers may quit smoking having been identified as smokers through carbon monoxide testing and therefore, a policy of routine testing might prevent some prenatal harm. The problem with justifying the policy on the basis that it could prevent some prenatal harm is

[50] While there may be potential consequential harms to pregnant women in employing policies such as routine carbon monoxide screening, the question being considered is whether such policies are justified on the basis that they reduce prenatal harm to future children. Therefore, this section will focus on the potential harms to the future children they seek to protect.

that it assumes that targeting the behaviour of pregnant women in this way is not in itself, harmful to future children.

There are three ways in which the policy to routinely test pregnant women for carbon monoxide has the potential to cause harm to future children. Firstly, by focussing on the behaviour of pregnant women other more significant causes of prenatal harm such as poverty and poor prenatal care are obscured and overlooked.[51] This can occur on both a public health level and an individual level. On a public health level, if responsibility for these harms lies with the pregnant women themselves then the calls for the state to address social factors such as poverty and education are weakened, resulting in a missed opportunity to improve the welfare of future children to a much greater extent. On an individual level, policies which require health professionals to focus on certain factors such as smoking cessation to the extent of testing every pregnant woman for carbon monoxide at every antenatal appointment has the potential to interfere with the professional's own assessment of the individual patient's health needs, requiring them to use the limited contact time they have with patients pursuing public health priorities rather than the health priorities of the individuals. As studies into the ethical issues raised by health visitors delivering public health measures have shown, this can lead to health professionals feeling that they are wasting time, inadequately addressing more pressing needs of the individual and eroding their ability to form relationships of trust with their patients.[52] Similarly, as Kukla has argued, healthcare policies which focus on maternal behaviour at signal moments surrounding pregnancy and birth fail to take account of the extended narrative of motherhood (and indeed parenthood) and so miss the opportunity to genuinely improve the

[51] Emily Jackson, *Regulating reproduction: Law, technology and autonomy* (Bloomsbury Publishing 2001).
[52] Julie Catherine Greenway, Vicky Ann Entwistle, and Ruud terMeulen, 'Ethical tensions associated with the promotion of public health policy in health visiting: a qualitative investigation of health visitors' views' (2013) 14(2) Prim Health Care Res Dev 200.

welfare of future children by supporting their parents to be "good parents" in the long term. This reductive view of motherhood focuses on individual responsibility rather than fostering the conditions which enable individuals to make good choices in the longer narrative of motherhood.[53] The welfare of future children depends on a wide range of factors and focusing narrowly on individual behaviour such as smoking during pregnancy oversimplifies the issue and prevents what are likely to be more significant factors from being addressed by obscuring their importance and restricting healthcare professionals' ability to deliver individualised patient centred care.

Secondly, the feeling of judgment and blame connected with such individualisation, could act as a deterrent to engaging with prenatal care. This is supported by recent studies in the context of support for self-management of long-term health conditions which have found that focusing on behavioural deficits and emphasising biomedical and clinical epidemiological research reinforces the position of health-care professionals as experts and this hierarchical view of the patient-professional relationship prevents patients from acting as effective partners in their own care.[54] Thus, presenting the problem of prenatal harm as one of pregnant women choosing not to conform to what medical science tells them is best for their babies, is likely to disempower pregnant women from taking an active role in their care. Further, as has been noted in connection with personal responsibility in other forms of healthcare there is likely to be a significant reduction in trust between health professionals and patients if judgment and blame is perceived.[55] This seems a particular risk in routine screening for carbon monoxide for all mothers regardless of whether they say they smoke

[53] Rebecca Kukla, 'Measuring mothering' (2008) 1(1) Int J Fem Approaches to Bioethics 67.
[54] Vikki Entwistle, Alan Cribb, and John Owens, 'Why health and social care support for people with long-term conditions should be oriented towards enabling them to live well' (2018) 26(1) Health Care Anal 48.
[55] Phoebe Friesen, 'Personal responsibility within health policy: Unethical and ineffective' (2016) 44(1) Journal Med Ethics 53.

and would like help to stop or not. This impact on the relationship between pregnant women and healthcare professionals means that not only are the most significant causes of prenatal harm obscured by the individualisation of the problem, but they are actually exacerbated by it. The most vulnerable women who would benefit most from good quality prenatal care may disengage with that care due to fear of judgment and blame and their future children are therefore more likely to suffer prenatal harm.

One study looking at the experiences of midwives administering the carbon monoxide test found that, despite initial concerns, midwives have not found carbon monoxide testing to be problematic.[56] The midwives interviewed reported that although they had initially been concerned about the lack of research and evidence base for using carbon monoxide testing as well as concerns about the potential for such testing to negatively impact on their relationships with their patients if the test was used as a 'lie detector', the test had quickly become an accepted part of routine care. While these findings are initially encouraging, as its authors recognise, this study is limited in a number of ways. Firstly, at the time of the study it was difficult to find midwives who were routinely using the test at the initial booking appointment, as currently advised. This prevents it being an accurate assessment of the impact of the policy to routinely test all women at all antenatal appointments. Secondly, most of the participants were recruited from an area with a low-smoking prevalence. It seems likely that the test would be most problematic in areas of high smoking prevalence as it is smokers who will potentially feel judged and blamed for their behaviour rather than non-smokers. Finally, the study only considered whether the midwives had found the use of carbon monoxide screening problematic and did not speak to the pregnant women regarding

[56] Maeve O'Connell and Maria Duaso, 'Barriers and facilitators of midwives' use of the carbon monoxide breath test for smoking cessation in practice: a qualitative study' (2014) 24(4) Midirs Midwifery Digest 453.

their experiences. Even if midwives did not feel the test significantly altered their interactions with pregnant women, the pregnant women might have experienced the test differently.

Thirdly, it is likely that outcomes for future children are improved when the autonomy of their mothers is respected during pregnancy.[57] In this context, respecting autonomy requires that women are encouraged to pay an active role in their own care and that they are trusted to be the ultimate decision makers, with health professionals supporting their decisions. In other aspects of healthcare this patient engagement has been shown to produce better outcomes for individual patients.[58] Due to the interconnected nature of the interests of a woman and her future child, something that is in the interests of pregnant women will most likely be in the interests of future children. If, as the evidence suggests, outcomes for patients are improved when they take an active role in their own care and are empowered to do so by healthcare professionals, it seems logical that outcomes for future children will improve when the individuals most connected to and invested in their wellbeing are empowered in this way. This is supported by studies in Bangladesh and Nepal which indicate that children born to mothers who have more power to make decisions in their everyday lives and regarding their medical care, have better outcomes than those born to women whose autonomy is less respected.[59] This is to be expected once the pregnant woman is recognised as a protector rather than a threat to the future child.

Pressurising pregnant women to stop smoking using routine carbon monoxide testing and

[57] Adhikari and Sawangdee (n 46); Sharma and Kader (n 46).
[58] Angela Coulter and Jo Ellins, 'Effectiveness of strategies for informing, educating, and involving patients' (2007) 335(7609) BMJ 24.
[59] Adhikari and Sawangdee (n 46); Sharma and Kader (n 46).

emotional coercion as opposed to presenting information and offering support if desired, assumes that pregnant women are either unable or unwilling to make the best choices for themselves and their future children in the way that other individuals are. There is no evidence that this is the case and policies based on this assumption in turn, contribute to the undermining of the autonomy of pregnant women. As argued by Entwistle et al in relation to support for self-management of long term health conditions, negative judgmental attitudes towards patients, including using tests to suggest that the patients' claims about their behaviour are false, can cause patients to feel anxious, hopeless and disrespected which can be understood as undermining their autonomy.[60] Even when looking narrowly at the issue of smoking, research has shown that the more confident and capable a woman considered herself to be at the transition to motherhood, the less likely she is to relapse into smoking.[61] Therefore, there is a very real possibility that routine carbon monoxide testing could cause pregnant smokers to feel undermined and so decrease the chances of them quitting in the long term.

The narrow focus on reducing harms to future children such as low birthweight and pre-term delivery has meant that harms to autonomy and the general wellbeing of pregnant woman and future child have not been taken into account. It is not part of the purpose of policies such as routine carbon monoxide testing to enhance or protect the autonomy of pregnant women and thus this potential negative impact on the welfare of future children is not part of the cost-benefit analysis undertaken. Therefore, such policies are potentially harmful to future children as well as to the women who bear them.

It could be argued that placing extra pressure to quit smoking on pregnant women is justified

[60] Entwistle (n 54).

[61] Cathy Ashwin, Jayne Marshall, and Penny Standen, 'Exploring women's experiences of smoking during pregnancy and the postpartum' (2012) 10(4) EBM 112.

because it is a case of one individual (the pregnant woman) harming another individual (the future child) rather than an individual harming *themselves* by smoking, or that there is something specific about it being a future child that is harmed and the pregnant woman's relationship to it, that makes smoking while pregnant more problematic than smoking at other times. While it seems likely that a pregnant woman who chooses to bring a child to birth has a moral duty to take the interests of the future child into account it is difficult to see why this should be any greater than the duty owed by a parent of an existing child.[62] Given the risks of passive smoking, if it is not necessary to screen parents of existing children for carbon monoxide, it is difficult to see why this would justify targeting pregnant women in this way. In any event, if the policy was to be justified on the grounds that it prevented an especially significant type of harm, i.e. harm to a future child by its mother during pregnancy, it would still be necessary to show that the policy did indeed prevent such harm.

Arguments could also be made against such policies on the basis that they are harmful to pregnant women. However, such arguments are problematic as they involve balancing harms and benefits to one individual (the future child) with those caused to another individual (the pregnant woman). It could be argued that preventing harm to one at the cost of another is justified either because one is more deserving of protection or because of some sense of culpability on the part of the other. In this case the argument would be that it is acceptable for pregnant women to be harmed by measures taken to protect future children because pregnant women are not as vulnerable as future children, and they are the ones creating the risk. However, there are several problems with this argument. First, policies such as carbon monoxide testing all pregnant women at every antenatal appointment have the potential to harm pregnant smokers and non-smokers and even women in general. The message of

[62] Brazier (n 1).

distrust is communicated to all women. Second, if such policies are to be based on the culpability of pregnant smokers, the argument to support this has not been made. There are clear issues surrounding the degree of choice exercised by women who do not give up smoking during pregnancy due to the addictive nature of smoking and it is not clear why a pregnant smoker should be considered more culpable for any resulting harm than a parent of an existing child or any other smoker. Finally, there is an inherent problem with balancing potential harms to pregnant women with those to future children because they are not two separate individuals; their welfare is uniquely interconnected because of their physical and emotional connection. Harming pregnant women will also harm future children. This illustrates the problematic nature of the traditional maternal-fetal conflict model which presents the interests of the pregnant woman as conflicting with those of the future child and therefore, the pregnant woman as a threat to her future child rather than the person who is most invested in its welfare. In any event, any argument supporting smoking cessation measures in pregnancy to address prenatal harm to future children requires evidence that such measures will reduce harm to future children before this can be considered alongside any potential harms to pregnant women.

It is clear that even if smoking during pregnancy causes significant prenatal harm and routine carbon monoxide testing has some positive effect on smoking rates during pregnancy fulfilling conditions 1 and 2, it is extremely unlikely that condition 3 will be met. Not only are there other causal factors which could be addressed to greater effect, but pressurising pregnant women to quit smoking in this way is harmful in itself. The policy is likely to obscure more significant causes of prenatal harm, have a negative effect on engagement with antenatal care and reduce rather than strengthen women’s autonomy and their role in their own care.

6.6 Is there an alternative, less problematic way to reduce prenatal harm?

An alternative strategy for improving outcomes for future children is to move away from presenting the needs of a developing fetus as being in conflict with those of the pregnant woman. Once we accept that in the vast majority of cases a pregnant woman wants to do what is best for her future child and will do whatever she can to protect that future child, it becomes clear that far from smoking during pregnancy warranting a more pressurised approach, if anything, given her additional motivation, less pressure is required and we should look instead to providing the woman with support.

It seems likely from the evidence discussed above that there would be some improvement in the outcomes for future children and their mothers if fewer women smoked during pregnancy. Similarly, there are lifestyle changes the wider population could take to improve their health. However, the assumption underlying pressurised interventions such as routine carbon monoxide testing is that pregnant women are not making these changes because they require additional motivation to do so. The policy ignores the very premise it is based on. The NICE Guidelines state that women feel intense pressure to quit smoking during pregnancy and this is preventing them from engaging with measures aimed at improving their health and the health of their future children.[63] This indicates that the way to help women make healthy lifestyle choices during pregnancy is to alleviate this pressure. This would make them more likely to feel able to be open and honest with healthcare professionals and engage in a more supportive method of ensuring the best outcomes for their future children.

[63] NICE 'Smoking' (n 2).

This is supported by evidence from a prenatal care programme founded by Jennie Joseph in America known as the JJ Way.[64] This programme aims to achieve positive pregnancy outcomes for all with particular efforts to reach low-income and marginalised people who are at risk of a poor birth outcome due to the social determinants of health and institutional and structural discrimination inherent in the health care system. The key to this approach to prenatal care is the empowerment of pregnant women:

> Empowerment results from having access to high quality, cost efficient services, and a connection with supportive culturally-responsive services and natural supports which lead to an increase in knowledge, agency and self-determination.[65]

This programme emphasises the importance of access to and engagement with, quality prenatal care. It seeks to move away from the paternalism evident in traditional maternity care where the pregnant woman is encouraged to trust the medical experts. The JJ Way encourages the pregnant woman to play an active role in her care, providing her with knowledge and support through peer educators and fluid group classes. Instead of viewing the pregnant woman and her future child as separate individuals whose interests may or may not align, the pregnant woman and her future child are viewed as a unit, with the understanding that the pregnant woman is the decision maker and has the full support of her care team.[66]

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[64] Lauren Josephs and Stephan Brown, *The JJ Way: Community-based Maternity Center Final Evaluation Report* (Visionary Vanguard Group Inc, 2017).
[65] ibid.
[66] JJ Way, <http://www.commonsensechildbirth.org/jjway/> accessed 27 April 2018.

As a result of this approach, the rate of preterm births in Orange County fell from 10% in 2015 to 4.3% in 2016 and the rate of low birthweight was reduced from 8.9% in 2015 to 5% in 2016/2017. By delivering prenatal care in this way the racial disparities in preterm birth outcomes were eliminated and there were significant reductions in low birthweight babies in at-risk populations.[67]

In choosing how best to reduce prenatal harm the options presented here are (1) to target pregnant smokers with pressurised smoking cessation interventions and (2) to employ a supportive and empowering approach to prenatal care. The evidence suggests that even assuming that smoking cessation interventions stopped every pregnant woman smoking, the rates of prenatal harm would be reduced by 13%.[68] However, a supportive and empowering approach to prenatal care appears to reduce such harm by around 50% based on the evaluation of the JJ Way. This is even before we take into account the potential harms of pressurising pregnant women to stop smoking discussed above.[69] Therefore, if we are interested in harm reduction, this is a much more effective option.

Even though a greater reduction in prenatal harm could be achieved by addressing factors other than the behaviour of pregnant women, it could be argued that addressing factors such as social inequality and education are far more difficult and costlier than getting individuals to stop smoking. After all, smoking cessation measures are already part of our health service. However, this argument would not justify policies such as carbon monoxide screening as opposed to offering supportive, empowering prenatal care as prenatal care is already part of our health service. Placing a greater emphasis in that prenatal care on empowering pregnant women and supporting them to make decisions rather than policing

[67] Josephs and Brown (n 64).
[68] Tominey (n 23).
[69] Pers-Anders Tengland has argued that there are moral reasons for preferring the empowerment approach to health promotion rather than the behaviour change approach; Pers-Anders Tengland, 'Behavior change or empowerment: On the ethics of health-promotion goals' (2016) 24(1) Health Care Anal 24.

their behaviour in a distrustful manner, would not be a particularly difficult or costly change. Indeed, it is in line with how many midwives already see their role.[70]

It is not possible to employ both of these approaches simultaneously as the pressurised smoking cessation interventions would not fit within a supportive and empowering approach to prenatal care. However, employing a supportive and empowering approach to prenatal care has the added advantage of achieving the stated aim of carbon monoxide screening policy. If pregnant women are unlikely to admit that they smoke because of the extreme pressure they feel to stop smoking, it would be reasonable to expect that a supportive, non-judgmental approach to prenatal care would alleviate that pressure and thus remove the need for carbon monoxide screening. Therefore, it is clear that targeting the behaviour of pregnant women with pressurised smoking cessation interventions is not justified on the grounds of harm reduction, as more effective measures which are no more difficult to put into practice are available. Even if conditions 1, 2 and 3 had been met, the fact that an alternative, less problematic approach is available, would be sufficient to prevent the policy of routine carbon monoxide testing in pregnancy being justified on the ground of preventing prenatal harm to future children.

6.7 Conclusion

Does the evidence suggest that public health measures such as carbon monoxide testing in pregnancy are likely to achieve their aim of preventing harm to future children?

Despite the fact that smoking when not pregnant is harmful to the smokers and those around

[70] The Royal College of Midwives, *High Quality Midwifery Care* (London 2014).

them, pregnant women are being singled out for a particular level of pressure to quit including being routinely tested for carbon monoxide at every antenatal appointment regardless of whether they say they smoke or not. Pressurising pregnant women to quit smoking is presented as necessary and proportionate in the interests of protecting future children from prenatal harm. This paper has examined the justification for such measures on the grounds of harm reduction. As stated above, for this to be the case four things would have to be established: (1) that smoking during pregnancy causes significant prenatal harm to future children; (2) that carbon monoxide testing reduces rates of smoking during pregnancy; (3) that such interventions do not cause more harm to future children than they prevent; *and* (4) that there is no other, less problematic way to reduce prenatal harm.

This paper has argued that while there is evidence connecting smoking during pregnancy to prenatal harm, there are other factors at play which prevent a clear causal link from being established. While reducing smoking during pregnancy is likely to have some beneficial impact on rates of prenatal harm, this is not the only way to achieve such a reduction. In fact, addressing other factors, such as social inequality, education, nutrition and the quality of prenatal care, would lead to a more significant reduction in rates of prenatal harm. Targeting pregnant women with pressurised smoking cessation measures such as carbon monoxide screening might help some women to quit smoking during pregnancy. However, even if carbon monoxide testing was 100% successful in getting women to quit smoking during pregnancy, the rates of prenatal harm would only fall by 13%[71] (compared to around 50% achieved by the JJ Way)[72] and this is without taking into account the potential harms of such interventions, for example, from women disengaging with prenatal care. Current

[71] Tominey (n 23).
[72] Josephs and Brown (n 64).

discussions of the potential benefits of smoking cessation measures in pregnancy have not sufficiently taken into account the potential harms of such measures. As argued above, constructing the problem of prenatal harm as one of individual behaviour and targeting this behaviour with routine carbon monoxide testing has the potential to cause harm as it obscures other more significant causes of prenatal harm, risks women disengaging with prenatal care and does not promote the autonomy of pregnant women. Perhaps the most troubling aspect is that routine carbon monoxide testing sends a message to pregnant women that they cannot be trusted either to truthfully answer questions as to whether or not they smoke, or to make decisions in the best interests of themselves and their future children in the way that non-pregnant individuals are. Extra pressure is thought to be required for pregnant women to quit smoking as they will not be able to make an appropriate decision when presented with information about the risks and appropriate support if requested. This distrust is defended on the basis of the extra pressure pregnant women face, but instead of alleviating this pressure, the policy exacerbates it, risking alienating pregnant women from their prenatal care team. Crucially, as such a policy is incompatible with a supportive and empowering approach to prenatal care, it is an obstacle to measures being put into place which the evidence suggests would significantly reduce prenatal harm. Far from being justified on the grounds of harm reduction, the policy to routinely test pregnant women for carbon monoxide has the potential to do more harm than good and there are other, more effective, less problematic ways to reduce harm to future children.

CHAPTER 7 - PAPER TWO: Can routine screening for alcohol consumption in pregnancy be ethically and legally justified?*

7.1 Introduction

Concerns have been raised about the effects of alcohol consumption in pregnancy since the 1970s. In more recent years the publication of studies that show correlation between alcohol exposure and low IQ[1] have resulted in a proliferation of media coverage[2] sending the message that 'Even moderate drinking during pregnancy can affect a child's IQ.'[3] In the last few years it has been reported[4] that the prevalence of Fetal Alcohol Spectrum Disorders (FASD) in the UK is significantly underestimated and called for urgent action to clarify and address this.

While the evidence regarding light or moderate drinking is not nearly as clear as the headlines might have us believe, there is evidence that *heavy* alcohol consumption in

* Written jointly with Professor Rebecca Bennett. The workload was approximately 50:50 and the original idea was mine.

[1] Sarah Lewis and others, 'Fetal alcohol exposure and IQ at age 8: Evidence from a population-based birth cohort study' (2012) 7(11) PLoS One e49407; Yvonne Kelly and others, 'Light drinking in pregnancy, a risk for behavioural problems and cognitive deficits at 3 years of age?' (2009) 38 Int J Epidemiol 129.

[2] Ellie Lee, Robbie M. Sutton, and Bonny L. Hartley, 'From scientific article to press release to media coverage: advocating alcohol abstinence and democratising risk in a story about alcohol and pregnancy' (2016) Health Risk Soc 18(5-6) 247.

[3] See for example Jeremy Laurance, 'Even Moderate Drinking During Pregnancy can Affect Child's IQ' *The Independent* (15 November 2012) <https://www.independent.co.uk/life-style/health-and-families/health-news/even-moderate-drinking-during-pregnancy-can-affect-child-s-iq-8317300.html> accessed 10 August 2022; BBC News, 'Moderate drinking in pregnancy 'harms IQ'' (15 November 2012) <https://www.bbc.co.uk/news/health-20325000> accessed 10 August 2022

[4] Cheryl McQuire and others, 'Screening prevalence of fetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study' (2019) 118 Prev Med 344.

pregnancy can lead to miscarriage and FASD[5] (a spectrum of conditions including growth issues, distinctive facial features and learning difficulties).[6] As a result, a so called 'precautionary approach'[7] has been adopted 'clarifying' the advice to women[8] before conception and during pregnancy to abstain from alcohol all together.[9]

This 'abstinence only approach' now forms the basis for all policies on alcohol consumption in pregnancy in the UK and is increasingly linked to recommendations for monitoring women during pregnancy.[10] Guidance on addressing alcohol consumption during pregnancy in England and Wales is currently in draft form and is expected to be finalised in the next year.[11] Although pregnant women are currently routinely asked by their midwives about their alcohol intake at the initial booking appointment, it is proposed that this should be increased to all women being screened using standard questionnaires at *every* antenatal appointment. In addition, there is an evident appetite for the development of biomarker

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[5] Mary Mather, Kate Wiles, and Patrick O'Brien, 'Should women abstain from alcohol throughout pregnancy?' (2015) BMJ 351 :h5232

[6] NHS Website, 'Foetal Alcohol Syndrome' <https://www.nhs.uk/conditions/foetal-alcohol-syndrome/> accessed 16 March 2022.

[7] UK Chief Medical Officers, *Low Risk Drinking Guidelines* (August 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf > accessed 27 October 2021

[8] While we do refer to pregnant 'women' throughout this paper, we recognise that it is important to acknowledge that not all pregnant people identify as women.

[9] For a critique of this approach see Colin Gavaghan, ' "You can't handle the truth"; medical paternalism and prenatal alcohol use' (2009) 35 J Med Ethics 300; Pam Lowe and Ellie Lee, 'Advocating alcohol abstinence to pregnant women: Some observations about British policy' (2010) 12(4) Health Risk Soc 301; Getsy Thom, Rachel Herring, and Emma Milne, 'Drinking in pregnancy: shifting towards the 'precautionary principle'' in Susanne MacGregor and Betsy Thom (eds), *Risk and Substance Use: Framing Dangerous People and Dangerous Places* (Routledge 2020)

[10] Scottish Intercollegiate Guidelines Network, *Guideline 156: Children and Young People Exposed Prenatally to Alcohol* (SIGN 156, 2019); National Institute for Health and Care Excellence (NICE), *Fetal Alcohol Spectrum Disorder: NICE quality standard draft for consultation* (March 2020) <https://www.nice.org.uk/guidance/indevelopment/gid-qs10139/documents> accessed 3 November 2021; Public Health England (PHE), *Maternity High Impact Area: Reducing the incidence of harms caused by alcohol in pregnancy* (December 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf> (accessed 3 November 2021).

[11] NICE 'Fetal Alcohol Spectrum Disorder' (n 10).

screening tools, testing blood, urine and even meconium to establish if a pregnancy is 'alcohol exposed'.[12] The Scottish Intercollegiate Guidelines Network (SIGN) published guidelines in 2019 recommending that standardised screening questionnaires and associated use of biomarkers should be considered to identify alcohol exposure in pregnancy.[13] This was followed in 2020 by the National Institute for Health and Care Excellence (NICE) Draft Quality Standard which recommended that pregnant women should have information on their alcohol consumption recorded throughout their pregnancy and this information transferred to the child's health records.[14] Most recently, Public Health England (PHE) have stated that the alcohol intake of all women should be recorded throughout pregnancy, not just at the initial booking appointment[15] and that tools such as blood biomarkers and meconium testing should be researched in order to determine true prevalence rates of alcohol in pregnancy.[16] The intention is to identify women who do not currently reveal their alcohol consumption to their healthcare professionals including those who have consumed even a small amount of alcohol during pregnancy, rather than only heavy drinkers. The reason that biomarker screening has not yet been introduced as part of this screening policy is because currently available tests are not sensitive enough to accurately detect low and moderate alcohol consumption in pregnancy.

In this paper we examine this proposed approach to screening for alcohol consumption in pregnancy and ask 'Can this kind of routine screening for alcohol use in pregnancy be ethically and legally justified?'. Routine screening in pregnancy is usually justified based on either prevention of fetal harm or on empowering women with information to make more

[12] PHE 'Maternity High Impact Area' (n 10) 12; SIGN (n 10) 13.
[13] SIGN (n 10) 13.
[14] ibid. 9 Quality Statement 2.
[15] PHE 'Maternity High Impact Area' (n 10) 10.
[16] ibid.

informed choices about their lives, or both. We argue that this move towards systematic and extensive routine screening of this population cannot be justified on either of these bases. Firstly, we argue that it is unlikely that this approach will achieve the public health and social aims that are the goals of this policy and may well be counterproductive resulting in more fetal harm. Secondly, we argue that unlike other screening policies that may arguably be justified in order to empower women with information about their pregnancy, screening for alcohol consumption will not result in women being better informed than they already were because the information gained about individual alcohol consumption is information these women already have, and the information given to women on which this policy is based is inconclusive and often contradictory.

7.2 Alcohol screening and consent issues

It is a central ethical and legal principle in modern healthcare that we should respect the autonomy of individuals accessing healthcare. This is seen as important to allow individuals control over their own lives and their own bodies, to avoid the medical paternalism of the past and develop a relationship of trust between healthcare professional and patient. As a result, all those able to make a sufficiently autonomous, informed choice have the right, under law, to make an uncoerced decision about whether they wish to provide any information or have any treatment or tests. In order to foster this kind of voluntary, informed consent we usually require that balanced information is given to patients in a non-directive way to foster a society where individuals are able to make the choices that they believe are the right ones for themselves.

An obvious exception to this rule is where there is strong evidence that providing treatment will prevent serious harm to others e.g., mandatory treatment or quarantine for serious infectious disease. Here it is argued that overriding individual autonomy is justified in these cases to protect the interests of others from serious harm.

However, there is a slightly less obvious exception to this rule of voluntary, informed consent for testing and treatment. This example is any routine programme for example, for screening or vaccination. Here, instead of an intervention as an option that individuals can opt in for, this intervention is introduced as a routine part of care with an inherent expectation that this intervention will be accepted. There is usually the option of refusing these interventions, but the routine nature of this offer arguably changes the usual non-directive nature of consent as making this part of routine care sends a message that this intervention is encouraged or recommended.[17] The fundamental aim of making an intervention routine is to improve the uptake of these interventions to encourage the participation of not only those who would have elected to be tested or vaccinated, but also those who may not have chosen this option if it was offered in the usual, non-directive, opt in way that other tests and treatments are usually offered in.

This is the rationale behind all routine vaccination programmes and routine screening programmes for serious and treatable conditions such as breast, cervical and bowel cancer. There are, of course, a number of established routine screening programmes in pregnancy. Some of these screening programmes aim to protect the welfare of the resulting child by preventing HIV infection, or treating syphilis or other preventable or treatable conditions.

[17] Rebecca Bennett, 'Routine antenatal HIV testing and informed consent: an unworkable marriage?' (2007) 33(8) J Med Ethics 446.

Other screening programmes aim to empower women with information that it is thought will be useful to them in order to make informed decisions about their pregnancies e.g. screening for Down's Syndrome. While these screening programmes are not without controversy,[18] the justification here is that this deviation from the 'gold standard' of non-directive informed consent for treatment is justified in order to either prevent harm to future children, or to give women information that they may find important when making choices about their pregnancies.

We argue that this proposal for extensive screening for alcohol use raises these challenges to respect for autonomy in the same way as other routine screening programmes and also has some additional features that intensify these challenges which we will come to later.

7.3 Justification for routine alcohol screening

The rationale for this proposed routine and regular screening of pregnant women for alcohol consumption is to increase the information that healthcare professionals have regarding how much pregnant women are drinking before and throughout their pregnancies. Information about alcohol intake is patchy with alcohol usage only being recorded for 60% of women at the initial booking appointment.[19] It is argued that this increased information about alcohol consumption will be helpful for two main reasons. Firstly, it is claimed that this systematic and routine screening approach 'supports the drive to improve wellbeing, reduce risk and tackle inequalities...and ensure every woman is fit for and during pregnancy and supported to

[18] See for example Anon, 'Ethics of Down's syndrome screening test questioned' (2015) 18(10) J Learning Disability Practice 7.
[19] PHE 'Maternity High Impact Area' (n 10) 9.

give children the best start in life.'[20] Secondly, it is argued that keeping a record of the alcohol consumption of these women, even if this is moderate, will help to later diagnose FASD in any resulting children.[21] Thus, the justification here for this deviation from the usual approach to respect for autonomy is based on an attempt to enhance the wellbeing of pregnant women and the children they bring to birth and to further enable accurate diagnosis and support of children affected by alcohol consumption in pregnancy. While these are, of course, laudable aims, if a strong case is to be made to justify this intervention based on these aims, then evidence needs to be available to convince that undermining the autonomy of women in this way is likely to have the public health and welfare gains that are sought.

7.3.1 Harm prevention?

Underlying the argument that the welfare of future children justifies the interference with women's autonomy is the assumption that the policy will maximise the welfare of future children by preventing harm to them. If evidence does exist that screening for alcohol use in pregnancy is likely to prevent serious harm to future children then this may provide a justification for this routine screening.

7.3.2 What is the evidence here?

The CMO's guidance that forms the basis of the approach of PHE adopts an abstinence only approach.[22] The rationale for this approach is that the evidence on issue this is complex particularly when it comes to light or moderate drinking, where evidence is at best

[20] ibid. 3.
[21] NICE 'Fetal Alcohol Spectrum Disorder' (n 10); SIGN (n 10) 10-14.
[22] UK CMOs (n 7) 8.

inconclusive and at worst contradictory with some studies indicating that light and moderate drinking is 'associated with better emotional and social adjustment than abstinence.'[23] It is thought that providing the detail of this information may be confusing to women and thus, in order to prevent fetal harm (from heavy drinking), the conclusion arrived at is to remove this uncertainty and to advocate abstinence.[24]

Given this lack of evidence of correlation between light and moderate drinking and fetal harm, if undermining women's autonomy is to be justified on the grounds that it is necessary in order to prevent harm to future children, it would be logical for the intervention to be targeted at the pregnancies most at risk of harm. However, the policy is not directed at those women who are believed to be drinking heavily during pregnancy, but at *all* women even though it is thought that only around 2.9% of pregnant women drink more than one alcohol unit a week.[25] Nor is the policy aimed at detecting high levels of alcohol consumption, but *any* level of alcohol exposure, despite the lack of evidence that low to moderate alcohol consumption is harmful. Therefore, we argue that this policy cannot be justified as a proportionate interference with women's autonomy in order to prevent harm to future children.

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[23] Jonathan Chick, 'Can light or moderate drinking benefit mental health?' (1999) 5(2) Eur Addict Res 74.
[24] Mather (n 5).
[25] PHE 'Maternity High Impact Area' (n 10) 8.

7.3.3 Better diagnosis of FASD?

It is also claimed that this policy will improve the welfare of future children because it will assist with the diagnosis of FASD.[26] The hope here is that this, often difficult to diagnose, condition might be more easily identified with the use of information about the alcohol use of the child's mother. However, it appears that while evidence that the child's mother consumed alcohol during pregnancy might assist in linking these conditions to the mother's behaviour, it is not necessary in order to diagnose the conditions themselves and determine the appropriate treatment and support.[27] In fact, the SIGN 156 document itself notes concerns that there was '...no evidence identified which directly links a maternal history that has involved alcohol use to improved rates of diagnosis and better outcomes for a woman or her children.'[28] Despite this the same document recommends that routine screening be intensified with the use of biomarkers in addition to screening questionnaires.[29]

7.3.4 The use of routine biomarker analysis?

There is little evidence to suggest that the inclusion of biomarker analysis will lead to a more accurate record of maternal alcohol consumption. The PHE document draws on a 2018 study that compared the prevalence of alcohol consumption in the first trimester of pregnancy revealed by self-reporting and blood biomarker analysis.[30] This study concluded that the prevalence of alcohol consumption estimated from blood biomarker analysis did not significantly differ from that revealed by self-reporting. Similarly, the SIGN 156 document

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[26] SIGN (n 10).
[27] It appears that the main reason for recording a woman's alcohol exposure is to assist in diagnosing whether the child's condition is due to alcohol consumption during pregnancy or genetic factors. ibid 11.
[28] ibid. 14.
[29] ibid.
[30] Helen Howlett and others, 'Assessing prevalence of alcohol consumption in early pregnancy: Self-report compared to blood biomarker analysis' (2018) 61(9) Eur J Med Genet 531.

notes that testing of meconium and placental tissues shows the greatest promise as blood biomarkers have been shown to be of limited use in screening for low and moderate alcohol consumption in pregnancy compared with self-reporting.[31] If biomarker analysis is no better than self-reporting, what is the justification for using it? Meconium and placental tissue testing might be more accurate in revealing low and moderate alcohol consumption but this would not be justified for two reasons. Firstly, given the lack of evidence that low to moderate level alcohol consumption during pregnancy is likely to harm the future child, it is not clear what testing for this level of consumption would achieve. Secondly, testing of meconium and placental tissues is retrospective and cannot be used to identify women who might benefit from specialist support services to reduce their alcohol consumption during pregnancy and so could only be of use in making a retrospective link between the child's conditions and the mother's alcohol intake during pregnancy. A policy of routine screening using blood biomarker analysis or meconium and placental tissue testing would be even more of an infringement on women's autonomy than routine alcohol questionnaires, given the physically invasive nature of this screening. The absence of evidence that these measures would improve the welfare of either the resulting child or the woman means that justification for this infringement is lacking.[32]

7.3.5 Counterproductive?

Not only is there no evidence that the use of routine questionnaires and blood biomarkers would be likely to improve the welfare of children born, but there are also concerns that this more extensive investigation of alcohol use in pregnancy might actually prove harmful to the

[31] SIGN (n 10) 12-13.
[32] Lenora Marcellus, 'Is Meconium Screening Appropriate for Universal Use?' (2007) 7(4) Adv Neonatal Care 207.

welfare of these future children. The pregnancies that are most at risk from harm associated with alcohol consumption are those where women are drinking heavily throughout their pregnancies. Given that these women are already reluctant to disclose their alcohol consumption to their healthcare team,[33] most likely through fear of judgment and even of having their children removed from their care, it seems unlikely that a routine questionnaires and biomarker blood tests implemented to identify even low levels of alcohol will encourage these women to engage with antenatal care. This added level of surveillance and the distrust inherent in it, has the potential to cause the women who would benefit most from good, supportive antenatal care, to disengage from that care leading to far worse outcomes for them and their future children.[34] The SIGN 156 document states that 'no evidence was identified to suggest that asking about alcohol history had a detrimental effect on attendance for care'[35] but this could easily change with the increased pressure of being asked at every antenatal appointment, having this recorded on the woman's (and potentially the child's) health records and the use of biomarker screening. In addition, the proposed use of meconium and placental tissue testing might conceivably lead to women choosing to conceal births in fear of such testing revealing that they have consumed alcohol during pregnancy and the very real possibility that this could be used in care proceedings to remove the child from the mother's care.[36]

The SIGN 156 document notes that some members of the development group reported that in their experience screening tools do not necessarily ensure that alcohol consumption is

[33] As noted in SIGN (n 10) 13, referring to Tessa Parkes and others, *Double exposure: a better practices review on alcohol interventions during pregnancy* <https://bccewh.bc.ca/wp-content/uploads/2014/08/Double-Exposure.pdf> accessed 13 April 2021.
[34] Alaina Brenick and others, 'Understanding the Influence of Stigma and Medical Mistrust on Engagement in Routine Healthcare Among Black Women Who Have Sex with Women' (2017) 4(1) LGBT Health 4.
[35] SIGN (n 10) 13.
[36] As we have already seen in cases such as *D (a minor) v. Berkshire County Council and others* [1987] 1 All E.R. 20, a woman's behaviour during pregnancy can be used against her in care proceedings concerning her children.

discussed effectively and that other issues such as experiences of violence and abuse need to be discussed.[37] Indeed, it states that 'To enable health behaviour change, including reduction in alcohol consumption during pregnancy, supportive relationships between patients and caregivers are key.'[38] Despite the potential benefits, no recommendations are made relating to enhancing this supportive relationship and encouraging wider discussions of other issues in the woman's life. Instead, it is recommended that use of biomarkers alongside screening questionnaires should be considered.[39]

7.4 Further challenges to respecting women's autonomy

In the face of this evidence, however, those proposing this change of approach may still insist that the *chance* that we might prevent fetal harm in this very small minority of pregnant women who do drink heavily is enough to justify, what they would argue is a minor infringement of autonomy. However, we argue that the infringement of autonomy is not inconsiderable.

While it is true that women can refuse to provide information and refuse to consent to blood biomarker testing, arguing that this ability to refuse makes this screening voluntary seems a stretch. If you are still doubting this consider the information that women will be given as part of the consent process to this screening. Accurate information is a pre-requisite of voluntary informed consent. This screening is presented as necessary on the basis that total abstinence is the only safe approach during pregnancy. However, as we have seen, evidence linking light or moderate drinking to fetal harm is not available and this approach is taken on

[37] SIGN (n 10) 13.
[38] ibid.
[39] ibid.

the basis that women might be confused by an accurate account of the risks involved.[40] This 'simplification' of the evidence calls into question whether participation in such screening can be considered to be voluntary and informed.

This approach misrepresents the evidence behind this request for engagement with screening and presents the evidence in a way that we argue is unjustifiably directive to the point of coercion. In the face of this version of the evidence midwives may even feel it is their duty to persuade women to participate in screening adding to directiveness of this interaction. This is, of course, not only ethically challenging but also potentially legally problematic in that not providing accurate and clear information when asking a patient to consent to screening may well render the consent given legally invalid.

Finally, it is important to recognise that this type of screening is very different from other routine screening programmes in that the participation in screening cannot be justified in order to empower those screened with information. This is for the simple reason that the participants already know the information that is being screened for. Women are already aware of the amount they are using alcohol. What could empower women is to be provided with accurate information of the risk of alcohol consumption in an environment where they feel able to discuss this issue freely. However, the proposed screening does not provide this.

[40] UK CMOs (n 7) 8; SIGN (n 10) 1; Gavaghan (n 9).

7.5 Conclusion

In this paper we have argued that proposals to enhance routine screening of all pregnant women for alcohol consumption using regular questionnaires and blood biomarkers are problematic, not only ethically and legally, but also when we consider the public health aims these screen programmes aim to address. We have argued that ‘simplifying’ the complexity of the evidence when it comes to FASD undermines women’s autonomy and their legal rights to be sufficiently informed to consent to screening. We have also argued that this proposed routine screening cannot be justified by appealing to the harm that is prevented to the fetus or the woman as the evidence just does not back this up. As a result, such proposals are not only ethically and legally problematic but also likely to be at best ineffective, and at worst counterproductive as a result of an undermining the trust relationship between women and health care professionals.

CHAPTER 8 - PAPER THREE: Is a relational approach required to close the door on criminal liability for maternal prenatal conduct?

8.1 Introduction

Women have not yet faced criminal liability in the UK for their prenatal conduct such as heavy drinking or drug taking during pregnancy which results in harm to their future children.[1] However, the criminal law has not expressly excluded pregnant women from liability for such harm in the way that the civil law has[2] and although such criminal liability seems unlikely at present, it remains a possibility.[3] Powerful arguments have been made by others as to why maternal criminal liability for prenatal conduct should be resisted on the ground that it would be ineffective at preventing harm and highly problematic for the lives of women, leading to calls for an exclusion of maternal liability in the criminal as well as the civil law.[4] However, those calls have so far gone unheeded and the door has not been firmly closed on maternal criminal liability.

[1] I use the terms 'prenatal conduct' and 'harm to a future child' to refer to harm due to events which occur prenatally. This includes prenatal events that cause harm to the foetus that is subsequently born alive and prenatal events which cause harm to the child *after* she is born alive. Where I refer to only one of these two types of prenatal events I make that distinction clear.

[2] With the exception of harm due to negligent driving, the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) is intended to exclude maternal civil liability for prenatal conduct. See ss 1(1) and 2 CDCLA.

[3] For a discussion of how the offence of concealment has been used to punish women for their conduct during pregnancy beyond the scope of the offence see Emma Milne, 'Concealment of Birth: Time to Repeal a 200-Year-Old "Convenient Stop-Gap"?' (2019) 27 Fem Leg Stud 139.

[4] Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Oxford and Portland Oregon: Hart Publishing, 2001); Margaret Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 Curr Leg Probl 359; Emma Cave and Catherine Stanton, 'Maternal Responsibility to the Child Not yet Born' in Catherine Stanton, Sarah Devaney, Anne-Marie Farrell, and Alexander Mullock (eds), *Pioneering Healthcare Law* (Routledge, 2015) 306; Sarah Fovargue and José Miola, 'Policing Pregnancy: Implications of the Attorney General's Reference (No. 3 of 1994)' (1998) 6(3) MLR 265.

In this paper I seek to establish three things: that maternal criminal liability for unintentional prenatal harm remains a possibility, that a relational approach could close the door on such liability, and that it would be appropriate for the criminal law to adopt such an approach.

Women who drink alcohol during pregnancy are commonly viewed as having committed a serious moral wrong, driving the argument that such behaviour should be criminalised.[5] This argument cannot be addressed until the criminal law captures the particular moral nature of how a pregnant woman might cause harm to her future child. Under the current law a woman who drinks heavily during pregnancy leading to the death of her child following its birth could be guilty of manslaughter in the same way as a man who stabs his pregnant partner unintentionally causing the death of the child after it is born.[6] The woman who drinks heavily during pregnancy is ingesting alcohol into her own body which is far from unusual in our society whereas someone who stabs a pregnant woman is acting in a violent manner towards another person which would attract criminal liability even where no harm occurred to a future child. To treat these individuals as equally blameworthy for the harm caused to the child after its birth fails to take account of the different reasons and interests pregnant women might have for acting towards their own bodies compared to third parties acting towards another individual. The right to make choices about one's own body is an important factor in assessing whether behaviour is

[5] Elizabeth Armstrong and Ernest Abel, 'Fetal Alcohol Syndrome: The Origins of a Moral Panic' (2000) 35(13) Alcohol Alcohol 276; Kirsten Bell, Darlene McNaughton, and Amy Salmon, 'Medicine, Morality and Mothering: Public Health Discourses on Foetal Alcohol Exposure, Smoking Around Children and Childhood Overnutrition' (2009) 19(2) Crit Public Health 155; Wilkinson, D. and others, 'Protecting future children from in-utero harm' (2016) 30(6) Bioethics 425; Emma Milne, 'Putting the Fetus First – Legal Regulation, Motherhood, and Pregnancy' (2020) 27(1) Mich J Gend Law 149.

[6] *Attorney-General's Reference (No 3 of 1994)* [1997] All ER 936, [1998] AC 245.

morally problematic and is an important legal principle.[7] It is therefore unsatisfactory for the law not to take account of the unique way in which this right is engaged in the unintentionally harmful conduct of pregnant women.

I argue that the solution lies in adopting what Seymour refers to as a 'relational approach' to cases of this kind, taking into account how the relationship between a pregnant woman and her foetus differs to that of a third party and a foetus, as well as the characteristics of the foetus.[8] This would capture the different moral nature of the harmful actions and thus the argument that women whose behaviour during pregnancy unintentionally harms their future children should face criminal liability because they have committed a serious moral wrong in the same way as a third party who causes such harm by attacking a pregnant woman, can be shown to be inaccurate. This has the potential to finally close the door to maternal criminal liability for unintentionally harmful prenatal conduct.

In order to answer the question of whether the criminal law should adopt a relational approach to prenatal conduct I must first explain the approach the law currently takes before going on to establish how this leaves the door open to maternal criminal liability.

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[7] For a detailed discussion of this see Rosamund Scott, *Rights, Duties and the Body* (Hart Publishing 2002).

[8] John Seymour, *Childbirth and the Law* (Oxford University Press, 2000) 159-164.

8.2 The current law

The civil and criminal law in England and Wales currently take different approaches to liability for harmful prenatal conduct. While a child who is born disabled as a result of events which occur while it is in utero or even prior to its conception can bring a civil claim against other individuals responsible for those events,[9] the child cannot bring such a claim against his own mother except in relation to negligent driving.[10] Under the criminal law individuals – potentially including the woman pregnant with the future child[11] – can commit an offence if their actions which occur when the victim is in utero cause harm to the child after she is born alive.[12]

8.2.1 Civil law

The civil law in this area is dominated by the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) brought into law following the thalidomide tragedy.[13] The CDCLA stipulates that a child born disabled as a result of an occurrence before or during its birth can bring a civil claim against the person whose wrongful act caused that disability.[14] However, the child's mother is expressly excluded from such liability except in relation to negligent driving.[15] Maternal liability is excluded in this way because of the extent of

[9] Such a claim is derivative from a breach of a duty of care owed to the affected parent s 1(3) CDCLA.
[10] ss 1(1) and (2) CDCLA. This is a policy decision due to the requirement for all drivers to have insurance, meaning that it would be the woman's insurer meeting any judgment in respect of her negligent driving, rather than the woman herself.
[11] See Fovargue and Miola (n 4); Cave and Stanton (n 4); Brazier, 'Liberty, Responsibility, Maternity' (n 4); Emma Cave, *The Mother of All Crimes: Human Rights, Criminalization and the Child Born Alive* (Ashgate 2004) 61-62.
[12] *Attorney-General's Reference (No 3 of 1994)* (n 6).
[13] See Harvey Teff and Colin Munro, *Thalidomide: The Legal Aftermath* (Saxon House, 1976).
[14] S 1(1) CDCLA.
[15] S 1(2) CDCLA.

the liability women would otherwise face and the potential for such liability to be used against women in matrimonial disputes.[16] As Jackson argues, there are three further reasons why this exclusion is required in civil law.[17] First, without such exclusion there would be practical implications on women's freedom to make choices about their bodies rendering them second class citizens in terms of autonomy and bodily integrity and subjecting them to continual surveillance.[18] For example, a pregnant woman would not be free to refuse a medical procedure such as a caesarean section without the prospect of being held liable for the consequences of that decision for her future child. Second, there would be practical difficulties in determining the standard of the 'reasonable person' used to determine standards of behaviour in the tort of negligence in relation to women's conduct during pregnancy.[19] Given the all-encompassing nature of pregnancy for nine months (as well as the potential for preconception care to impact on the health of a future child) and the extensive list of factors which can impact on the welfare of a future child, applying such a standard to pregnancy would permit judicial scrutiny of every aspect of women's lives. Third, judicial reasoning is primarily based on analogy and precedent which cannot easily be applied in the unique biological relationship of pregnancy.[20] In law, a foetus is not a legal person and so the pregnant woman and foetus are not analogous to two individuals. However, the foetus is also 'not nothing' and what is thought to be in its interests can be considered, meaning that the pregnant woman and foetus are considered not one but not two.[21] This makes analogy to other relationships between individuals problematic.[22] For all of these reasons a relational

[16] Law Commission, *Report on Injuries to Unborn Children* (Law Com No 60, 1974) 24-25.
[17] Jackson (n 4) 142-147.
[18] ibid 143.
[19] ibid 143-144.
[20] ibid 144.
[21] *Attorney-General's Reference (No 3 of 1994)* (n 6) 687.
[22] Jackson (n 4) 146.

approach differentiating maternal liability from third party liability is adopted by the civil law.

8.2.2 Criminal law

In contrast to the civil law described above, the criminal law on prenatal conduct does not clearly differentiate between harm caused by the pregnant woman carrying the foetus and harm caused by third parties. Instead, the focus of the criminal law is on the status of the victim and so the criminal law can be seen to take a definitional approach, leaving the door open to maternal criminal liability for unintentional prenatal harm. This definitional approach can be seen in the following criminal offences.

Section 1 of the Infant Life (Preservation) Act 1929 (ILPA) makes it a criminal offence punishable by life imprisonment, to intentionally destroy the life of a child capable of being born alive before it has an existence independent of its mother.[23] Overlooking the troubling language of this provision and indeed the problematic title of the legislation,[24] it is notable that this section is only concerned with the *destruction* of the foetus capable of being born alive; it is not relevant to prenatal conduct which causes harm short of destruction to a future child (i.e. one that is later born alive). Further, no distinction is drawn between a pregnant woman who destroys the foetus she is carrying and a third party who destroys a foetus being carried by someone else.[25] This offence reflects the definitional approach of the criminal law; focussing

[23] Unless it is done only to preserve the life of the mother (s 1 ILPA) or the termination is in accordance with the provisions of the Abortion Act 1967 (s 5(1) Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990).
[24] It is troubling and inaccurate to refer to a foetus of any stage gestation as a child or an infant.
[25] Although the pregnant woman is a potential perpetrator of this offence, there appears to have been only one expectant mother convicted under this 90-year-old law. Maisha Mohamed was convicted despite no

on the status of the foetus rather than who has caused the harm and how. This definitional approach is illustrated by the family law case of *C v S*[26] in which the father of a foetus sought a court order preventing his ex-partner from terminating her pregnancy on the grounds that a termination at the stage of 18–21 weeks would be an offence under section 1 ILPA, in that it would be destroying a foetus capable of being born alive. The father sought to bring the claim in his own name but also to join the future child as a party to the action. However, the Court of Appeal followed the reasoning in *Paton v Trustees of the British Pregnancy Advisory Service*[27] and held that a foetus could not be a party to an action, and that a foetus born at 18-21 weeks that might show some discernible signs of life but would never be capable of breathing either naturally or with artificial assistance, could not be considered a 'child capable of being born alive' within the meaning of section 1 ILPA and so rejected the father's claim.[28] It can be seen that in focussing solely on the status of the 'victim', the foetus capable of being born alive, this offence reflects a definitional approach to harmful prenatal actions, rather than a relational approach which would distinguish between the actions of the pregnant woman and those of third parties.

In section 58 Offences Against the Person Act 1861 (OAPA) the actions of a pregnant woman and a third party who intentionally destroy a foetus of any gestation are described separately but both constitute the same offence:

> Every woman, being with child, who, with intent to procure her own miscarriage, shall

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evidence as to what happened to the foetus. See BBC News, 'Baby destruction woman sentenced' (24 May 2007) <http://news.bbc.co.uk/1/hi/england/manchester/6687893.stm> accessed 19 August 2020.

[26] [1987] 1 All ER 1230.

[27] [1978] 2 All ER 987.

[28] *C v S* (n 26) 151-152.

> unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life.[29]

Under this provision, a pregnant woman who intentionally attempts (whether successfully or not) to abort her pregnancy or a third party who intentionally attempts to abort a woman's pregnancy can be guilty of a criminal offence and sentenced to life imprisonment.[30] It is this legislation (together with section1 ILPA and section 59 OAPA) that makes abortion a crime in England and Wales unless one of the exceptions set out in the Abortion Act 1967 apply.[31] The language used in section 58 OAPA hints at the distinction a relational approach seeks to draw in that it talks about a pregnant woman administering a noxious substance *to herself* while a third party administers the noxious substance to the pregnant woman. However, this distinction has little significance in section 58 OAPA as the pregnant woman faces the same liability as a third party.

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[29] S 58 OAPA 1861.

[30] For example, a woman was convicted of an offence under s 58 OAPA after she took a drug, misoprostol, in order to bring about an abortion towards the end of her pregnancy in *R v Catt* [2013] EWCA Crim 1187.

[31] In summary, abortion is not an offence if the pregnancy is no more than 24 weeks of gestation and two medical practitioners certify that the continuance of the pregnancy poses a greater risk to the woman's physical or mental health than a termination, or after 24 weeks, two medical practitioners certify that the abortion is necessary to prevent a risk to the life of the pregnant woman or grave permanent harm to the woman's health, or there is a substantial risk that the child would be seriously handicapped if born. S 1(1) Abortion Act 1967.

There are strong arguments against imposing criminal liability on a pregnant woman acting to abort her own pregnancy that are beyond the scope of this paper.[32] However, while this remains a criminal act it is less problematic for the pregnant woman who intentionally brings about her own abortion and a third party who intentionally brings it about on her behalf to be guilty of the same offence than in the case of unintentional prenatal harm. Provided that the third party is bringing about the abortion at the woman's request it is the woman's right to bodily integrity that is engaged regardless of whether she is the defendant or the third party. However, when we are dealing with unintentional prenatal harm, because of the bodily relationship of pregnancy, the interests of a pregnant woman are engaged in a way that they are not when the harm is caused by a third party. It is this that necessitates a relational approach in the criminal law.

Having now established that the criminal law takes a definitional approach to intentional prenatal harm, in the next section I will show that a similar approach is taken to unintentional harm, leaving the door open to maternal criminal liability for conduct such as heavy drinking during pregnancy.

8.2.3 The Potential for Maternal Criminal Liability for Unintentional Harm

It is a well-established principle in English law that a foetus cannot be considered a legal person until it has a separate existence to its mother.[33] Therefore, actions that

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[32] For a detailed discussion of the arguments against criminal liability for abortion see Sally Sheldon and Kaye Wellings (eds), *Decriminalising Abortion in the UK: What would it mean?* (Policy Press 2020) <https://www.oapen.org/search?identifier=1007882> accessed 6 April 2020.

[33] *Paton v BPAS* [1978] 2 All ER 987 in which it was held that a foetus cannot be considered a legal person until it has a separate existence to its mother; *Re F (In Utero)* [1988] Fam 122 in which it was held that the court had no jurisdiction to make an unborn child a ward of court in order to protect it from harm as a result of its

are not intended to destroy the foetus which cause harm short of destruction to individuals in their foetal stage cannot attract criminal liability.[34] However, events which happen during an individual's foetal stage can attract criminal liability if they result in harm occurring to that individual *following birth* as the victim is then a legal person.[35] As explained below, the principle of legal personhood has dominated the law on unintentionally harmful prenatal conduct leading to the courts adopting a purely definitional approach leaving maternal criminal liability a possibility.

In the criminal law the leading case on prenatal conduct is *Attorney-General's Reference (No 3 of 1994)*[36] in which the defendant was found guilty of the 'dangerous act manslaughter' of a child after he stabbed his pregnant girlfriend in the abdomen causing her to deliver her baby prematurely. Although the foetus was not directly injured by the stabbing the baby was born alive but subsequently died 121 days later as a complication of its prematurity.[37] The defendant had committed an unlawful act which any sober and reasonable person would recognise as creating a risk of harm to some other person in stabbing the pregnant woman. It was not necessary to establish that the risk of harm to the ultimate victim (the future child) was obvious; only that the risk to someone, in this case the pregnant woman, was obvious.[38] It is clear that the status of the victim was central to the decision in this case. If the victim had died *in utero* a charge of manslaughter could not have been made out. It was the fact that the baby had been born alive and therefore the death had been of a legal person that enabled the charge to succeed.

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pregnant mother's drug abuse; and *Re MB (an adult: medical treatment)* [1997] 8 Med LR 217 which stated that as a foetus cannot be a legal person, a pregnant woman has the same right to refuse medical treatment as any other competent adult.

[34] However, actions intended to cause the destruction of the foetus which fail to destroy the foetus but instead cause harm, or even no harm at all, could be subject to criminal liability under s 58 OAPA, discussed above.

[35] *Attorney-General's Reference (No 3 of 1994)* (n 6).

[36] ibid.

[37] ibid 250-251.

[38] ibid 246.

It could be argued that this definitional approach, focussing on the status of the victim, is appropriate given that the case was not addressing the actions of a pregnant woman; the defendant in the case was not in the unique biological relationship of pregnancy with the victim. Therefore, his actions were towards another separate being; he had stabbed his pregnant girlfriend. However, this definitional approach means that there is nothing in the judgment precluding a pregnant woman facing criminal liability for her actions during pregnancy which cause the death or other harm to her own child following its birth.[39] As Cave and Stanton have pointed out, the ruling in *Attorney-General's Ref (No 3 of 1994)* and the subsequent case of *CP v Criminal Injuries Compensation Authority*[40] discussed below leave open the possibility that a pregnant woman could be prosecuted for gross negligence manslaughter if she takes heroin during pregnancy and her child is born alive but later dies of Sudden Infant Death Syndrome (SIDS) as a result of her heroin use.[41] In this scenario although the heroin would be taken while the 'victim' is in its foetal stage the subsequent death would be of a child that had been born alive bringing it within the reasoning in *Attorney-General's Ref (No 3 of 1994)*.

It could be argued that the door to maternal criminal liability is not left open in this way as such a scenario could not constitute the offence of gross negligence manslaughter because that requires the existence of a duty of care between the pregnant woman and her future child, something excluded in the civil law by the CDCLA. A duty of care in the criminal law appears unlikely given the exclusion of maternal liability expressed in the CDCLA and the opinion of Lord Dyson MR in the case of *CP v CICA* that the

[39] Magaret Brazier and Emma Cave, *Medicine Patients and the Law* (6th edn, Manchester University Press 2016) 346.
[40] [2014] EWCA Civ 1554.
[41] Cave and Stanton (n 4) 290.

criminal law should reflect the civil law in these circumstances:

> Since the relationship between a pregnant woman and her foetus is an area in which Parliament has made a (limited) intervention, I consider that the court should be slow to interpret general criminal legislation as applying to it.[42]

> The law would be incoherent if a child were unable to claim compensation from her mother for breach of a duty of care owed during pregnancy, but the mother was criminally liable for causing the harm which gave rise to damage and a right to compensation (…).[43]

However, it appears that despite the exclusion of maternal liability under section 1(1) CDCLA a woman could still owe a civil duty of care to her future child in respect of heavy drinking during pregnancy in some circumstances. The CDCLA applies to a child 'born disabled' as a result of an occurrence before its birth bringing a claim in respect of those disabilities.[44] Further, section 1(2) states that:

> An occurrence to which this section applies is one which –
>
> *a.* affected either parent of the child in his or her ability to have a normal, healthy child; or
>
> *b.* affected the mother during her pregnancy, or affected her or the child in the course of its birth, *so that the child is born with disabilities* which would not otherwise have been present. (emphasis added)

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[42] *CP v CICA* (n 40) [65] (Lord Dyson).
[43] ibid [66] (Lord Dyson).
[44] S 1(1) CDCLA 1976.

Therefore, the CDCLA is not applicable to harm which occurs *after* the child is born alive as a consequence of something that happened prior to its birth. For example, if a woman drinks heavily during pregnancy and her child is born with FASD, the CDCLA would exclude her child from bringing a claim against her in respect of the FASD itself, but if the woman's drinking caused the child to suffer seizures after its birth resulting in brain damage, this could be construed as falling outside of the CDCLA. The child would be bringing a claim in respect of disabilities it was not born with and which were due to an occurrence after its birth.

If such a duty of care is not excluded under the CDCLA it is possible that one could be found to exist by applying the normal criteria set out in *Caparo v Dickman*:[45] it is foreseeable that a pregnant woman's future child could be harmed by her heavy drinking given the current understanding of the impact of the prenatal environment on the health of future children; there is likely to be sufficient proximity between a pregnant woman (who is aware she is pregnant) and her future child as there is a clear relationship distinguishing this from a duty owed to the world at large; and although there are strong public policy reasons why a duty in negligence should not exist (discussed above), these could be threatened by arguments that it would be fair, just and reasonable for a duty of care to exist because of the seriousness of the moral wrong that has been committed.

Therefore, returning to Cave and Stanton's example above, a woman who takes heroin during pregnancy, whose child is born alive but later dies from SIDS associated with

[45] [1990] 2 AC 605.

her drug taking during pregnancy, could be said to owe a duty of care sufficient for the offence of gross negligence manslaughter as a civil duty of care in relation to post-birth harm caused by pre-birth events is not prohibited by the CDCLA and could be found applying the principles in *Caparo v Dickman.* Therefore, criminal maternal liability for prenatal conduct remains a possibility.

Even assuming that the CDCLA does exclude a duty of care in civil law, despite the comments of Lord Dyson MR, a lack of a duty of care in civil law does not necessarily preclude the existence of a duty of care in criminal law. The purposes of the two branches of law are distinct and therefore where it might be considered inappropriate for a duty of care to exist in one, it could be entirely appropriate in the other.[46] The purpose of a duty of care in civil law is to distribute loss in a manner necessary for the functioning of society, whereas a duty of care in criminal law is centred on protecting individuals from harm caused in a blameworthy manner.[47] Indeed, in order to protect individuals it might be more necessary for the criminal law to act where the civil law does not.[48] Consequently, not all of the arguments against a duty of care in civil law apply equally against a duty of care in criminal law and so it should not be assumed that the civil law exclusion is sufficient to rule out a duty of care in criminal law.

The possibility of criminal maternal liability for harmful prenatal conduct is further increased by the language used in *Attorney-General's Ref (No 3 of 1994).* As Fovargue and Miola have argued, in finding that a third party could be liable in manslaughter in

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[46] It was acknowledged in *CP v CICA* that the public interests in play in tort and the criminal law are different. *CP v CICA* (n 40) [47] (Lord Treacy).

[47] See Michael Jefferson, *Criminal Law* (11th edn, Pearson Education 2013) 463; and *Wacker* [2003] QB 1207 (CA).

[48] Michael Allen, *Criminal Law* (13th edn, Oxford University Press 2015) 368.

these circumstances, and further holding that the pregnant woman and foetus are 'two distinct organisms living symbiotically, not a single organism with two aspects',[49] the House of Lords took a step towards personalising the foetus despite rejecting the possibility that the foetus could be a separate legal personality.[50] This step towards personalisation is based on the assumption that while the State has a duty to protect the rights of women, it also has an interest, or perhaps even a duty, to protect foetuses not only from harm by third parties, which would reflect their value to their parents, but also from harm *by their parents*, because they have their own intrinsic value. Further, the pregnant woman was objectified as the 'maternal environment of the foetus'[51] in Lord Mustil's comments:

> The unlawful and dangerous act of B *changed the maternal environment of the foetus* in such a way that when born the child died when she would otherwise have lived.'[52] (emphasis added)

This reflects a separation of mother and foetus to an extent that it treats pregnant women in the same way as other potential defendants. Further, the conception of the pregnant woman as 'maternal environment' raises the possibility that such liability may be extended beyond intentionally harmful actions to the woman's failure to maintain that environment to the standard acceptable to the law.[53]

In addition, the harm that the woman could be liable for is not limited to the *death* of

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[49] *Attorney-General's Reference (No 3 of 1994)* (n 6) 255 (Lord Mustill).
[50] Fovargue and Miola (n 4) 287-290.
[51] *Attorney-General's Reference (No 3 of 1994)* (n 6) 264 (Lord Mustill).
[52] ibid.
[53] Kristin Savell, 'The Mother of the Legal Person' in S James & S Palmer (eds), *Visible Women: Essays on Feminist Legal Theory and Political Philosophy* (Hart Publishing, 2002) 46.

the child born alive. One of the five rules Lord Mustill considers to have been established is that:

> Violence towards a foetus which results in *harm* suffered after the baby has been born alive can give rise to criminal responsibility even if the harm would not have been criminal (apart from statute) if it had been suffered in utero.[54] (emphasis added)

Therefore, a woman could be criminally liable for disabilities suffered by her child as a result of her conduct during pregnancy provided that the harm occurred to the child after it was born alive.[55]

The above discussion shows that the definitional approach taken in *Attorney-General's Ref (No 3 of 1994),* which fails to distinguish between the harmful conduct of a third party and a pregnant woman, together with the step it took towards the personalisation of the foetus means that maternal criminal liability for unintentional prenatal harm remains a possibility. This approach is problematic as it does not permit the law to take account of the unique way in which a pregnant woman might harm her future child and the interests she may have in acting in that way. As I will explain in the next section, the door to maternal criminal liability was more recently left ajar by the definitional approach taken in the case of *CP v CICA* which considered the specific question of whether the actions of a pregnant woman which unintentionally harm her future child could constitute a crime.

[54] *Attorney-General's Reference (No 3 of 1994)* 254 (Lord Mustill).
[55] Brazier, 'Liberty, Responsibility, Maternity' (n 4) 382.

8.2.4 CP v CICA

In *CP v CICA* the Court of Appeal was asked to consider whether heavy alcohol consumption during pregnancy resulting in a child born with Foetal Alcohol Spectrum Disorder (FASD) could amount to a crime of violence under section 23 OAPA 1861 and therefore form the basis of a claim for compensation from the Criminal Injuries Compensation Authority (CICA).[56] Compensation had been previously granted under CICA for similar injuries before the scheme was reformed in November 2012 to exclude children damaged by alcohol in the womb.[57] The action brought on behalf of CP was governed by the 2008 CICA scheme and had the potential to cast doubt on the legitimacy of this exclusion by seeking a ruling that heavy drinking during pregnancy could be considered a crime of violence and thus worthy of compensation under the scheme.

The offence states that:

> Whosoever shall unlawfully and maliciously administer to or cause to be administered to or taken by *any other person* any poison or other destructive or noxious thing, so as thereby to endanger the life of *such person*, or so as thereby to inflict upon *such person* any grievous bodily harm, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for any term not exceeding ten years.[58] (emphasis added)

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[56] The biological mother in this case did not face criminal investigation or charges. *CP v CICA* [11] (Lord Treacy).
[57] ibid [1] (Lord Treacy).
[58] S 23 OAPA 1861.

The Court of Appeal unanimously ruled that the harm had occurred while CP was a foetus and a foetus could not be 'any other person' for the purposes of section 23 OAPA. Therefore, CP was not entitled to compensation on the basis of this offence.[59]

This definitional approach is clearly illustrated in the remarks of Lord Dyson MR who stated that:

> If s 23 [OAPA] had expressly included a foetus as well as "any other person", EQ [CP's mother] would have committed the *actus reus* of the offence during pregnancy.[60]

Thus, the case hinged on the definition of the required victim.

It could be argued that as a foetus lacks legal personhood and cannot be the victim of a section 23 offence, nor any other offence drafted to protect legal persons, maternal criminal liability for unintentionally harmful prenatal acts is only possible if new legislation was passed to make a foetus a specific victim of such an offence. However, the reasoning in *CP v CICA* does not alter the potential for maternal liability on the basis of the invocation of the born-alive rule in *Attorney-General's Ref (No 3 of 1994)* where the victim is the child following its birth as explained above.

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[59] It is worth noting that if the Court of Appeal had ruled that heavy drinking during pregnancy is capable of being a crime of violence for the purposes of the CICA scheme, it would not automatically follow that pregnant women could face criminal liability for such actions; it would be for the courts to consider whether this amounted to a criminal act if and when such as case was brought by the Crown Prosecution Service (CPS) and this would have to also pass the initial hurdle of being considered to be in the public interest. Crown Prosecution Service, 'The Code for Crown Prosecutors' 2018 <https://www.cps.gov.uk/publication/code-crown-prosecutors > accessed 20 August 2020, para 4.9.

[60] *CP v CICA* (n 40) [64] (Lord Dyson MR).

Further, it is not only liability for gross negligence manslaughter that remains a possibility for women in relation to their conduct during pregnancy, but liability for harm short of death such as under section 20 OAPA. This statutory provision makes it an offence to maliciously (ie intentionally, or recklessly) wound or inflict grievous bodily harm upon any other person.[61] Following the ruling in *CP*, harm done at the foetal stage would not be sufficient for this offence for the same reason it was not sufficient for a section 23 offence; the foetus cannot be 'any other person'. However, a section 20 offence could be committed if the heavy alcohol consumption during pregnancy causes harm *after* the child is born alive such as seizures[62] which result in brain damage. It could be argued that in that scenario the brain damage is connected to the harm suffered at the foetal stage and so is not harm to the child born alive but merely the child born alive suffering the effects of the harm done to it at its foetal stage.[63] However, this is not the view taken by the House of Lords in *Attorney-General's Ref (No 3 of 1994)*. In that case the death of the child born alive was held to be harm *to the child* caused by the attack on the child's mother during pregnancy rather than merely an effect of the prenatal harm. If prenatal events which cause the death of a child later born alive can be considered to be sufficient for manslaughter, there is no reason why brain damage due to a seizure could not be sufficient for section 20 OAPA on the same basis.

A further argument as to why maternal criminal liability is unlikely following the case of

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[61] S.20 OAPA.

[62] Francesco Nicita and others, 'Seizures in Fetal Alcohol Spectrum Disorders: Evaluation of Clinical, Electroencephalographic, and Neuroradiologic Features in a Pediatric Case Series' (2014) 55(6) Epilepsia e60-e66.

[63] CP's disabilities were held to be the effects of the harm done to her *in utero* rather than harm occurring following her birth, as the harm had already occurred, but in the case of seizures, new, post-birth harm would be occurring. *CP v CICA* (n 40) [42] (Lord Treacy).

CP v CICA is that in that case the Court of Appeal expressed an intention for the criminal law to reflect the approach of the civil law and to 'be slow to interpret general criminal legislation as applying to [the relationship between a pregnant woman and her foetus].'[64] However, this reluctance to impose criminal liability on women for their conduct during pregnancy is not the exclusion that commentators such as Fovargue and Miola have called for.[65] *CP v CICA* was decided on the basis of the status of the victim at the time the harm occurred leaving the born-alive rule from *Attorney-General's Ref (No 3 of 1994)* in operation and reinforcing the definitional approach of the criminal law. Conceptual reasons as to why the civil law exclusion should be followed were not given. There was no explanation of why the relationship between the potential victim and the potential defendant should mean that criminal liability would be inappropriate in these circumstances. Therefore, while the Court of Appeal has expressed an intention for the criminal law to follow the relational approach of the civil law, without a robust conceptual basis it is not certain that this intention will be followed in all circumstances that come before the courts. Further, while this is a decision of the Court of Appeal the ruling in *Attorney-General's Ref (No 3 of 1994)* which did not adopt a relational approach to prenatal conduct came from the House of Lords and so takes precedence indicating that a purely definitional approach to harmful prenatal conduct is likely to prevail at least where the harm occurs after the child is born alive. Therefore, the intention expressed by the Court of Appeal to follow the civil law is not sufficient to close the door firmly on maternal criminal liability.

If a woman was found guilty of an offence such as gross negligence manslaughter, or

[64] ibid [65] (Lord Dyson MR).
[65] Fovargue and Miola (n 4) 292-293.

inflicting grievous bodily harm under section 20 OAPA, in relation to her conduct during pregnancy which caused harm to her child after he was born alive, it is unlikely that this would be the end of the matter. Those who believe that a woman who drinks heavily during pregnancy has committed a serious moral wrong in the same way as the man who stabs his pregnant partner are unlikely to be satisfied by maternal criminal liability only when some additional harm associated with the alcohol consumption occurs after birth.[66] Arguments will continue to be made for the law to be reformed to hold women legally responsible for harm caused to their future children at the foetal stage. After all, there appears to be little to distinguish the conduct of a pregnant woman which results in harm to her child after he is born alive from the same conduct which causes harm to a foetus that is later born alive. Therefore, the potential for maternal criminal liability for prenatal conduct remains under the born alive rule and could lead to prenatal conduct that causes harm at the foetal stage. Having now established that the door remains ajar to criminal maternal liability for prenatal conduct I will now consider how the intuitive moral judgment of the conduct of pregnant women has the potential to push that door wide open and how a relational approach, which reflects who has caused the harm and how, could address this.

8.3 The moral judgment of the conduct of pregnant women

If we accept that parents are under a moral duty to do what they can to protect their children from unreasonable and avoidable harm then it seems to follow that women

[66] A man who stabs his pregnant partner causing harm to the foetus, rather than to the child after it is born alive, would still face criminal liability for the infliction of grievous bodily harm on the woman.

who intend to bring a foetus to birth have a moral duty to protect their child from harm even if this harm is due to events before its birth. The fact that the child is a foetus rather than a legal person at the time the harmful events occur is irrelevant as the duty is owed to the future child not the foetus.[67] Indeed, as Brazier has argued, a pregnant woman can be seen to be under a particularly strong moral duty not to injure her future child due to the future child's total dependency on the pregnant woman.[68] The argument is that this total dependency, coupled with the woman's intention to bring this future child to birth, mean that the pregnant woman should at least take that future child's interests into account when making decisions. Her conduct during pregnancy will affect the welfare of an individual; that cannot be disregarded on the grounds that that individual is not yet born.[69]

Strong arguments have been made by Brazier and other commentators that it would be inappropriate for this moral duty to be translated into a legal one on the basis that it would be ineffective in preventing harm to future children and it would be an unjustified trespass on women's autonomy.[70] Unfortunately, these arguments have not been sufficient to prevent cases such as *CP v CICA* being pursued in the courts. I argue that it is the interpretation of this moral duty that lies behind cases such as *CP v CICA* and has the potential to push the door to criminal maternal liability for prenatal conduct wide open.[71] The influence of the moral view of pregnancy can be seen in cases such as *Attorney-General's Ref (No.3 of 1994)* itself. As Fovargue and Miola

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[67] Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses,* (Oxford University Press, 1992) Ch 4.
[68] Brazier 'Liberty, Responsibility, Maternity' (n 4) 367.
[69] ibid 369.
[70] ibid, Jackson (n 4); Fovargue and Miola (n 4); Cave and Stanton (n 4).
[71] Something which Fovargue and Miola argue lies behind many of the court ordered caesarean section cases, Fovargue and Miola (n 4) 280-281.

argued:

> The decision in [*Attorney-General's Ref (No.3 of 1994)*] suggests that the courts are willing to interpret the law in such a way as to provide a morally 'correct' outcome. In crossing the gap between moral and legal culpability where a foetus is concerned, the courts have opened up a range of possibilities which have the potential to extend even further than at present.[72]

The courts' desire to interpret the law to achieve a morally 'correct' outcome could therefore lead to the perceived moral duty associated with pregnancy being translated into criminal maternal liability for harmful prenatal conduct at least in circumstances where the harm occurs after the child is born alive.[73] Indeed, as Milne argues, the assumption that a 'good mother' will always act to prioritise the needs of her future child in front of her own (what Milne refers to as the 'foetus-first' mentality) already influences the courts' interpretation of offences such as Concealing the Birth of a Child[74] to punish women for their behaviour during pregnancy.[75] The moral judgment of pregnant women will continue to push on the door to maternal criminal liability while the law is unable to address the argument that a woman whose conduct during pregnancy unintentionally causes harm to her future child has committed a serious moral wrong in the same way as a man who stabs his pregnant partner. Therefore, if we are to avoid the trespass on women's autonomy that criminal liability for behaviour during pregnancy would represent, an approach is needed that distinguishes between a woman whose conduct

[72] ibid.
[73] Brazier argues strongly that this would be inappropriate, Brazier, 'Liberty, Responsibility, Maternity' (n 4).
[74] S 60 OAPA.
[75] Milne (n 5).

during pregnancy unintentionally causes harm to her future child and a third party who unintentionally causes such harm. Having established that the door to maternal criminal liability for unintentional prenatal harm remains open, and the potential for the moral judgment of the conduct of pregnant women to push it wide open, in the next section I will explain why it would be appropriate for the criminal law to adopt a relational approach to finally close that door.

8.4 Why a relational approach is appropriate

The significance of a relational approach, distinguishing between a pregnant woman and a third party who unintentionally cause harm to a future child, lies in its ability to account for the interests that a woman might have in conduct directed towards her own body which would not be engaged in the case of a third party. Although this distinction is missing in the definitional approach taken by the courts in *Attorney-General's Ref (No 3 of 1994)* and *CP v CICA*, I argue that it can be seen in the statutory offences under sections 23 and 58 OAPA.

Starting with the offence considered in *CP v CICA* of administering a poison or noxious substance under section 23 OAPA, we can compare a third party who administers a noxious substance to a foetus *in utero* with a woman who indirectly administers the noxious substance to the foetus by consuming the substance herself. Both of these scenarios are likely to involve indirect administration as the third party would have to administer the substance through the woman's body. Indirect administration has

been held to be included in the meaning of 'administered' in English law.[76] However, in the pregnant woman's case the 'administration' is not only indirect but is through the defendant's own body. The defendant administers the alcohol *to herself* and as a consequence it is administered to the foetus: her actions are towards her own body. Even in circumstances where alcohol is consumed during the latter stages of pregnancy passes to the baby after it is born alive while the umbilical cord is still intact,[77] the pregnant woman should not be considered to have simply administered the alcohol to another person (her baby) but rather to herself.

If a woman drank heavily with the intent of procuring a miscarriage, this would be an offence under section 58 OAPA as she would have administered to herself a noxious substance for the purpose of procuring her own miscarriage. Despite it being noted in *CP v CICA* that the 'focus of section 58 is on the administration of drugs or the use of instruments on the woman rather than the child',[78] the Court of Appeal was of the opinion that the only thing that distinguishes a section 58 offence from a section 23 offence is that the former requires an intention to bring about a miscarriage.[79] The *actus rei* of the two offences were viewed as the same. This ignores the fact that section 58 OAPA refers to 'administering to herself' while section 23 OAPA refers to 'administering to another'. This conflation of the *actus reus* of section 23 OAPA with that of section 58 OAPA misses the significance of Parliament, in enacting section 58

[76] The meaning of 'administered' was defined in the case of *Gillard* (1988) 87 Cr App R 189 which considered it to mean 'takes, postulates some, ingestion' by the victim. Bringing a noxious thing into contact with the body, directly or indirectly, was enough, therefore, spraying with CS gas was included.
[77] This has been the basis for criminalising drug taking in pregnancy in some American States. See for example *Johnson v State 578* So.2d 419 Ct App FL 5th Dist (1991).
[78] *CP v CICA* (n 40) [47] (Lord Treacy).
[79] CP's mother could not be charged with a s 58 offence as she did not have the requisite intention to procure her own miscarriage.

OAPA, only seeing fit to criminalise a pregnant woman's actions towards her own body where she intends to destroy the foetus.

The unique manner in which a pregnant woman may cause prenatal harm is reflected in the construction of the CDCLA. The fact that a pregnant woman's harmful prenatal acts are towards her own body means that maternal civil liability would be impossible under the CDCLA even if the express exclusion in section 1(1) CDCLA had not been included. Liability to a child under the CDCLA is dependent on a duty of care being owed to the parent whose reproductive health is affected.[80] For example, an employer who exposes workers to radiation which causes genetic mutations in his employee's gametes will only be liable to the child born disabled as a result if the employer owes a duty of care to the employee in respect of such exposure. A person cannot be liable in tort to herself and so a pregnant woman could not be liable to her future child for what was referred to in the parliamentary debate putting forward the legislation for its second reading as 'self-inflicted injury'.[81] Therefore, the CDCLA can be seen to reflect the indirect manner in which a pregnant woman may cause prenatal harm. Something that the potential for liability under the principle in *Attorney-General's Ref (No 3 of 1994)* and the definitional approach taken in *CP v CICA*, do not.

The above consideration of the *actus rei* of section 23 and section 58 OAPA demonstrates that the criminal law does recognise that a pregnant woman can cause harm to her future child by acting towards her own body and Parliament has only seen fit to expressly criminalise this when those actions are intended to destroy the foetus.

[80] S 1(3) CDCLA 1976.

[81] Hansard Debate 06 (February 1976, volume 904) 1593 <https://api.parliament.uk/historic-hansard/commons/1976/feb/06/congenital-disabilities-civil-liability> accessed 25 August 2020. However, an exception to this was permitted in the case of negligent driving as noted above.

However, the approach of the common law in *Attorney-General's Ref (No 3 of 1994)* and *CP v CICA* does not recognise the unique way in which a pregnant woman might unintentionally harm her future child. This is problematic because it fails to account for the interests that a woman might have in conduct directed towards her own body which would not be engaged in the case of a third party. In order to illustrate this I will now consider the currently hypothetical scenario of ectogenesis in which a foetus develops outside of the woman's body. Ectogenesis is a useful thought experiment as it removes the physical relationship between a woman and her developing foetus so that the ways in which she can cause harm to that foetus are akin to those of a third party. By comparing this to a bodily pregnancy I will show why it would be appropriate for the criminal law to adopt a relational approach to unintentional prenatal harm.

8.4.1 Ectogenesis

Brazier has set out three considerations for determining the extent to which the law should interfere with a pregnant woman's conduct during pregnancy in the name of protecting the interests of her future child:

1. We cannot demand a woman 'subordinate her interests to the potential child's, where in the case of a child already born no such demand could be made';
2. A woman's obligation is to make judgements based on what is best for herself, her child and any other children; and
3. It must be proportionate and practical and able to be defined within agreed limits.[82]

[82] Brazier, 'Liberty, Responsibility, Maternity' (n 4) 375-376.

In the case of ectogenesis, where a foetus gestates in an artificial womb outside of the woman's body,[83] Brazier's three considerations are clearly less likely to be problematic when considering criminal liability for harmful prenatal acts than when the foetus is within the woman's body. The woman's interests in health, privacy and liberty are not engaged in the same way. Imposing criminal liability on a woman who administered alcohol to an externally gestating foetus would be akin to the demand made in respect of a child already born.[84] The obligation on her in making decisions about the care of the externally gestating foetus is likely still to be to take the interests of her future child into account and weigh these against her own interests and those of her other dependants. However, whatever course of action is in the interests of her externally gestating future child, it is unlikely to represent a significant impact on her own interests in the same way as for a bodily pregnancy.

As others have discussed this is not the case in the current reality of pregnancy.[85] It is the fact that the foetus is developing inside the woman's body that necessitates a different approach by the law rather than the status of the foetus in isolation. The location of the foetus is not simply a matter of geography but a factor which engages the interests of the pregnant woman in a unique way. Further, the location of the foetus changes the nature of the prenatal conduct which might be harmful. For example, FASD could in theory be

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[83] For the purposes of this thought experiment, I use the term 'ectogenesis' to refer to complete ectogenesis, where the foetus is not inside the woman's uterus at any time. I also make the assumption that the externally gestating foetus would not be considered a legal person as it has not been 'born alive' *(Paton v British Pregnancy Advisory Service Trustees* [1978] 2 All ER 987). See Amel Alghrani and Margaret Brazier, 'What is it? Whose it? Re-positioning the Foetus in the Context of Research?' (2011) 70 CLJ 51; Elizabeth Chloe Romanis, 'Challenging the "Born Alive" Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood' (2020) 28 MLR 93.

[84] It is an offence to give a child under 5 alcohol unless in an emergency or under medical supervision, Children and Young Persons Act 1933.

[85] See note 4 above.

caused in ectogenesis by the expectant mother administering alcohol to the external foetus but in a bodily pregnancy it could be caused by the pregnant woman administering alcohol to herself. Similarly, avoiding causing such harm in the case of ectogenesis would require the woman not to administer alcohol to another being (even if not another person) something which other individuals are also required to do in instances where that could result in harm. For example, even administering alcohol to an animal can be a criminal offence under section 7 Animal Welfare Act 2006.

In the scenario of ectogenesis the actions of a woman who administers alcohol to the external foetus are akin to those of the third party in *Attorney-General's Ref (No 3 of 1994)* in that her actions are directed towards another being rather than herself.[86] If that caused harm either to the external foetus or to the resulting child later 'born' alive, there would be a strong argument in favour of criminal liability for that harm. After all, the woman would have administered a noxious substance to another being resulting in harm to that being.[87] This might mean that a definitional rather than a relational approach would be appropriate in the scenario of ectogenesis, however, this is not the case with a bodily pregnancy.

8.4.2 A relational approach to prenatal harm

We need to be clear about what behaviour would be criminalised in the case of

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[86] Although not towards a legal person. See note 33 above.

[87] While this might not come under any existing offence, we might be justified in creating an offence or even amending s 23 OAPA to include an external foetus as a potential victim (although this would be in conflict with the title of the Act which refers to offences against the *person*). This would then cover intentional *and reckless* harm by administration of a noxious substance to the external foetus. For example, if a woman administered a potentially harmful substance to her external foetus in the hope that it would make her baby taller, provided she was aware of the risk of harm to her future child, she would have committed an offence under the modified version of s 23 OAPA.

unintentionally harmful prenatal conduct of pregnant women. Take the example of FASD linked to heavy drinking during pregnancy. Avoiding such harm in a bodily pregnancy would require the pregnant woman to avoid alcohol or at least restrict her consumption to a minimal amount for the whole nine months of pregnancy. Alcohol is an addictive substance and it would seem likely that those who drink heavily would be influenced by some level of addiction. This raises questions regarding the appropriateness of criminal liability in circumstances of addiction.[88]

Returning to Cave and Stanton's example of the woman who takes heroin during pregnancy causing the death of her child after it is born alive; in this scenario the pregnant woman could be guilty of manslaughter following the reasoning in *Attorney-General's Ref (No 3 of 1994)* as the death would be of a child who had been born alive. It would be irrelevant that the perpetrator was the pregnant woman; she would be considered as much to blame for the unintended death of the child as the man who stabbed his pregnant partner. This leaves no room for consideration of the argument that an individual who fails to resist a highly addictive substance such as heroin and administers it to herself bears a very different level of moral blame for the unintended consequences of her actions than a third party who attacks a pregnant woman.[89] The same argument applies to alcohol consumption.

Unfortunately, in *CP v CICA*, it was not contested that CP's mother had administered alcohol to the foetus[90] and so an opportunity was missed for the court to highlight

[88] For a discussion on this topic see Tony Honoré, *Responsibility and Fault,* (Bloomsbury, 2002) Chapter 6, 121-142; Julia Tolmie, 'Alcoholism and Criminal Liability' (2001) 64 Mod Law Rev 688.
[89] Indeed, Emma Cave argues that seeking retribution from pregnant addicts for prenatal harm resulting from their addictions would be inappropriate as they have little choice or control over that behaviour. Cave 'Mother of All Crimes' (n 11) 86-8.
[90] *CP v CICA* [14] (Lord Treacy).

that what it was being asked to consider a crime of violence was the failure to resist administering to herself a highly addictive substance for nine months or more. Had it done so, the argument could then have been made that this was not sufficiently blameworthy behaviour to be subject to criminal penalties. This is clearly illustrated in *CP v CICA* itself as CP's biological mother had shown what might be considered superhuman levels of self-control and determination in giving up illicit drugs and reducing her alcohol intake considerably for the sake of her future child, but still CP suffered from FASD.[91] Although a full discussion of this issue is beyond the scope of this paper, the point remains that addiction plays a role in harmful maternal prenatal conduct in a way it does not for third parties. There is a debate regarding the impact of addiction on criminal liability[92] and the criminal law on prenatal conduct can only take account of and inform this debate, if it adopts a relational approach to prenatal conduct.

The wider need for a relational approach is illustrated by Wilkinson et al's argument that:

> In the non-lethal gestational harm case, where a pregnant woman ingests a toxin that she is aware will harm her future child, she should be held accountable for that wrong.[93]

As Wilkinson et al appear to acknowledge, the blameworthiness of the pregnant woman

[91] *CICA v First-tier Tribunal and CP (CIC)* [2013] UKUT 0638 (AAC) [3].
[92] See Tolmie 'Alcoholism and Criminal Liability' (n 88).
[93] Wilkinson and others (n 5) 428.

might be influenced by addiction.[94] However, I would argue that referring to heavy drinking during pregnancy as simply 'a pregnant woman ingesting a toxin' is not sufficiently accurate to enable a proper consideration of blameworthiness to take place. This description does not reflect the fact that the unique relationship of pregnancy means that what would be criminalised is the failure to maintain a sufficient 'maternal environment' for nine months or more. If we acknowledge that adults have an interest in consuming substances which might be considered toxins such as alcohol or medicines, what we would be criminalising is the failure of pregnant women to subordinate their own interests to those of their future children. It is this oversimplification of the nature of the conduct that leads to the assumption that ingesting a toxin that she is aware will harm her future child will be a wrong. The fact that she might have other interests served by administering that toxin *to her own body* is lost in this description. For example, if she ingests a toxin as part of chemotherapy treatment.

As the criminal law is concerned with harm caused in a blameworthy manner it would be appropriate for it to adopt a relational approach to prenatal harm as this would enable it to capture the moral nature of the unintentionally harmful prenatal conduct. Once this has been achieved, the argument that pregnant women whose conduct unintentionally causes harm to their future children should face criminal penalties because they have caused harm to those future children in an equally morally blameworthy manner as the man who stabs his pregnant partner, can be shown to be inaccurate. This has the potential to finally close the door to maternal criminal liability for unintentionally harmful prenatal conduct.

[94] Although, their argument appears to be that some factors that might lead to addiction (rather than the addiction itself) could warrant a more lenient approach, ibid 431.

8.5 Conclusion

The rulings in *Attorney-General's Ref (No 3 of 1994)* and *CP v CICA* leave open the possibility of women being held criminally liable for their conduct during pregnancy which unintentionally causes harm to their future children, at least where that harm occurs after the child has been born alive. The potential for this door to be pushed wide open is increased because the criminal law leaves no room for the argument to be made that a pregnant woman whose conduct unintentionally harms her future child is not worthy of the same level of moral blame for the unintended consequences of her actions as a third party who attacks a pregnant woman. While the criminal law views pregnant women in this way, arguments in favour of criminalising women for their behaviour during pregnancy based on misguided notions of 'bad mothering' cannot be fully addressed. It would be appropriate to adopt a relational approach to harmful prenatal conduct as this would enable the criminal law to take account of the different reasons and interests pregnant women might have for acting towards their own bodies compared to third parties acting towards another individual and the implications of this for the blameworthiness of their conduct. This approach is also desirable because it could lend valuable support to those who call for the door to maternal criminal liability to be firmly closed by addressing the arguments in favour of such liability based on misguided notions of what constitutes the 'good pregnant woman'. The question which follows on from this discussion is *how* should a relational approach to prenatal conduct be reflected in the criminal law? Although a detailed consideration of this question is beyond the scope of this paper, it seems that we will have to wait for a decision of the Supreme Court limiting the ruling in *Attorney-General's Ref (No 3 of 1994)* to cases involving

third parties and distinguishing this from considerations of maternal conduct, if and when such an opportunity arises. This is necessary both to protect the interests of pregnant women and to enable the criminal law to accurately consider when harm has been caused in a blameworthy manner. Until then, in the absence of legislative reform, there is a risk that the particular moral condemnation directed at pregnant women could translate into criminal maternal liability for prenatal harm with the extreme intrusion into women's lives this would represent.

CHAPTER 9 - PAPER FOUR: Is the unequal treatment of maternal and paternal liability under the Congenital Disabilities (Civil Liability) Act 1976 justified?

9.1 INTRODUCTION

Under the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) a child born disabled as a result of an occurrence prior to its birth can bring a claim against the individual responsible for that occurrence. Significantly, mothers are exempt from liability under the CDCLA (except in relation to negligent driving) but fathers are not.[1] Since the CDCLA came into force in 1976, there have been significant shifts in the landscape in which it operates: the move towards an acceptance of a more gender-neutral model of parenting; non-disclosure of a sexually transmitted infection to a sexual partner can now be the basis of a criminal offence; and there is growing evidence regarding the impact of prenatal events on future children. In addition, there is a growing trend for presenting prenatal harm as a problem of individual behaviour.[2] This article presents a timely consideration of the potential for parental liability under the CDCLA and asks whether restricting the exemption of parental liability to mothers but not fathers can be justified in light of these shifts.

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[1] In the context of this paper I use 'father' to refer to the genetic father or sperm donor and 'mother' and 'pregnant woman' to refer to the genetic mother and gestator. I acknowledge that not all sperm donors or pregnant people will identify with these terms.

[2] Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Hart Publishing 2001) 151-159, Catherine Bowden, 'Are We Justified in Introducing Carbon Monoxide Testing to Encourage Smoking Cessation in Pregnant Women?' [2019] 27(2) Health Care Anal 128.

The arguments in favour of the unequal treatment of maternal and paternal liability differ depending on the timing of the event. Therefore, it is necessary to distinguish between three categories of events which could lead to liability under the CDCLA; those that occur prior to conception (pre-conception harm), those that occur at the time of conception (conception harm) and those that occur during pregnancy or birth (gestational harm). I will consider each of these in turn to establish precisely how the liability of mothers and fathers is unequal under the CDCLA before considering whether such an inequality is justified. This will lead me to conclude that while there are reasons for treating paternal and maternal liability differently in relation to gestational harm these are not sufficient to justify restricting the broad exemption to mothers but not fathers. Therefore, a change in the law is required to bring the CDCLA up to date with advances in the criminal law, society and medical science.

9.2 LIABILITY UNDER THE CDCLA

The CDCLA was brought into law following the thalidomide tragedy[3] to provide compensation for a child born alive suffering disabilities as a result of either, an occurrence prior to conception which affected either parent's ability to have a healthy child, an occurrence affecting the mother during pregnancy, or one affecting the mother or child during its birth.[4] Any such liability under the CDCLA is dependent on a breach of legal duty owed to the parent although there is no requirement that the affected parent is harmed themselves.[5] In this way, although the claim is brought by the child, it reflects liability for harm done to the parent's ability to have a healthy child. For example, if a doctor fails to warn a pregnant woman of a risk associated with a caesarean section and that risk

[3] See Harvey Teff and Colin R. Munro, *Thalidomide: The Legal Aftermath* (Saxon House 1976).
[4] CDCLA, s 1.
[5] CDCLA, s 1(3).

materialises causing the child to be born disabled, whether that child can bring a claim against the doctor will depend on whether the risk was one which the doctor had a duty to warn the woman of.[6] If there was no duty to warn the woman of that risk the child will have no claim. Crucially, the CDCLA provides an exemption for harm due to the actions of the child's mother, other than for injuries caused by negligent driving.[7] Therefore, a child cannot sue its mother for harm suffered as a result of her conduct before or during pregnancy, or her choices regarding delivery.[8] There is no equivalent exemption for paternal conduct.

Before I can consider whether the unequal treatment of maternal and paternal liability under the CDCLA is justified, I must first establish that the treatment *is unequal* by demonstrating that paternal liability is a possibility where maternal liability is not.

9.3 Is paternal liability possible where maternal liability is not?

Under the CDCLA, section 1(1), the child's mother is excluded from liability under the Act but there is no parallel provision excluding fathers from liability. Although fathers are not included in the exemption under CDCLA, section 1(1) this might not amount to unequal treatment if paternal liability is not possible for another reason. Indeed, in 1997 Margaret Brazier argued that the exclusion of maternal but not paternal liability under the CDCLA was justified in part because the construction of the CDCLA meant that liability for either parent

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[6] The question of whether the risk falls within the scope of the doctor's duty to warn will be decided by applying the principle in *Montgomery v Lanarkshire* [2015] UKSC 11 discussed below.

[7] CDCLA, s 2. As a policy decision the maternal exemption does not apply to liability in relation to negligent driving as such liability would be covered by motor insurance which is a legal requirement for all drivers. Law Commission, *Injuries to Unborn Children* (Law Com No 60, 1974) para 60.

[8] The CDCLA does take some account of the potential for maternal responsibility in that in a case where a child is suing a third party such as the mother's doctor in relation to an injury suffered prenatally, under CDCLA, s 1(7) the child's damages may be reduced if the mother contributed to the disability. As Brazier and Cave note, this provision envisages cases where a pregnant mother contributes to the child's disability by smoking, drinking or failing to take precautions, against medical advice. M Brazier and E Cave, *Medicine, Patients and the Law* (6th edn, Manchester University Press 2016) 344.

was extremely unlikely even without the exclusion.[9] This is supported by the lack of claims against fathers since the CDCLA has been in force. However, since then there have been significant developments in medical science and in the law on the duty to warn sexual partners of sexually transmissible infections which mean that paternal liability might not be as unlikely as it once was. If this is the case, paternal liability would be possible under the Act where maternal liability is not. In order to establish the potential for paternal liability under the CDCLA I will consider parental liability for gestational, pre-conception and conception harm separately.

9.4 Gestational Harm

The construction of the CDCLA means that liability of either parent for gestational harm is only possible in very limited circumstances even without the maternal exclusion in section 1(1).[10] As explained above, the CDCLA does not create a duty of care, it merely extends any existing duty of care owed to the affected parent to also provide a cause of action for the child born disabled as a result of the defendant's actions. Therefore, any liability of a mother to her child would be dependent on her already owing a duty of care to the child's father which, if breached, could affect his ability to have a healthy child (the mother could not owe a duty of care to herself) and vice versa.

Without the exclusion in CDCLA, section 1(1) maternal liability for gestational harm might be possible under the Act. For example, if the pregnant woman was the father's employer

[9] Margaret Brazier 'Parental Responsibilities: Foetal Welfare and Children's Health' in C Bridge (ed), *Family Law Towards the Millennium: Essays for P M Bromley* (Butterworth-Heinemann Ltd 1997).
[10] Except for liability in relation to negligent driving by the mother which does not depend on a duty of care to the affected parent.

she would owe him a duty of care as his employer, and she could breach this duty by having an unsafe work environment (perhaps stress or exposure to a toxin). Even if this does not harm the father, if it harms her future child that child could potentially claim against the mother for disability if the maternal exemption was not in place. It is questionable whether this would count as having affected the father's ability to have 'a normal, healthy child'[11] as the harm is occurring through the pregnant woman's body and so it may be the mother rather than the father who is considered to be the affected parent. However, it could be argued that the pregnant woman's breach of duty towards him has prevented him having the normal, healthy child he otherwise would. Even if technically possible, such liability seems highly unlikely particularly as the child would be able to claim against the company employing his father rather than the mother as an individual. If maternal liability for gestational harm is at most a remote possibility even without the exclusion in section 1(1), the exclusion has little impact on liability in relation to gestational harm.

What about paternal liability for gestational harm? As the CDCLA does not create a new duty of care, paternal liability is dependent on the father owing an existing duty of care to the pregnant woman or otherwise being liable to her in tort.[12] Perhaps the clearest example of this is where a father commits an intentional tort such as a battery against his pregnant partner. In this case the father would be liable to the mother in tort and so would be liable to the child under the CDCLA for any disabilities it was subsequently born suffering from as a result of the battery.

[11] CDCLA, s 2(a).
[12] Brazier (n 9) 275.

Is paternal liability for *negligent* gestational events possible under the CDCLA? For example, if a man regularly smokes in the home he shares with his pregnant partner, knowing that there is a risk to the health of his partner and the future child, could this be a breach of a duty care in negligence? The existence of a duty of care would most likely depend on the three-part test set out by the House of Lords in the case of *Caparo v Dickman*: (i) damage must be reasonably foreseeable as a result of the defendant's conduct; (ii) the parties must be in a relationship of proximity or neighbourhood; and (iii) it must be considered fair, just, and reasonable to impose liability.[13] The first two requirements are likely to be satisfied as firstly, it is foreseeable that the woman could suffer harm from the effects of passive smoking as this is a known risk,[14] and secondly, there is likely to be sufficient legal proximity as there is a close relationship between the father and his pregnant partner which could be argued to be a relationship of some responsibility. However, even if these requirements are met, there are strong arguments against imposing liability on the basis that it would not be fair, just, and reasonable.[15] Interfering with an individual's conduct in the privacy of their own home requires a high degree of justification, and it is difficult to see what would be gained from litigation in these circumstances.[16] In addition, the partner has some degree of choice over whether smoking is permitted in the home and/or whether she remains in the same room as

[13] [1990] UKHL 2, [1990] 2 AC 605. This was confirmed as the relevant test for novel scenarios in which there is no established duty of care in negligence in the case of *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4.

[14] The NHS website states that 'Secondhand smoke is dangerous, especially for children. The best way to protect loved ones is to quit smoking. At the very least, make sure you have a smokefree home and car…Pregnant women exposed to passive smoke are more prone to premature birth and their baby is more at risk of low birthweight and cot death.' NHS 'Passive Smoking' <https://www.nhs.uk/live-well/quit-smoking/passive-smoking-protect-your-family-and-friends/> accessed 20 May 2021

[15] Many of these arguments apply to paternal liability in general and are discussed below.

[16] Imposing liability on an individual for smoking in their own home could also raise human rights issues. The smoker might argue that such liability interferes with his right to respect for home and private life under article 8 of the European Convention on Human Rights as given effect by the Human Rights Act 1998. However, this would have to be balanced against the claimant's article 8 rights to not be exposed to smoke. For a consideration of the case law on this point see John Coggon, 'Public Health, Responsibility and English Law: Are There Such Things as No Smoke without IRE or Needless Clean Needles' [2009] 17 Med L Rev 127; Neil Allen, 'A human right to smoke?' [2008] 158 New Law J 886; Yvette van der Eijk and Gerard Porter, 'Human rights and ethical considerations for a tobacco-free generation' [2015] 24(3) Tob Control 238.

her partner when he smokes or not. Further, even if a duty of care were held to exist, liability under the CDCLA would still be unlikely as the mother (the affected parent) would be likely to have been aware of the risk and viewed as having chosen to accept that risk in all but exceptional circumstances.[17]

Therefore, in relation to gestational events, it seems that the only significant potential for paternal liability is where the father's conduct represents an intentional tort such as a battery against the pregnant woman. As any liability pregnant women could have faced for gestational harm is excluded under the CDCLA, we can conclude that there is unequal treatment of mothers and fathers in relation to gestational harm under the CDCLA.

9.5 Pre-Conception Harm

There is a growing body of medical science demonstrating the impact of the pre-conception behaviour of both men and women on the health of their future offspring.[18] Fathers are not exempt from liability under the CDCLA for pre-conception conduct such as smoking or drug taking which damages their own gametes leading to their future children being born disabled. However, such liability is unlikely as this would require the man to owe a duty of care to his sexual partner, or even his future sexual partner, to tailor his conduct in order to safeguard her ability to have healthy children. It is highly improbable that the law would ever consider it fair, just and reasonable to impose such a duty given the extreme interference with

[17] CDCLA, s 1(4).
[18] For example, Kathleen Abu-Saad and Drora Fraser, 'Maternal nutrition and birth outcomes' [2010] 32(1) Epidemiologic Reviews 5; Jonathan Day and others, 'Influence of paternal preconception exposures on their offspring: through epigenetics to phenotype' [2016] 5(1) Am J Stem Cells 11; D Savitz, P Schwingl and M Keels, 'Influence of paternal age, smoking, and alcohol consumption on congenital anomalies' [1991] 44(4) Teratology 429.

individual liberty this would represent.[19] For example, such a duty might hold a man liable for taking a job as a research scientist in nuclear energy (with the risk of exposure to radiation and damage to his sperm[20]) decades before he had either contemplated fathering a child or met the woman with whom he would have a child. The improbability of such a duty of care existing in relation to pre-conception harm at the gamete stage means that the lack of paternal immunity under the CDCLA does not represent unequal treatment in any meaningful way in relation to pre-conception harm.

9.6 Conception Harm (Failure-to-Warn)

A more problematic way in which unequal treatment arises under the CDCLA is in relation to cases involving a duty to warn a sexual partner of risks such as sexually transmitted infections such as HIV prior to them having unprotected sexual intercourse. If there were such a duty and the risk was not disclosed, any resulting child that is born HIV positive could have a potential claim against him under the CDCLA.[21]

At the time that the CDCLA came into force liability based on such a duty was unlikely on two grounds. First, it had not been considered a criminal offence for an individual to infect a sexual partner with HIV having failed to inform that partner of his HIV positive status and so it was unclear whether a duty existed to disclose HIV status to a sexual partner in the civil law of negligence. This has since changed with the criminal case of *R v Dica.*[22] Secondly, it was possible that claims by a child under the CDCLA would be excluded as wrongful life

[19] Brazier (n 9) 275-276.
[20] Although there are evidential issues in proving causation in such cases – see for example, *Reay v British Nuclear Fuels Plc* [1993] 10 WLUK 71.
[21] Brazier (n 9) and Catherine Stanton, 'Genetic transmission of disease: a legal harm?' 24 [2016] Health Care Anal 228, 240-241.
[22] [2004] EWCA Crim 1103, [2004] QB 1257.

claims following the ruling in *McKay v Essex*.[23] However, both of these grounds have shifted, making paternal liability under the CDCLA more likely.

9.6.1 Is there a duty to disclose HIV status to a sexual partner?

In the criminal case of *R v Dica,*[24] Dica was convicted of two counts of inflicting grievous bodily harm contrary to Offences Against the Person Act 1861 (OAPA), section 20 after he infected his lovers with HIV. The Court of Appeal held that the transmission of an infection can amount to the infliction of harm for the purposes of OAPA, sections 18 and 20 and that consent to sexual intercourse should not be regarded as consent to the risk of consequent disease.[25] The lack of consent to the risk of contracting HIV did not vitiate the consent to the sexual intercourse so that the charge is one of rape. However, this did not preclude a conviction for inflicting serious bodily harm as an assault is no longer required for this offence; it simply requires that serious harm is inflicted on the victim without her consent.[26]

The reasoning in *R v Dica*[27] falls short of making it a criminal offence to fail to disclose one's HIV status to a sexual partner as it is the transmission of the infection that founds a conviction under OAPA, section 20, not the failure to disclose the risk; a conviction is only possible if the infection has in fact been passed on following the failure to disclose the risk. However, the judgment in *R v Dica*[28] can be used to make a strong argument that a duty of

[23] [1982] 1 QB 1166, [1982] 2 All ER 771; Brazier (n 9) 276
[24] *R v Dica* (n 22).
[25] ibid [59].
[26] This reasoning has been followed in cases such as *R v Golding* [2014] EWCA Crim 889 and *R v Konzani* [2005] EWCA Crim 706. Cases such as *Assange v Sweden* [2011] EWHC 2849 (Admin), *R(F) v DPP* [2013] EWHC 945 (Admin), [2014] QB 581 and *McNally* [2013] EWCA Crim 1051 re-opened the question of whether non-disclosure could invalidate consent for the purposes of sexual offences, however, it seems likely that non-disclosure of HIV would not invalidate consent as it does not alter the nature of the act as discussed in Law Commission, *Reform of Offences Against the Person* (Law Com No 361, 2015) 157-159.
[27] *R v Dica* (n 22).
[28] ibid.

care to disclose material risks to sexual partners should be recognised in the civil law of negligence.

As explained above, a duty of care in negligence can be established in a novel scenario by applying the requirements set out in *Caparo v Dickman.*[29] The requirements of foreseeability of harm and legal proximity between the claimant and the defendant are likely to be satisfied as it is known that HIV can be transmitted via unprotected sexual intercourse and there is a close connection between the claimant and defendant who have assumed some responsibility towards each other by becoming sexual partners.[30] It seems likely that such a duty would be considered fair, just and reasonable as following *R v Dica,*[31] a breach of such duty could lead to criminal liability if the infection is passed on.

It could be argued that the current lack of civil claims indicates that a civil duty of care between sexual partners is unlikely to ever be more than hypothetical. However, there are several reasons to believe that such a duty is a real possibility. First, as I argue below, the landscape in which the law operates has shifted due to developments in societal norms, the criminal law, and medical science, meaning that the current lack of cases is not guaranteed to continue. Secondly, civil liability between sexual partners is a reality in other jurisdictions such as the USA[32] and Canada.[33] Thirdly, some law firms in the UK are already indicating in

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[29] [1990] UKHL 2.
[30] As argued by Stanton in relation to a duty to warn sexual partners of genetic risks, Stanton (n 22).
[31] *R v Dica* (n 22).
[32] Lane Powell PC 'Liability for transmission of HIV and other sexually transmitted diseases in Washington' Lexology, (*Lexology*, 5 May 2011) <https://www.lexology.com/library/detail.aspx?g=617851df-13a5-4e31-9d81-2773c133f75e> accessed 28 March 2022; Adam Liptak 'People who pass on AIDS virus may be sued', (*New York Times*, 4 July 2006) <https://www.nytimes.com/2006/07/04/health/people-who-pass-on-aids-virus-may-be-sued.html> accessed 28 March 2022; Neil Shouse 'Can I sue someone for giving me herpes?' (*Shouse Injury Law Group*, 8 July 2021) <https://www.shouselaw.com/ca/blog/personal-injury/can-i-sue-someone-for-giving-me-herpes/> accessed 28 March 2022.
[33] Anna Matas 'Liability and the sexually transmitted disease' (*The Lawyers Weekly*, 7 February 2014) <https://lernerspersonalinjury.ca/wp-content/uploads/Liability-and-the-sexually-transmitted-disease.pdf> accessed 28 March 2022.

their promotional material that civil claims against partners for transmission of HIV could be possible.[34] Fourthly, an absence of reported claims does not necessarily mean that no claims have been made; it is possible that claims have settled out of court. Therefore, a civil law duty to warn sexual partners of material risks seems a real possibility.[35]

The parameters of the duty to warn in a medical context might provide a useful model for determining what would count as a 'material risk' to be disclosed between sexual partners. The case of *Montgomery v Lanarkshire*[36] established that in a medical context a risk is material if:

> …in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.[37]

It seems reasonable to suggest that an individual should have a duty to inform a sexual partner of risks which a reasonable person in the partner's position would attach significance to, or that the individual is or should be reasonably aware that the particular partner would be likely to attach significance to. Basing the duty on this model would take account the seriousness of an HIV infection, the likelihood of transmission, and any particular concerns of the particular partner. This would not necessarily support a blanket duty to inform a

[34] Cohen Cramer Solicitors 'Catching a sexually transmitted disease' <https://www.cohencramerpi.co.uk/cica-claims/claims-for-victims-of-rape-and-sexual-assault/claim-for-sexually-transmitted-disease/> accessed 28 March 2022; Katie Allard 'HIV – still a death sentence?' (*Kingsley Napley*, 20 November 2015) <https://www.kingsleynapley.co.uk/insights/blogs/medical-negligence-and-personal-injury-blog/hiv-still-a-death-sentence> accessed 28 March 2022.

[35] Margaret Brazier cites the case of *Shepherd v Davies* (1 November 1989, unreported) in support of a duty of care between sexual partners but I have not been able to find details of this case. Brazier (n 9) 276.

[36] [2015] UKSC 11.

[37] ibid [87].

sexual partner of a HIV-positive status: for example, if the individual was taking medication and was frequently tested showing a minimal viral load and condoms were being used. However, given the potential seriousness of an HIV infection, it would support a duty of care to inform a sexual partner of HIV-positive status if the risk was more than minimal or that partner had expressed a concern regarding contracting HIV.[38]

If there were a duty of care in negligence to disclose risks of serious infections to sexual partners, liability under the CDCLA could exist even where the infection is not passed on to the sexual partner. This is because it is possible for the infection to be passed from the father to the child without the mother being infected.[39] If the defendant (D) failed to disclose his HIV status to the victim (V) but the infection was not in fact transmitted, it is likely that D owed V a duty of care to disclose and D breached that duty. There would be no causation of any recoverable loss to V. Therefore, V's claim in negligence would fail. However, that would be no barrier to a subsequent child born disabled as a result of that failure to disclose bringing a claim against D under the CDCLA. Therefore, following *R v Dica*,[40] it seems likely that a duty to disclose HIV status to a sexual partner would be recognised in negligence.

9.6.2 Would such claims be prohibited as claims for wrongful life?

The second reason that at the time the CDCLA was passed it was unlikely that a child could bring a claim based on a duty to disclose risks of sexually transmitted infection such as HIV,

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[38] For a discussion of how the varying levels of risk and definitions of sexual partners might affect a duty to disclose risks to sexual partners (pre *R v Dica*) see Rebecca Bennett, Heather Draper and Lucy Frith, 'Ignorance is bliss? HIV and moral duties and legal duties to forewarn' [2000] 26(1) J Med Ethics 9.
[39] S Murugan and R Anburajan, 'Father to child transmission of human immunodeficiency virus disease while sero-discordant status of the mother is maintained' [2013] 34(1) Indian J Sex Transm Dis AIDS 60.
[40] *R v Dica* (n 22).

is the potential for such a claim to be prohibited as a claim for wrongful life. Medical science at the time was such that in these circumstances the only way for that child to not have been born suffering from HIV was for her conception not to have taken place and her not to have been born at all. In the view of the Court of Appeal in *McKay v Essex AHA*,[41] such claims lie outside the scope of the CDCLA as the aim of the CDCLA is to compensate children born with disabilities which would not otherwise have been present.[42] However, following the recent case of *Toombes v Mitchell*[43] it is no longer clear that such claims would be prohibited and even if they were prohibited, the treatment options now available mean that non-existence is no longer the only way of avoiding the harm.

9.6.3 Toombes v Mitchell[44]

The question of how the prohibition on claims for wrongful life impacts on claims under CDCLA, section 1(2)(a) was considered in the recent case of *Toombes v Mitchell*.[45] The claimant in this case had been born with a neural tube defect causing spinal cord tethering resulting in limited mobility and double incontinence. She alleged that her disability was caused by her mother's failure to take folic acid supplements prior to her conception as a result of her general practitioner's failure to advise her of the benefits of such supplements. It was the claimant's contention that but-for the Defendant GP's failure to advise her mother of the benefits of folic acid, her mother would have delayed attempting to conceive until she had increased her folic acid levels and therefore the claimant would not have been born. Any child that would have been subsequently conceived would have been a genetically different

[41] *McKay v Essex* (n 23).
[42] See J Fortin 'Is the "Wrongful Life" Action Really Dead?' [1987] J Soc Wel L 306.
[43] [2020] EWHC 3506 (QB).
[44] ibid.
[45] ibid.

person to the claimant. The issue for the Court was whether such a claim for wrongful conception and birth represents a lawful cause of action under the CDCLA. The Court drew a distinction between claims involving an occurrence during pregnancy under CDCLA, section 1(2)(b) and claims under section 1(2)(a) which deals with preconception occurrences. CDCLA, section 1(2)(b) carries the rider 'so that the child is born with disabilities which would not otherwise have been present' which the Explanatory Note to the draft Bill explains as follows:

> the clause gives the child no right of action for 'wrongful life' […] Subsection (2)(b) is so worded as to import the assumption that, but for the occurrence giving rise to a disabled birth, the child would have been born normal and healthy (not that it would not have been born at all).[46]

However, section 1(2)(a) relating to preconception occurrences does not contain this rider and so does not prohibit claims by children who, but for the wrongful act, would never have been conceived. In relation to preconception occurrences Lambert J. stated that:

> …all that a claimant must prove to come within the Act is a wrongful act or omission leading to an occurrence (as defined) which results in a child who is born with disabilities. Unlike in a post-conception case, there is no need for the claimant to prove that, but for the wrongful act, he or she would still have been born. It is sufficient that the claimant was, in fact, born with a disability resulting from the occurrence.[47]

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[46] CDCLA (n 7) [6].
[47] *Toombes v Mitchell* (n 45) [53].

On this basis Lambert J. held that sexual intercourse without the protective benefit of folic acid supplementation was a relevant occurrence for the purpose of section 1(2)(a) and therefore, a claim such as this, based on the assertion that the conception itself had harmed the claimant, was valid.[48] This is supported by the Law Commission's opinion that a child's claim based on her father's failure to inform her mother that he was infected with a sexually transmissible disease prior to sexual intercourse would *not* amount to a claim for wrongful life. In the Law Commission's opinion:

> Where the disabilities with which a child is born are actually caused by the sexual intercourse which results in his conception we do not think that any action he may have for such disabilities is properly called a 'wrongful life' action. It is not for being born that he seeks a remedy but for compensation for the disability resulting from the sexual intercourse. If that sexual intercourse and consequent disability can be shown to have resulted from the fault of another, then we do not think that the child should be without a remedy.[49]

Therefore, claims based on the mother's assertion that had she been informed of the father's HIV status she would not have had unprotected sexual intercourse with him, would appear not to be prohibited as claims for wrongful life.

A different view was taken by Lord Justice Henderson in the Court of Appeal in *Criminal Injuries Compensation Authority v First-tier Tribunal and Y (CICA v F-tT and Y)*[50] for the

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[48] ibid [46]-[48].
[49] CDCLA (n 7) [88].
[50] [2017] EWCA Civ 139.

purposes of a claim under the Criminal Injuries Compensation Scheme. Henderson L.J. was of the opinion that for an injury to have taken place the individual must have previously existed (albeit as an embryo or foetus) in an uninjured state. In his opinion, a claim in relation to conception harm was a claim for wrongful existence and as such was not one for which compensation could be assessed as held in *McKay v Essex*.[51]

If claims based on the mother's assertion that had she been informed of the father's HIV status she would not have had unprotected sexual intercourse with him at all were not barred as claims for wrongful life; it is also possible that claims based on the mother's assertion that had she been informed of the father's HIV status she would have not had unprotected sexual intercourse with him *at that time*, but would have on another occasion to which the same risk would attach, could also succeed. Causation could be established on a similar basis to that in *Chester v Afshar*.[52] The risk of the resulting child being infected would be unaffected by the failure to warn (as in *Chester*) and that risk would be less than 50% at any time.[53] Therefore, but-for the failure to warn, on the balance of probabilities the harm would not have occurred and the principle in *Chester* could be applied to establish legal causation.[54] Factual causation does not fail because the claimant *could* still have suffered the same harm on another occasion, but only if the claimant *would* have suffered the harm, on the balance of

[51] ibid [31].
[52] [2004] UKHL 41.
[53] Prior to interventions the risk in Europe of vertical transmission (parent to child) of HIV was approximately 20% and with interventions this is reduced to about 1%. L Sherr and N Barry (2004) 'Fatherhood and HIV-positive heterosexual men' 5 [2004] HIV Med 258, 260.
[54] As explained by the Court of Appeal in *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 [56-58], factual causation had been established in *Chester* on a traditional 'but-for' basis. The claimant faced a 2% chance of the harm occurring on the day she had the procedure. If she had the procedure on another day she would have faced the same 2% risk. Therefore, if she had been warned of the risk and so had the procedure on another day, the chance that she would have still suffered the harm is only 2%. This means that on the balance of probabilities, but-for the failure-to-warn, her harm would not have occurred. Thus, factual causation was established. The question in *Chester* was one of legal causation i.e. whether the fact that if warned of the risk the claimant would still have had the procedure but on a different day, made the loss too remote to be recoverable at law. In *Chester* it was held that in order to uphold the claimant's right to autonomy and dignity, legal causation was established. *Chester* (n 54) [24], Lord Steyn.

possibilities.[55] However, subsequent cases have confined the principle in *Chester* to its particular circumstances,[56] and so it is not clear if the argument in *Chester* could be relied upon to establish causation beyond a failure to warn of a risk of treatment scenario.

Lambert J. justified limiting the classification of prohibited wrongful life claims to those involving post-conception occurrences and not pre-conception occurrences on the basis that post-conception occurrences engage social and moral policy issues in a unique way:

> A negligent failure to prevent the birth of an already conceived child engages a range of social and moral policy issues, not least the imposition upon the medical profession of a duty to advise abortion in possibly dubious circumstances. However, claims based upon a wrongful act before conception which leads to the intercourse and conception raise no such difficulties.[57]

Thus, a distinction is drawn between claims in which the child says it would have been better if her mother had aborted her pregnancy, and claims in which the child says that it would have been better if her mother had not conceived her. Given that in both of these scenarios the alternative for the child is non-existence and the mother could bring a claim for wrongful birth in either scenario, it is not clear why this distinction should be relevant from the child's perspective.

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[55] T Clark and D Nolan 'A critique of *Chester v Afshar*' 34 (4) [2014] Oxf J Leg Stud, 664.
[56] *Duce* (n 56), *Beary v Pall Mall Investments* [2005] PNLR 35, *Meiklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120, *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356, and *Shaw v Kovac* [2017] 1 WLR 4773.
[57] *Toombes v Mitchell* (n 43) [52].

The interpretation of CDCLA, section 1(2)(a) in this case appears to be reflecting the role of the CDCLA in protecting the reproductive health of the parent. What was central to the decision in *Toombes*[58] was the fact that but-for the defendant's negligence, the claimant's mother could have had *a* healthy child; it did not matter whether the claimant could have been a healthy child. However, as we will see, it is not clear whether it is sufficient that the mother could have had a healthy child with another partner or whether it is necessary that that couple could have conceived a healthy child together.

Lambert J. illustrates this point with the example of a couple who conceive a child following negligent advice regarding their genetic status and that child is born suffering from an inherited genetic condition. It is Lambert J.'s assertion that such a child would have no claim under the CDCLA as there would be '…no circumstances affecting the intercourse in which a healthy child could have been conceived and no causal connection between the occurrence and the disability.'[59] This differs from the scenario in *Toombes*, as in that case the claimant's mother would have been more likely to conceive a healthy child with the same partner at a later date after having increased her folic acid levels, whereas the couple in Lambert J.'s example could not improve their chances of conceiving a healthy child together at any time even if they had been accurately informed of their genetic status, and it is this that it is alleged would bar the child's claim. However, in the case of sexually transmitted infections such as HIV, if the mother states that had she been informed of the risk of HIV infection she would not have had unprotected intercourse with the father there are no circumstances in which a healthy child could have been conceived between that couple (as is the case for the couple in Lambert J.'s example).[60] The mother could have conceived a healthy child but

[58] ibid.
[59] ibid [55].
[60] Unless the mother states that she would not have had unprotected intercourse with the father but they would have attempted to conceive with the assistance of fertility treatment including sperm washing, which can reduce

would not have done so with that partner. It is not clear from the discussion in *Toombes*[61] whether that is sufficient for a claim under CDCLA, s 1(2)(a) or whether it is necessary that the couple could have conceived a healthy child together at another time.

Lambert J.'s example could be distinct from a case involving a sexually transmitted infection such as HIV if that example was limited to the scenario in which any child of either parent would inherit the genetic condition as opposed to only children that they conceived together. If the couple receiving genetic counselling were both wrongly informed that they did not carry a gene for an inheritable condition when in fact any child that either parent conceived would inherit that condition, then the negligent advice has not affected the parent's ability to have a healthy child and so would not satisfy CDCLA, section 1(2)(a). However, in the case of a father's failure to warn of his HIV status, the mother could have had a healthy child with another partner and so her ability to have a healthy child has been affected by the father's breach of his duty to warn. In this case, what matters for pre-conception occurrences is whether but-for the breach of duty the mother could have had a healthy child even if this would have been with another partner.

It appears that the interpretation of CDCLA, section 1(2)(a) and its interaction with the bar on claims for wrongful life is not yet fully resolved but it is clear that the CDCLA was intended to cover claims by children born disabled after having been conceived in circumstances where the father does not disclose that he has a sexually transmitted infection to his sexual partner.[62] In relation to HIV, such a claim may no longer need to be on the basis that the

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the chances of transmission of HIV infection. V Savasi and others, 'Safety of sperm washing and ART outcome in 741 HIV-1-serodiscordant couples' [2007] 22(3) Hum Reprod 772.

[61] *Toombes v Mitchell* (n 43).

[62] Law Commission, Explanatory Notes to the Draft Bill, (n 7), 47 para 5.

claimant should not have been conceived but could instead be brought on the basis of a missed opportunity for treatment.

9.6.4 Missed opportunity for treatment

Due to developments in medical science, treatment options to prevent the infection passing to the future child are now available if the HIV-positive status of the father is known.[63] Therefore, a child's claim based on her father's failure to inform her mother of his HIV-positive status prior to sexual intercourse would no longer need to be a claim for wrongful conception and birth. Instead, it could be for the claimant's disability which could have been avoided but-for the father's breach of his duty to inform his sexual partner that he was infected with a sexually transmissible disease. This would also remove the need for the claimant to show that her mother would not have consented to sexual intercourse had she been informed of the risk.

The child's claim could be based on the assertion that if the father had informed the mother of his HIV status, his mother would have still consented to having unprotected sexual intercourse with him but she would have then sought treatment to prevent the infection from passing to the future child. Treatments such as antiretroviral therapy (ART), appropriate management of delivery, and avoidance of breastfeeding have been shown to reduce transmission rates from mother to child to 1-2%.[64] Some studies indicate even lower

[63] Claire L Townsend and others, 'Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000–2006' [2008] 22 AIDS 973.
[64] European Collaborative Study 'HIV-infected pregnant women and vertical transmission in Europe since 1986' [2001] 15 AIDS 761; European Collaborative Study 'Mother-to-child transmission of HIV infection in the era of highly active antiretroviral therapy' [2005] 40 Clin Infect Dis 458; E R Cooper and others 'Combination antiretroviral strategies for the treatment of pregnant HIV-1-infected women and prevention of perinatal HIV-1 transmission' [2002] 29 J Acquir Immune Defic Syndr 484; Centers for Disease Control and Prevention 'Achievements in public health. Reduction in perinatal transmission of HIV infection – United States, 1985–2005' [2006] 55 MMWR Morb Mortal Wkly Rep 592.

transmission rates from women on ART for at least the last 14 days of pregnancy, with each additional week of treatment corresponding to a 10% reduction in the risk of transmission.[65] This means that if the mother had been warned of the father's HIV status, and she would have sought treatment, it is more likely than not that the child's harm would have been prevented. Therefore, it seems likely that a child would have a valid claim under the CDCLA on the basis of a failure by the father to warn the mother of the risk of a sexually transmitted infection such as HIV, if three things were established: (i) that the mother would still have consented to the sexual intercourse; (ii) she would have then sought treatment to prevent the infection passing to the child; and (iii) that treatment would have had a greater than 50% chance of preventing the infection passing to the child.[66]

It could be argued that a child's claim under the CDCLA against her father based on his failure to warn his sexual partner of his HIV status would fail on the basis that the mother was aware that having unprotected sexual intercourse carries a risk of HIV infection for her and any resulting future child and she chose to accept that risk.[67] However, this argument is unlikely to succeed as even if the mother was aware of a general risk, without being informed of her partner's HIV status she cannot be said to have been aware of the actual risk she was taking.[68]

Given the likelihood of a duty of care to warn sexual partners of significant infection risks following the case of *R v Dica*[69] and the availability of highly effective treatments to prevent

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[65] Townsend and others (n 63).
[66] It is possible that a claim could be successful even if there was a less than 50% chance of the treatment preventing the infection passing to the child following the departure from usual causation principles in *Chester v Afshar* (n 52), although this would have to take into account subsequent case law such as *Duce v Worcestershire Acute Hospitals NHS Trust* (n 54), which has sought to limit the scope of this departure.
[67] CDCLA, s 1(4).
[68] *R v Dica* (n 22) [59].
[69] ibid.

vertical transmission of HIV and the possibility that treatment might not be sought without knowledge of the HIV status of the parents, paternal liability for conception harm is a real possibility. However, maternal liability for conception harm is excluded under CDCLA, section 1(1). Therefore, paternal and maternal liability is unequal under the CDCLA.

9.7 Is the unequal treatment of mothers and fathers justified?

Maternal liability under the CDCLA was originally excluded due to fears that the mother would not have the funds to meet any award without causing hardship to the rest of the family, the parental bond between mother and disabled child would be disturbed, and a legal action, or the threat of one, could be used as a weapon by fathers against mothers in custody disputes.[70] At that time the Law Commission did not believe that these dangers warranted an exclusion of paternal liability.[71] As Collier and Sheldon have argued, it was the mother's familial role that was thought to require protection as it was assumed that mothers would be the primary carers for their children and fathers the breadwinners.[72] Since then, there has been a significant shift towards a more gender-neutral model of parenting adopted in law and policy, moving away from the father as breadwinner model and acknowledging fatherhood as including a role of care.[73] There has also been a shift in the experience of fatherhood since the 1970s. The time that British fathers spend in primary care has increased by 15-20 minutes each decade since the 1970s and paternal care in 2015 was equal to the amount of

[70] Law Commission (n 7) [54]-[64].
[71] ibid [92].
[72] R Collier and S Sheldon, *Fragmenting Fatherhood: A socio-legal study* (Bloomsbury Publishing 2008) 56.
[73] ibid 101-137.

maternal care in the 1960s.[74] However, the gap between the time investment of mothers and fathers in caring for children has increased.[75] While childcare remains highly gendered, with the majority of the responsibility still falling to women,[76] a shift has taken place in the decades since the CDCLA came into force, at least in the perception of what the roles of mothers and fathers *should* be. According to the British Social Attitudes survey, in 1987, 48% of people supported a gendered separation of roles, with the woman as the primary carer and the father as the breadwinner, but this has declined to just 13% in 2012.[77] However, this has not translated into a more equal distribution of familial roles between mothers and fathers in practice, and one possible explanation for this is a 'structural lag' whereby societal institutions such as parental leave, childcare, and employment, have not yet caught up with the changes in women's roles, significantly in paid employment.[78] Instead of lagging behind these societal changes, there is an opportunity here for the CDCLA to contribute to the reconceptualising of reproduction and childrearing as a shared enterprise. Somewhat paradoxically, by extending the exclusion of liability under the CDCLA to fathers, the law could support the move towards fathers bearing more of the responsibility in reproduction and childrearing; instead of reinforcing the view that reproduction and childrearing is and should be 'women's business', the law would be acknowledging the importance of the father-child bond and the acceptance of male single-parent families. Therefore, it appears that the Law Commission's reasons for excluding maternal liability could now also be seen as

[74] E Altintas 'Are British parents investing less time in their children?' Centre for Social Investigation Briefing Note 27 (Oxford Nuffield College, 2016) <http://csi.nuff.ox.ac.uk/wp-content/uploads/2016/09/CSI-27-Are-British-Parents-investing-less-time.pdf> accessed 19 November 2021.
[75] ibid.
[76] In 2012 men reported spending an average of 10 hours a week looking after family members, while women reported spending an average of 23 hours a week. A Park and others (eds), British Social Attitudes: the 30th Report (London, NatCen Social Research 2013) 126 <https://www.bsa.natcen.ac.uk/media/38457/bsa30_gender_roles_final.pdf> accessed 19 November 2021.
[77] ibid 119.
[78] ibid 134.

justifying an exclusion of paternal liability in order to support the move towards a more gender-neutral model of parenting.

An underlying reason for the Act's exemption of maternal but not paternal liability is the concern that maternal liability has the potential to conflict with abortion law[79]; how can a woman be liable for causing harm to her foetus but not for destroying it? As Brazier points out, this is a perceived rather than an actual conflict as it is possible that a woman could owe a duty of care to a future child that she intends to bring to birth, but be permitted to abort a foetus she does not intend to bring to birth.[80] The subject of her duty of care is the child that will exist in the future rather than the foetus that currently exists. No such conflict would be perceived in relation to paternal liability as a man has no power to request an abortion. However, the desire to avoid a perceived rather than real conflict does not seem to justify the unequal treatment of mothers and fathers under the CDCLA.

Paternal immunity was considered by the Law Commission but ultimately rejected for several reasons. First, a father's conduct was not thought to be able to affect the future child to the same extent as the mother's and so paternal liability would not lead to the same extreme surveillance of men's lives as it would women's.[81] While this is likely to be true in terms of gestational events, there is growing scientific evidence that a man's behaviour can lead to pre-gestational harm to a future child in the same way as a woman's. Everything from how much he smokes and how much alcohol he consumes, to how much stress he experiences and what he eats, can all have an impact on the health of his future child.[82] Similarly, although a pregnant woman has a unique physical connection to the future child, a

[79] Brazier (n 9) 269.
[80] ibid 270.
[81] Law Commission (n 7) [92].
[82] Jonathan Day and others (n 18); Savitz, Schwingl and Keels (n 18).

father's behaviour during the pregnancy can still have a significant impact on the health of that future child, for example, smoking in the home, domestic violence, or creating a stressful environment for the pregnant woman.[83] Therefore, paternal liability, particularly in relation to pre-gestational harm, could lead to extreme surveillance of men's lives. However, it is notable that, despite the Law Commission's efforts to protect women from extreme surveillance, women's behaviour is subject to increasing surveillance in the name of protecting future children, in a way that men's behaviour is not.[84] Evidence that a man's conduct can affect the health of his future child has been substantial for decades and as yet the surveillance of pre-gestational conduct remains focussed on women as the potential cause of prenatal harm. The view that women rather than men are almost exclusively the cause of prenatal harm to men is not simply a matter of biology but instead relies heavily on ideas of gender.[85] This is clearly evident in the parliamentary debates leading to the CDCLA in which the dangers posed by male bodies were conceptualised as occupational, and those posed by female bodies were associated with individual 'choices' such as drugs and alcohol.[86] Cynthia Daniels connects this to four ideals of reproductive masculinity: the assumption that men are secondary in biological reproduction, the assumption that the male reproductive system is less vulnerable than the female reproductive system to the harms of the outside world, the assumption of male virility, and the presumption that men are more distant (than women) to the children they father.[87] As Daniels argues, these ideals are not

[83] For example, B M Donovan, and others, 'Intimate partner violence during pregnancy and the risk for adverse infant outcomes: a systematic review and meta-analysis' [2016] 123 BJOG 1289; Lijuan Zhao and others, 'Parental smoking and the risk of congenital heart defects in offspring: An updated meta-analysis of observational studies' [2020] 27 Eur J Prev Cardiol 1284.
[84] For example, the recent policies to screen all pregnant women for carbon monoxide and alcohol consumption. Bowden (n 2), and Ellie Lee, Jennie Bristow, Rachel Arkell and Clare Murphy, 'Beyond 'the choice to drink' in a UK guideline on FASD: the precautionary principle, pregnancy surveillance, and the managed woman' [2021] 24 Health, Risk & Society 17.
[85] Sally Sheldon, 'Reconceiving masculinity: imagining men's reproductive bodies in law' [1999] 2 J Law Soc 129, 132.
[86] ibid 141-142.
[87] Cynthia Daniels, *Exposing men: The science and politics of male reproduction* (Oxford University Press 2008); See also Sheldon (n 85).

only harmful to women because they are more likely to be blamed for prenatal harm than men, but they are also harmful for men because little attention is paid to developing safe workplace regulations to protect men's reproductive health.[88] Rather than reinforcing this harmful ideal of masculinity and relying on it to protect men from surveillance, the CDCLA could acknowledge the potential for men's behaviour to impact on future children and so avoid contributing to the conflict view of pregnancy by posing pregnant women as a unique threat to future children.

The Law Commission argued that because the potential allegations of paternal harm were more limited than those of maternal harm it was far less likely that legal action under the CDCLA would be used as a weapon in matrimonial disputes against fathers than against mothers.[89] Given our enhanced understanding of the impact of paternal behaviour on the health of future children and the desire to move towards a more gender neutral model of parenting discussed above, it seems that if the potential use in custody disputes is sufficient to justify the exclusion of maternal liability it could also justify an exclusion of paternal liability.

Another reason given by the Law Commission for not extending the exclusion of liability to fathers was that the father of the child might not be the husband of the mother and so any legislation excluding fathers from liability could lead to 'very bizarre litigation'.[90] Any problems defining who counts as the child's father could be overcome by limiting father to genetic father in relation to pre-conception harm and those individuals (regardless of gender)

[88] Daniels (n 86) chapter 5.
[89] Law Commission (n 7) [92].
[90] ibid. It is assumed that what the Law Commission was referring to was the possibility that a child may not be able to bring a claim against her biological father with whom she may not have a loving bond but she could bring a claim against her social father with whom she does.

who go on to have parental responsibility for gestational harm. Applying an exclusion on the basis of these definitions would avoid the scrutiny of men's lives linked to harmful lifestyle factors and avoid the harm to the parental bond in relation to those who go on to have parental responsibility for the child. In any event, this is a problem the law deals with in many circumstances and is no more problematic for fathers than mothers given the potential for surrogacy arrangements, gamete donors, trans parents and other non-traditional definitions of parent. Therefore, any difficulties in defining father do not justify the unequal treatment of mothers and fathers under the CDCLA.

In the Law Commission's opinion, the conclusive justification for not extending the exemption to fathers was the desire to permit a child born disabled as a result of an assault by her father on her mother to bring a claim against her father in respect of those disabilities:

> We are also of the opinion that […] a child born disabled as a result of an assault by a man on the mother should have a cause of action against that man, even though it was the assault itself which caused the conception. [91]

Although this would include assaults at the pregnancy stage (see below), the Law Commission's main concern appears to have been the scenario, whereby a child is born disabled having been conceived in circumstances in which her father did not disclose to his sexual partner that he was suffering from a sexually transmissible disease. It is clear from the Law Commission's consideration of the example of a man who does not inform his sexual partner that he is infected with syphilis that this is what is meant by the Law Commission's

[91] Law Commission (n 7) [92].

reference to 'an assault which causes the conception'.[92] Although this would no longer be termed an assault,[93] it could still constitute a civil wrong in the form of a breach of a duty to warn as explained above.

If a man is under a duty of care to warn his sexual partner of the risk of transmission of an infection such as HIV and he breaches this duty, it seems entirely in keeping with the purpose of the CDCLA for him to be liable to any subsequent child born disabled whose disabilities would have been avoided if the father had fulfilled his duty of care to the mother. After all, this is merely extending his liability to the affected parent to include liability to the child born disabled as a result of his breach.[94] However, if this is the case, it is not clear why it would be inappropriate for mothers to face similar liability under the CDCLA for a failure to warn their sexual partners of their disease status. The possibility of a woman committing a civil wrong against her sexual partner by not informing him that she is infected with a sexually transmissible disease was not considered by the Law Commission. A woman (presumably) owes the same duty to inform her sexual partner of her HIV positive status. If she breaches that duty and a child is born with HIV, the father could argue that had he been informed of her status, even if he would still have had unprotected sexual intercourse with her, he would have made medical staff aware and sought treatment for the child at least immediately following birth (treatment during pregnancy may not have been something he could have arranged on the balance of probabilities as the woman would have been unlikely to consent given that she did not seek treatment herself).[95] Alternatively, if, as suggested by the

[92] ibid [88], [92], [93].
[93] *R v Dica* (n 22) [47].
[94] Brazier (n 9).
[95] Treatment of the child after birth can be highly effective in reducing signs of the virus resulting in less damage to the immune system. Pilar Garcia-Broncano and others, 'Early antiretroviral therapy in neonates with HIV-1 infection restricts viral reservoir size and induces a distinct innate immune profile' [2019] 11 Sci Transl Med.

judgment in *Toombes*,[96] a claim can be brought under CDCLA, section 1(2)(a) on the basis that the affected parent would have had a child with another partner if he had been informed of her status, the child could argue that the father would not have consented to sexual intercourse and so she would not have been conceived. If this is the case, exempting mothers from liability arising out of a failure to warn her sexual partner of the risk of transmission of a sexually transmitted infection but retaining such liability for fathers does not appear to be justified. Either it is appropriate for a parent to be liable to a child born disabled as a result of that failure to warn, or it is not.

9.8 A. Gestational Harm

Although, as explained above, a woman can commit an equivalent wrong in relation to pre-gestational harm, there is no equivalent maternal conduct during pregnancy to the man that commits a battery against a pregnant woman; any intentional violence by the pregnant woman that caused harm to the future child would be directed at her own body. This might appear to justify the unequal liability of mothers and fathers. However, this is one specific type of conduct and does not necessarily justify retaining liability for all forms of paternal conduct. Further, retaining paternal liability for gestational harm might not be necessary as other forms of redress might be available to a child whose congenital disabilities are caused by violence against the mother during pregnancy. In particular, in these circumstances, it may be possible for a child to be compensated by the Criminal Injuries Compensation Authority.

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[96] Matas (n 33).

9.8.1 *Is CICA compensation available in relation to harm in utero?*

The Criminal Injuries Compensation Scheme (the Scheme) provides compensation to those who have sustained a criminal injury which is directly attributable to their being a direct victim of a crime of violence.[97] Although a foetus lacks legal personhood it does have some protection under the criminal law[98] and so a child who suffered harm at the foetal stage may be able to be considered a victim of a crime of violence. Indeed, under the earlier versions of the Scheme children born with Foetal Alcohol Spectrum Disorder were compensated as victims of their mothers' drinking during pregnancy.[99] In addition, Annex B to the 2012 Scheme states that:

> 4. (1) A crime of violence will not be considered to have been committed for the purposes of this Scheme if, in particular, an injury:
>
> […]
>
> (e) was sustained in utero as a result of harmful substances willingly ingested by the mother during pregnancy, with intent to cause, or being reckless as to, injury to the foetus.[100]

Significantly, this implies that other forms of harm sustained in utero such as from an attack on the pregnant woman *can* be compensated.[101]

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[97] Criminal Injuries Compensation Scheme 2012, para 4.
[98] For example, under OAPA, s 58 and s 59; Infant Life Preservation Act 1929, s 1.
[99] *CP (A Child) v First-tier Tribunal (Criminal Injuries Compensation)* (CA) [2014] EWCA Civ 1554 [3] (Treacy LJ).
[100] Criminal Injuries Compensation Scheme 2012, Annex B <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808343/criminal-injuries-compensation-scheme-2012.pdf> accessed 5 August 2021.
[101] There does not appear to be any data available as to whether any awards have been made on this basis, however, there is some anecdotal evidence that it has not. For example, Nick McCarthy, 'Stabbed mum's unborn baby is refused criminal injuries compensation' *Birmingham Mail* (24 November 2016) <https://www.birminghammail.co.uk/news/midlands-news/stabbed-mums-unborn-baby-refused-12225378> accessed 5 August 2021.

The Court of Appeal considered the possibility of a child being compensated for a crime against her mother that occurred prior to her birth in the case of *CICA v F-tT and Y*.[102] In this case Y had been born suffering from a serious genetic disorder after being conceived by incestuous rape. Initially, the claim for compensation was refused and this refusal was upheld by the First-tier tribunal on the grounds that Y was not a victim of a crime of violence and he had never had an uninjured state as it was the crime that had led to his conception. An application for judicial review was heard by the Upper Tribunal which granted compensation, finding that Y had suffered injuries which were directly attributable to a crime of violence within the meaning of paragraph 8 of the 2008 scheme which was applicable at the time. [103] CICA appealed the decision of the Upper Tribunal to the Court of Appeal which upheld the appeal, refusing Y compensation because Y had not been conceived at the time of the crime as it was the crime itself that led to Y's conception and so he could not be considered a victim of a crime of violence and there was no 'uninjured state' with which to compare the child's current state for the purposes of assessing compensation.[104] In the case of an attack on the pregnant woman, this problem would not arise as the child would have been conceived prior to the attack and so there is an 'uninjured state' with which to compare the child's current state. Therefore, it seems likely that a child born disabled as a result of her father committing a battery against her mother during pregnancy could be compensated under the Scheme.

An award under the Scheme is likely to be less than the damages available in a civil claim with claims under the Scheme capped at £500,000 and the vast majority of claims being

[102] *CICA v F-tT and Y* (n 50) [26].
[103] *Y v First-tier Tribunal and Criminal Injuries Compensation Authority* [2016] UKUT 0202 (AAC) 2, JR/2930/2014.
[104] *CICA v F-tT and Y* (n 50) [26].

substantially less than that.[105] However, the levels of compensation could be increased if the level of redress available to the child was the concern rather than the source of that redress.

Because of this potential for redress under the Scheme and the option to limit paternal liability under the CDCLA to intentional torts against the mother during pregnancy, the desire to provide redress to the child born disabled as a result of her father committing a battery against her mother during pregnancy does not justify retaining all paternal liability under the CDCLA while mothers are exempt except in relation to negligent driving.

9.9 CONCLUSION

Liability of either parent under the CDCLA might be unlikely due to the dependence on a duty of care owed to the affected parent but such liability is possible particularly in relation to failure to disclose risks to sexual partners. Mothers are protected from such liability by virtue of the exemption in section 1(1) CDCLA but fathers are not. This inequality in treatment is not justified by the outdated view of how parental roles should be split between the genders, the danger of liability under the CDCLA being used in matrimonial disputes, the practical difficulties in defining fathers, nor the desire for redress for a child born disabled as a result of an attack by her father on her mother during pregnancy.

While there is a case for permitting a child to claim against its father for intentional harm such as an attack on the mother during pregnancy this could be argued to be unnecessary as

[105] Criminal Injuries Compensation Scheme [31]; Criminal Injuries Compensation Calculator <https://criminal-injuries-compensation.co.uk/how-much-compensation-will-i-receive/> accessed 5 August 2021.

the child could instead be compensated by CICA for this harm. Given that a child harmed in this way would not be without redress, retaining paternal (but not maternal) liability to cover such scenarios does not justify the resulting unequal liability for pre-gestational harm such as the failure to warn of risks between sexual partners. At most, it would justify making an exception to a paternal exemption to cover intentional torts against the pregnant woman.

The solution largely depends on whether it is desirable for a child born disabled as a result of her parent's failure to warn their sexual partner of their HIV status to be able to bring a claim against that parent under the CDCLA. If it is desirable, this liability should apply equally to mothers and fathers. If it is not, there is a strong case for extending the maternal exemption to fathers as well. Changes in society since the CDCLA came into force mean that the problems associated with a child bringing a claim against her parent identified by the Law Commission in relation to maternal liability, such as taking funds away from those caring for the child, disturbing the parental bond and the potential for use in matrimonial disputes, now apply equally to paternal liability. Therefore, it is likely that such liability would do more harm than good. This is not to say that the individual who does not disclose their HIV status to a sexual partner should not face any form of liability, only that liability to the child is not appropriate. Either parent could still face criminal and civil liability to each other in respect of their non-disclosure.

An alternative solution would be to remove the maternal exemption, however, the significant symbolic value of the exemption of maternal liability in reinforcing the principle that there is no legal obligation for women to prioritise the welfare of their future children would then be lost.[106] It is possible that extending the exemption to include fathers would have a similar

[106] Brazier (n 9) 266.

value to men. While there are historical and current social reasons for making a clear statement that women are not to be considered primarily as vessels for future children, this does not require the law to place men under an obligation to prioritise the welfare of their future children in a way that women are not. Indeed, the case against maternal liability would be strengthened by an equal statement applying to men as this would remove any objection to the maternal exemption based on unjustified unequal treatment. Therefore, it would appear that the most appropriate solution is for the exemption to be extended to fathers with an exception for intentional torts committed against the mother during pregnancy.

CHAPTER 10 - CONCLUSION

The aim of this thesis was to consider the potential for women to be held responsible for prenatal harm due to their conduct during pregnancy and ask whether this would be justified. As women have not faced legal liability for unintentionally causing harm to their future children through their behaviour during pregnancy in this country, it is tempting to assume that women's rights are secure from the interference this would represent. However, as this thesis has demonstrated, there is no room for complacency, especially as women currently face criminal sanctions for accessing essential healthcare services under the Abortion Act 1967.[1] Women's behaviour during pregnancy is being increasingly policed by public health campaigns which frame them as the problem to be addressed. This could lead to legal liability particularly as the criminal law currently views a pregnant woman whose behaviour harms her future child as equivalent to a third party who causes such harm. Even the exclusion of maternal liability in the civil law is not as sound as it appears due to the potential for this to be challenged as unjustified treatment because the exclusion does not apply to fathers for harm caused at any stage.

Others have put forward compelling arguments as to why maternal liability should be resisted[2] and have argued that maternal legal liability for prenatal harm remains a possibility

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[1] Royal College of Obstetricians and Gynaecologists and Faculty of Sexual and Reproductive Healthcare 'RCOG and FSRH statement on decriminalisation of abortion' (July 2022) <https://www.fsrh.org/documents/fsrh-rcog-statement-decriminalisation-of-abortion-2022/> accessed 16 August 2022.

[2] Margaret Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 Curr Leg Probl 359; Margaret Brazier, 'Parental Responsibilities: Foetal Welfare and Children's Health' in Caroline Bridge (ed), *Family Law Towards the Millennium: Essays for P M Bromley* (Butterworth-Heinemann Ltd 1997); Emily Jackson, *Regulating*

following *AGs Ref (No.3 of 1994)*[3] and *CP*[4]. This thesis has built on and added to these arguments by considering how the behaviour of pregnant women is being policed in current public health policies; how the focus on the status of the victim in *CP*, rather than the conduct of the defendant, contributes to the possibility of maternal liability; and how the potential for paternal liability in the civil law weakens the exclusion of maternal liability.

At the beginning of this thesis, I set out the research questions that form the basis of this thesis. These included some ethical questions as well as some legal ones and were intended to address the link between the policing of pregnancy evident in public health campaigns and the potential for women to face legal liability for prenatal harm. I will now return to those questions and the link they establish. Those questions are:

- What are the ethical problems with singling out pregnant women for public health interventions aimed at reducing prenatal harm?
- Are we justified in singling pregnant women out in this way?
- Could this lead to maternal legal liability for prenatal harm?
- How could women be held liable for prenatal harm due to their behaviour during pregnancy under the current law in light of *CP* and the exclusion of civil liability under the CDCLA?

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reproduction: Law, technology and autonomy (Bloomsbury Publishing 2001); Emma Cave, *The Mother of All Crimes: Human Rights, Criminalization and the Child Born Alive* (Aldershot: Ashgate, 2004); Erin Nelson, *Law, policy and reproductive autonomy* (Bloomsbury Publishing 2013); Catherine Stanton and Emma Cave, 'Maternal responsibility to the child not yet born' in Catherine Stanton, Sarah Devaney, Anne-Marie Farrell, and Alexandra Mullock, (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015); Catherine Stanton, 'Genetic transmission of disease: a legal harm?' (2016) 24 Health Care Anal 228: Sara Fovargue and José Miola, 'Policing pregnancy: implications of the Attorney-General's Reference (No. 3 of 1994)' (1998) 6 MLR 265.

[3] ibid Fovargue and Miola 'Policing Pregnancy'.

[4] Cave and Stanton (n 2).

- Is the law governing prenatal harm consistent with its own principles of equality before the law, and the moral role of the criminal law?
- Could maternal liability for prenatal harm be more strongly resisted if the law was consistent with these principles?

In this final chapter, I will reiterate and draw together the arguments I have made throughout this work in order to explain how I have answered these research questions, to demonstrate how my answers are pertinent to the development of public health interventions aimed at pregnant women and to the law on prenatal harm, and to elaborate on the common threads running through all four papers included in this work.

10.1 Principal arguments

Through the legal analysis in this thesis, I have argued that legal maternal liability for prenatal harm remains a possibility for two reasons; the focus on the status of the foetus in the criminal law, and the unjustified unequal treatment of mothers and fathers in the civil law. By considering this alongside the treatment of pregnant women in public health interventions aimed at reducing prenatal harm, I have argued that there is an appetite for holding women responsible for prenatal harm and that this could be used to support calls for legal liability.

10.1.1 Ethical argument

The ethical problems with singling out pregnant women for public health interventions aimed at reducing prenatal harm.

While others have considered the merits of health interventions aimed at pregnant women including drug treatment programmes[5] and advice on alcohol consumption,[6] in this thesis I have considered the ethics of the growing trend for routine screening of pregnant women for behavioural factors such as smoking and alcohol consumption.

In Chapters 6 and 7, I explored how pregnant women are singled out for special treatment in public health interventions aimed at reducing smoking and alcohol consumption and asked whether that is justified. It seems that part of the reason that pregnant women are singled out for public health interventions in this way is simply that they can be. It is NHS policy to 'Make Every Contact Count'[7] and pregnancy is a time when women have a high degree of contact with the NHS. Therefore, this is not only an opportunity to prevent prenatal harm, but an opportunity to advance more general public health campaigns such as smoking cessation and reducing alcohol consumption.[8] However, utilising the increased contact with health services in pregnancy in order to advance public health agendas can only be justified if a similar approach is taken to other similar contacts. While the NHS aims to make *every* contact count, not just those related to pregnancy, it is only those related to pregnancy that are seen as an opportunity for routine screening in the form of carbon monoxide tests and

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[5] Jackson (n 2) 150-151.
[6] Pam K. Lowe and Ellie J. Lee, 'Advocating alcohol abstinence to pregnant women: Some observations about British policy' (2010) 12(4) Health Risk Soc 301; Colin Gavaghan, ' "You can't handle the truth"; medical paternalism and prenatal alcohol use' (2009) 35 J Med Ethics 300; Betsy Thom, Rachel Herring, and Emma Milne, 'Drinking in pregnancy: shifting towards the 'precautionary principle'' in Susanne MacGregor and Betsy Thom (eds), *Risk and Substance Use: Framing Dangerous People and Dangerous Places* (Routledge 2020).
[7] NHS, Health Education England, *Making Every Contact Count* <http://www.makingeverycontactcount.co.uk> accessed 29th September 2021.
[8] See also World Health Organisation, *Global alcohol action plan 2022-2030* (July 2021) <https://cdn.who.int/media/docs/default-source/alcohol/alcohol-action-plan/first-draft/global_alcohol_acion_plan_first-draft_july_2021.pdf?sfvrsn=fcdab456_3&download=true> accessed 25 July 2022.

alcohol biomarker testing. Therefore, singling out pregnant women for such interventions cannot be justified simply on the basis of making every contact count.

Of course, the thing that separates pregnant women from other individuals in contact with the NHS is their pregnant status and so singling out pregnant women for particular public health interventions could be justified by the potential to improve outcomes for future children as well as pregnant women. As Margaret Brazier has argued, ceasing to recognise the pregnant woman's capacity to make her own moral choices for herself and her child could only be justified if we were:

> …satisfied both that the compelling nature of the child's interests justified abrogating maternal rights and that any measures taken would be effective in protecting future children from prenatal harm.[9]

However, as I have demonstrated, the routine screening of pregnant women with biomarker testing such as carbon monoxide breath tests, and urine, blood and meconium tests[10] for alcohol consumption, is likely to do more harm to future children than good. This is because this approach threatens the relationship of trust between a woman and her care team, obscures other more significant causes of prenatal harm and threatens the autonomy of women, which plays a crucial role in the outcomes for future children. Given that singling pregnant women out for such public health interventions is likely to do more harm to future children than good it is difficult to see how it is justified. Far from the interests of future children being a

[9] Brazier 'Liberty, Responsibility, Maternity' (n 2) 367.

[10] For a consideration of the feasibility of using meconium screening to detect alcohol use in pregnancy see Rachel Arkell and Ellie Lee, 'Using meconium to establish prenatal alcohol exposure in the UK: ethical, legal and social considerations' (2022) J Med Ethics <https://jme.bmj.com/content/early/2022/07/22/jme-2022-108170> accessed 25 July 2022.

compelling reason justifying the abrogation of maternal rights, the interests of future children are best served by upholding those rights.

A possible explanation for why pregnant women are targeted in this way is that a misconstruction of the problem has taken place. Although the starting point for these public health interventions is improving outcomes for children, this has slipped into an aim to stop pregnant women smoking and consuming alcohol. It is this slip that prevents due attention being paid to the unintended harms that such interventions cause. This can be seen in the way that the success of the policy to routinely test pregnant women for carbon monoxide is judged by how many smokers are identified, rather than any reduction in pre-term or low birthweight births.[11] The solution therefore appears to be to refocus on what will lead to better outcomes for women and children and this requires a recognition of the role of women's autonomy.

10.1.2 Autonomy and the assumption of conflict

One theme that has emerged from the research in this thesis is that the treatment of pregnant women in both public health and the law fails to capture the true nature of the unique relationship between a pregnant woman and her future child. An assumption of conflict and an inaccurate notion of what it means to protect the autonomy of pregnant women currently dominates in both fields. A new model of the maternal-future child relationship is needed.

As explained in Chapters 2 and 4, pregnant women are (in theory even if it is not always evident in practice) entitled to the same respect for autonomy as anyone else, with many of their choices meriting an enhanced level of respect given the significance of being able to

[11] See for example, Agnes McGowan and others, ''Breathe': The stop smoking service for pregnant women in Glasgow' (2010) 26(3) Midwifery e1–e13.

determine one's own experience of pregnancy. Trespassing on the autonomy of pregnant women can only be justified if there is strong evidence that such trespass is necessary to prevent serious harm to others. However, we should not be too quick to assume that the autonomy of pregnant women and the welfare of future children are at odds with each other and that one must be sacrificed for the sake of the other.

As we have seen, public health campaigns and the law on prenatal harm are concerned with protecting the future child *from* the pregnant woman and thus reflect and support the conflict view of the maternal-foetal relationship. It is this assumption of conflict that has prevented/obscured a clear consideration of how future children are being harmed and how that is best addressed.

What lies behind this assumption of conflict is a traditional, individualistic view of autonomy. This gives the impression that to respect an individual's autonomy is to allow and support that individual to make choices based on what they determine to be in their own interests. Therefore, to respect the autonomy of pregnant women is to leave future children unprotected and uniquely vulnerable to the consequences of the choices of another. If, instead, we adopt a more socially sensitive concept of autonomy as outlined in Chapter 4, we can recognise that pregnant women are more than capable of making (and in the vast majority of cases do make) decisions that take into account the interests of their future children. Far from being uniquely vulnerable, future children are uniquely protected in this way, as the person who is likely to be most invested in their future is able to make decisions that will affect them. Therefore, those concerned with the interests of the future child have nothing to fear from respecting the autonomy of pregnant women as they are far more likely to protect the interests of the future child than to threaten them. Once autonomy is viewed in this way,

it is clear that treating pregnant women as a risk to be managed rather than a manager of risk[12] is likely to be harmful to future children rather than beneficial to them, as 'managing' the pregnant woman prevents her from exercising her autonomy in the interests of her and her future child.

This management of pregnant women is evident in the current trend for screening for behavioural factors in pregnancy, such as smoking and alcohol consumption, discussed in Chapters 6 and 7. This screening is aimed, not at obtaining information *for* pregnant women (after all, the women already know whether they have consumed alcohol, or smoked), but instead these measures are aimed at obtaining information *about* pregnant women. Consequently, such policies are themselves a threat to the welfare of future children, because they weaken the protection given to the future child that comes from the autonomous choices of the pregnant woman.

If we recognise that the interests of future children are closely intertwined with those of pregnant women, we can see that far from justifying a trespass on the rights of women, the interests of future children require us to support the rights of women.

Respecting this reconceptualised concept of autonomy would require public health interventions that focus on removing barriers that prevent pregnant women accessing good quality prenatal care rather than attempting to police their behaviour. If women are managers of risk, protecting the interests of their future children, then the interests of future children are served by promoting the decision-making capacity of pregnant women by providing them

[12] Ellie Lee and others, 'Beyond 'the choice to drink' in a UK guideline on FASD: the precautionary principle, pregnancy surveillance, and the managed woman' (2022) 24(1-2) Health Risk Soc 17.

with accurate information, support, and meaningful choice. This approach has been proven to be highly effective at improving outcomes for women and children, even eliminating the racial disparity in some outcomes between white and non-white women.[13] Such results are far more promising than public health policies which focus on developing biomarker tests that are sensitive enough to detect very low-level alcohol consumption during pregnancy. The evidence does not support the claim that low level drinking is harmful to the woman or future child and such policies risk becoming an additional barrier to women who would benefit most from good quality antenatal care. If non-judgmental, supportive care that respects women's autonomy is capable of improving outcomes for women and children in this way, it is illogical to pursue policies that increase women's feelings of judgment and decrease trust in the relationship with her care provider.

A relationship of trust is a two-way relationship; it is much more difficult to trust someone who does not trust you.[14] Therefore, it seems inevitable that surveillance through screening programmes designed to obtain information *about* rather than *for* pregnant women will reduce the trust pregnant women have in their care providers. This erosion of trust is compounded by the paternalistic presentation to pregnant women of the risk of alcohol consumption during pregnancy. The Chief Medical Officer advises that pregnant women

[13] Josephs, L. and Brown, S., *The JJ Way: Community-based Maternity Center Final Evaluation Report* (Visionary Vanguard Group Inc, 2017) <https://secureservercdn.net/198.71.233.72/qj7.106.myftpupload.com/wp-content/uploads/2022/03/The-JJ-Way%C2%AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf > accessed 6 September 2022

[14] Alaina Brenick and others, 'Understanding the Influence of Stigma and Medical Mistrust on Engagement in Routine Healthcare Among Black Women Who Have Sex with Women' (2017) 4(1) LGBT Health <https://www.liebertpub.com/doi/abs/10.1089/lgbt.2016.0083> accessed 25 July 2022.
Studies in the context of support for long-term health conditions have found that focusing on behaviour reinforces the hierarchical view of patient-professional relationship and prevents patients from acting as effective partners in their own care: Vikki A. Entwistle, Alan Cribb, and John Owens, 'Why health and social care support for people with long-term conditions should be oriented towards enabling them to live well' (2018) 26(1) Health Care Anal 48.

should avoid consuming any alcohol during pregnancy or when trying to conceive.[15] This is not because there is evidence that low to moderate levels of alcohol consumption are likely to harm future children, but because pregnant women might be confused by an accurate account of the risks involved and might underestimate the amount they drink.[16] As Gavaghan points out '…if they are seen to be exaggerating risks that recent (and well-publicised) studies have shown to be negligible, their advice on *genuine* risks will carry less authority.'[17] If women feel that they are not being told the whole story and that they are not trusted to make decisions for themselves, this will further reduce the trust that they have for their care providers.

The current trend in public health for treating prenatal harm as a problem of the individual behaviour of pregnant women, and women's autonomy as something that must be sacrificed in the interests of future children, is informed by the traditional, individualistic concept of autonomy. It is this conflict model of pregnancy that leads to the conclusion that if future children are being harmed it must be because women are prioritising their own interests without sufficient regard for the welfare of their future children, and should therefore be morally condemned. This has the potential to be used to argue for women whose behaviour during pregnancy causes harm to their future children to face criminal sanctions due to the function of the criminal law in reflecting the moral norms of society.[18] Therefore, a shift to a

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[15] UK Chief Medical Officers, *Low Risk Drinking Guidelines* (August 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf> accessed 27 October 2021.
[16] Colin Gavaghan, ' "You can't handle the truth"; medical paternalism and prenatal alcohol use' (2009) 35(5) J Med Ethics 300; Elizabeth Armstrong, 'Making Sense of Advice About Drinking During Pregnancy: Does Evidence Even Matter?' (2017) 26(2) J Perinat Educ 65; Ellie Lee, Robbie M. Sutton, and Bonny L. Hartley, 'From scientific article to press release to media coverage: advocating alcohol abstinence and democratising risk in a story about alcohol and pregnancy' (2016) Health Risk Soc 18(5-6) 247.
[17] Gavaghan (n 16)
[18] As explained in Chapter 4.4 above.

socially sensitive concept of autonomy could also reduce the likelihood of women facing legal sanctions for their conduct during pregnancy that results in prenatal harm.

10.1.3 Legal argument

The potential for women to face legal liability for prenatal harm due to their conduct during pregnancy.

As is the case with public health interventions addressing prenatal harm, the criminal law also fails to reflect the unique intertwining of the interests of pregnant women and their future children. This is because it does not adequately distinguish between a pregnant woman and a third party who causes prenatal harm.

As the law stands, a woman cannot be guilty of a criminal offence for harming her future child at the foetal stage unless she intended to destroy the foetus. However, neither could a third party. A third party could of course be guilty of an offence against the pregnant woman (for example, if he stabbed the woman in the abdomen not knowing she was pregnant) but not against the foetus as he would lack the intention required for destruction of a child capable of being born alive (s.1 ILPA) or procuring a miscarriage (s.58 and s.59 OAPA 1861). In order for the third party to be guilty of an offence for harming the foetus, his actions would have to result in some fresh harm occurring to the child after it is born alive, as occurred in *AG's Ref (No.3 of 1994)* where the defendant stabbed a pregnant woman in the abdomen causing the premature birth of the child and the subsequent death of the child 121 days later. Similarly, the mother of the child could be guilty of a criminal offence if her behaviour during pregnancy resulted in harm to the child *after* it is born alive. This equality

of treatment is not justified because the ways in which pregnant women can cause harm to their future children are very different to the ways in which a third party can cause such harm. A woman who drinks heavily or takes drugs during pregnancy should not be treated in the same way as a man who stabs his pregnant partner. The failure to resist a highly addictive substance for nine months or more is not the same as committing a violent act against a separate individual. As my consideration of the currently hypothetical scenario of ectogenesis shows,[19] the bodily nature of pregnancy engages the rights and interests of a pregnant woman in a unique way and so there may be reasons for her harmful behaviour that could not apply to third parties. For example, she might unintentionally harm her future child by taking drugs as part of her chemotherapy treatment, or by working in a stressful environment, or by failing to resist a common highly addictive substance for nine months or more. The woman's interests in receiving treatment for cancer, earning a wage, pursuing a career, or relieving the pressures of addiction, should not be ignored if there is to be an accurate assessment of the blameworthiness of her conduct. Further, in some cases the future child's interests might also be served by the mother's 'harmful' conduct. For example, the chemotherapy that preserves the life of the child's mother, enabling the child to have a relationship with her mother, or the stressful job that provides financially for that child. By equating a pregnant woman who unintentionally harms her future child with a third party, this intertwining of interests is lost and the criminal law fails to accurately reflect the blameworthy nature of the behaviour in question.

What is novel about the analysis of the criminal law in this thesis is the approach I take to the case of *CP*. While commentary on this case has focussed on the key issue of the status of the

[19] See Chapter 8 above.

victim,[20] I have focussed on the treatment of the pregnant woman. Given the wording of the offence, it is appropriate that the case centred on the finding that FASD is caused in the foetal stage and a foetus cannot be a person for the purpose of s.23 OAPA (or any other offence against a person). However, in my view, it is troubling that the pregnant woman was found (because it was accepted by both sides) to have administered alcohol to the foetus. CP's mother administered the alcohol to herself and only indirectly, through her own body, did this pass to the foetus. In treating this as 'administering to another' the significance of her bodily relationship with the foetus was obscured and so her actions became equivalent to a third party who had harmed a child at its foetal stage.

As explained in Chapter 2, the unborn status of a foetus is not simply a matter of geography, but represents a unique intertwining of rights and interests. The fact that a foetus is inside a woman's body means it cannot be a legal person, but it is not only significant what a foetus is not, but also what it *is*; it is not a legal person and *it is* inside a woman's body. If the foetus is to be viewed by the law as 'more than nothing' or 'another', it is imperative that the foetus is not viewed as 'another' in relation to the pregnant woman in the same way as it is 'another' to a third party. The fact that the foetus is inside the pregnant woman's body is highly significant even if the foetus is not a legal person. The unique bodily relationship of pregnancy means that a pregnant woman whose behaviour unintentionally harms her future child should not be seen as equivalent to a third party who causes such harm.

[20] Charles Foster and Julian Savulescu, 'Should pregnant mothers owe a duty to their unborn children?' (2018) New Law J; Dominic Wilkinson and others, 'Protecting future children from in-utero harm' (2016) 30(6) Bioethics 425; Emma Cave and Catherine Stanton, 'Maternal responsibility to the child not yet born' in Catherine Stanton, Sarah Devaney, Anne-Marie Farrell, and Alexandra Mullock, (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015).

The failure to distinguish between pregnant women and third parties whose actions unintentionally cause harm to future children has left a small but significant opening in the door to maternal liability for prenatal harm. I have argued that it is the moral judgment of pregnant women, the intuition that a pregnant woman who harms her future child is committing a serious moral wrong, that lies behind efforts to criminalise the behaviour of pregnant women. It may be that this same intuition lies behind the singling out of pregnant women for public health interventions displaying a distrust of pregnant women. Perhaps it is no coincidence that biomarker tests for addictive substances are commonly associated with detecting criminals (driving under the influence of alcohol or drugs) or drugs cheats in sport.[21] This seems to reflect a similar view of pregnant women; they are committing a serious moral wrong (in a way that a non-pregnant smoker or drinker is not) and so they cannot be trusted. It is possible that in reflecting and supporting this intuition by treating a pregnant woman who consumes alcohol as equivalent to a man who stabs a pregnant woman, the criminal law makes it more likely that pregnant women will be singled out for distrustful public health interventions, and vice versa.[22] I argue that this intuition can only be tackled by a clear articulation of the significance of the bodily relationship of pregnancy; that when we condemn a woman who 'administers alcohol to her future child' or who has an 'alcohol exposed pregnancy' or who smokes during pregnancy, we are in fact condemning a woman who fails to resist a commonly used, highly addictive substance for nine months or more. Only when this is articulated can the intuition that women who smoke or drink during pregnancy are committing a serious moral wrong be addressed, the door to maternal criminal

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[21] Pamela Bean and others, 'Alcohol Biomarkers as Tools to Guide and Support Decisions About Intoxicated Driver Risk' (2009) 10(6) Traffic Inj Prev 519; Reid Aikin and others, 'Biomarkers of doping: uses discovery and validation' (2020) 12(11) Bioanalysis 791.

[22] Amnesty International have called for the global decriminalisation of abortion based in part on the argument that criminalising abortion leads to the stigmatisation of women and girls by health care practitioners; Amnesty International, 'Key Facts on Abortion' <https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/abortion-facts/> accessed 16 August 2022.

liability closed, and perhaps distrustful public health interventions aimed at pregnant women be stopped.

Similarly, a clear articulation of the significance of the bodily relationship of pregnancy is needed to justify the exclusion of maternal liability in the civil law. The civil law on prenatal harm encapsulated in the CDCLA has rightly been praised for its exclusion of maternal liability (even if the value of this exclusion is primarily symbolic)[23] and held up as a model for the criminal law to follow.[24] However, without sound justification any protection of women's rights it offers could be weakened if it is seen to represent unfair discrimination against fathers. The civil law recognises the complex interaction between the interests of a pregnant woman and her future child, but by failing to recognise that fathers similarly have a complex relationship to their future children prior to, and at the time of, conception, the protection of women's autonomy is weakened. There is even the potential for this to be challenged as a breach of Article 14 ECHR and s.13 of the Equality Act 2010, if it is seen as discrimination on the ground of sex.[25] Margaret Brazier considered whether the unequal treatment of mothers and fathers under the CDCLA was justified in 1997,[26] and Catherine Stanton considered whether parental liability for transmission of genetic harms was a possibility in her 2015 article.[27] Since then, as I have argued, developments in society, medical science, and the criminal law have increased the possibility of paternal liability under the CDCLA and therefore, have increased the potential for the exclusion of maternal liability to be challenged. In particular, I have argued that paternal liability for non-disclosure of HIV status at the time of conception is now a real possibility. As mothers are excluded from

[23] Brazier 'Parental Responsibilities' (n 2).
[24] Fovargue and Miola 'Policing pregnancy' (n 2).
[25] See Chapter 4.4 above.
[26] Brazier 'Parental Responsibilities' (n 2).
[27] Stanton (n 2).

liability for an equivalent non-disclosure, there is the potential for such unequal treatment to be challenged as unequal treatment before the law. My examination of the justification for the maternal exclusion and for not extending the exclusion to fathers, demonstrates the need for the CDCLA to be updated by extending the exemption to fathers with an exception for intentional torts committed against the mother during pregnancy.

One possible reason why the unequal treatment of mothers and fathers under the CDCLA has gone largely unchallenged is that there is a degree of acceptance that women need to be protected from a legal duty to prioritise the health of their future children that would render them reproducers first and foremost, and a fear that offering a similar protection to men would threaten the protection of women. However, this is not necessarily the case. As I have argued, extending the exclusion of liability to fathers with an exception for intentional torts committed against the mother during pregnancy would strengthen the message that a legal duty to prioritise the welfare of one's future children (including hypothetical future children) is inappropriate, whilst acknowledging the significance of the bodily relationship in pregnancy. Further, if we are to encourage men to play a more equal role in parenting and prevent reproduction being seen as only 'women's business', we should acknowledge that men can and do have a significant impact on the welfare of their future children and ask whether legal liability for either parent is appropriate when that impact is a negative one.

The rejection of criminal liability by the Court of Appeal in the case of *CP* was based on the policy reasons underlying the maternal exemption in CDCLA.[28] As I have shown in Chapter 9, many of these policy reasons also support an exclusion of paternal liability. However, this would not justify an equality of treatment of maternal and paternal liability in the criminal

[28] *CP* 1178-1179 para [67].

law. This is because the criminal law on prenatal harm is solely concerned (in its current form) with harm done during pregnancy; there is no criminal offence of causing harm to a future child at conception or even preconception.[29] As I have argued in Chapter 9, it is the bodily relationship of pregnancy that necessitates unequal treatment of pregnant women and third parties (including fathers) at this stage. It is at the preconception and conception stage that unequal maternal and paternal liability is unjustified.

By drawing together how maternal prenatal harm is viewed in public health, the criminal and the civil law, this thesis presents a strong argument in favour of a re-examination of how we think about the maternal-future child relationship.

The research in this thesis shows that the conflict model of pregnancy is not fit for purpose when considering wanted pregnancies that women intend to bring to birth. It leads to public health interventions that are likely to do more harm than good, it encourages the criminal law to view the foetus as 'other' to the pregnant woman in the same way as it is to a third party, and it fails to accurately reflect the complex relationship that mothers *and* fathers have with their future children prior to, and at the time of, conception. I argue that a peacetime model of pregnancy is needed; one that recognises that by respecting and enhancing the social autonomy of pregnant women, we are enabling her to make choices that are in the best interests of her *and* her future child. This concept of autonomy and peacetime view of pregnancy enables prenatal harm to be tackled, not as a problem of the morally condemnable behaviour of pregnant women, but as a problem caused by social and economic factors such as poverty and education, which prevent women from making choices in the interests of

[29] *Criminal Injuries Compensation Authority v First-tier Tribunal and Y (CICA v F-tT and Y)* [2017] EWCA Civ 139.

themselves and their future children. A shift away from the individualistic view of prenatal harm and the moral condemnation of pregnant women could reduce the likelihood of maternal legal liability for prenatal harm. Conversely, if the door to maternal legal liability was more firmly shut, this could weaken the moral condemnation of pregnant women, as it would be clear that their behaviour is not of the same moral character as that of a third party whose actions cause harm to a future child. In this way, the 'policing of pregnancy' in public health campaigns could be reduced and more effective measures adopted to reduce prenatal harm.

10.2 Final Reflections and Future Research

The writing of this thesis has provided me with the opportunity to revisit the arguments surrounding maternal legal liability for prenatal harm and to question what has become a prevailing narrative of maternal and foetal interests as being in conflict with each other. What has emerged is the realisation that far from being in conflict, in the case of wanted pregnancies that women intend to bring to birth, the interests of pregnant women and future children are closely aligned and that any attempt to impose a legal duty on pregnant women to act in the interests of their future children is likely to be unwarranted and counterproductive.

It is time for a shift in the view of pregnancy taken by the law and in public health. If we want to protect future children from the conduct of pregnant women, we need to stop viewing that conduct as something the pregnant woman does to her future child, and consider why she is doing it to herself. The welfare of future children and future adults, some of whom will

also be future pregnant women, would be improved if we address the social conditions that are so closely associated with potentially harmful behaviours. Similarly, the law has so far struggled to grasp the true nature of pregnancy and has seemed uncomfortable with defining its role in protecting future children and the rights of pregnant women. The cases on court ordered caesarean sections, for example, demonstrates the pre-eminence of the principle of respect for bodily autonomy in theory, but a reluctance to uphold this in practice where foetal harm will result.[30] The difficulty lies in the unique nature of pregnancy which means that the system of precedent and analogy that our legal system is based on is not appropriate.[31] It is time for the law to address pregnancy head on and grasp its true nature to determine what limits are appropriate on the choices pregnant women have that can cause harm to someone who is not yet a person? In my view, intentionally causing harm; doing an act with the aim of causing the future child harm, might warrant legal intervention, but there is no evidence that this is happening and intention would be difficult to prove beyond reasonable doubt, or even on the balance of probabilities, given that the woman would presumably be administering a substance to herself for which there could be other motives.

Similarly, legal liability for non-intentional harm would be inappropriate. Women should not be placed under a duty to prioritise the interests of their future children as to do so would reduce them to foetal containers, rather than fully capacitous adult persons. As Brazier states, the moral duty that a pregnant woman owes to her future child is to take its interests into account in her decision making.[32] This is not something that the law can or should seek to enforce as it would be impossible to prove that she did not consider the interests of her future child at all, and the possibility of any legal sanctions would expose women to coercion, for example, in matrimonial disputes, and consent to medical treatment.[33] Therefore, we are left

[30] See Chapter 2.3 above.
[31] Jackson (n 2) 144.
[32] Brazier 'Liberty, Responsibility, Maternity' (n 2).
[33] ibid 379-380.

with the conclusion that the maternal-future child relationship is unique and the law should play no part in policing the decisions women make regarding their conduct during pregnancy.

A further observation that has arisen from my research for this thesis is that the trend for viewing prenatal harm as a problem of individual behaviour is not an isolated one, it applies to health more generally. One very clear example is the moralising of obesity. Instead of viewing obesity as a social problem of high cost healthy food; mass marketing of poor quality, high calorie, addictive junk food; poorly designed cities; mental health; unavailability of leisure facilities and green spaces; and the pressure to work long hours leaving little time or energy to prepare healthy meals, it is instead presented as a problem of laziness and weakness.[34] It does not seem far-fetched to suggest that obese patients could be charged for their medical care, or for their medical care to be seen as less worthy of funding, or even for them to face legal sanctions such as findings of contributory negligence against them for unreasonably contributing to their harm. This thesis has drawn attention to the individualisation of illness evident in interventions aimed at reducing prenatal harm (see Chapters 6 and 7). The extent to which this is reflected in funding decisions, treatment guidelines, and the concept of contributory negligence is something that requires further research.

Another area that warrants further research is the impact of current public health interventions aimed at pregnant women on the relationship of trust they have with their

[34] Alexandra Brewis and Amber Wutich, *Lazy, crazy, and disgusting: stigma and the undoing of global health* (Johns Hopkins University Press 2019); Josefina Bressan, Fernanda de Carvalho Vidigal, and Helen Hermana M. Hermsdorff, 'Social components of the obesity epidemic' (2013) 2 Curr Obes Rep 32; Claudia Sikorski, and others, 'The stigma of obesity in the general public and its implications for public health - a systematic review' (2011) 11 BMC Pub Health 661.

caregivers, from both the professional and patient point of view.[35] The studies so far have been limited, particularly in relation to routine screening, but there is a study under way by a collaboration of BPAS and the University of Southampton surveying midwives' experience of these interventions.[36] If, as seems likely for the reasons explained in Chapters 6 and 7, the move towards routine screening has a negative impact on the relationship of trust between women and their healthcare team, this would strengthen the argument that such measures are counterproductive and unjustified.

One further concern is the potential impact of the overturning of the constitutional right to abortion in *Roe v Wade*[37] in the USA on legal liability for prenatal harm in the USA and in this country. Although the law on abortion is on a very different footing in England and Wales than in the USA, abortion remains a criminal offence in this country and there is the potential for the exemptions in the Abortion Act 1967 to be altered or simply construed more narrowly.[38] If the expectation that a pregnant woman must prioritise the interests of a foetus were to gain wider acceptance, it seems likely that calls for pregnant women to prioritise the interests of their future children would be strengthened. After all, future children will become fully fledged persons, with a full set of rights and so it seems less controversial to say that a pregnant woman should prioritise her future child's interests, than it is to say a pregnant woman should prioritise the rights of a foetus who she does not intend to bring to birth. However, it must be remembered that the law does not expect anyone to prioritise the

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[35] A recent study looked at women's experiences of public health messages and concluded that more individualised care, continuity, and less judgement and stigmatisation from health care professionals would improve experiences for women and may lead to better engagement with services: Rebecca Blaylock and others, 'WRISK voices: A mixed-methods study of women's experiences of pregnancy-related public health advice and risk messages in the UK' (2022) 113 Midwifery.
[36] Fiona Woollard, Responses to Alcohol and Pregnancy Policy (University of Southampton, 2022) <https://www.southampton.ac.uk/publicpolicy/support-for-researchers/New%20Things%20Fund/202122/fiona-woollard.page> accessed 25 July 2022.
[37] 410 US 113, 163-64 (1973); *Dobbs v Jackson Women's Health Organization* 597 US (2022).
[38] See for example the recent (unsuccessful) challenge to s.1(1)(d) of the Abortion Act 1967 by disability rights campaigners in *R (Crowter) v Secretary of State for Health and Social Care* [2021] EWHC 2536 (Admin).

interests of another over their own in decisions regarding their healthcare. Even a parent of an existing child cannot be compelled to donate a drop of blood to save the life of their child.[39] Therefore, even though the future child is a future legal person, it would be unjust to require a pregnant woman to prioritise its interests.

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In this thesis I have taken a fresh approach to the question of maternal liability for prenatal harm by considering how the behaviour of pregnant women is currently being policed through public health measures aimed at reducing prenatal harm and examining the potential for this to be translated into legal liability. The principle arguments that maternal legal liability for prenatal harm remains a possibility because of the current focus on the status of the victim in the criminal law and the unequal treatment of mothers and fathers in the civil law, and that the current approach to prenatal harm in public health demonstrates a view of the maternal-future child relationship that could be used to support such liability, raise significant concerns for the hard-won rights of women. The resolution of these issues has implications not only for pregnant women and future children, but also for how we are all held responsible for our own health.

[39] Brazier, M., and Cave, E., *Medicine, patients and the law* (6th edn, Manchester University Press 2020) para 11.21.

BIBLIOGRAPHY

Abel, E. L., 'An update on incidence of FAS: FAS is not an equal opportunity birth defect' (1995) 17(4)

Abu-Saad, K. and Fraser, D., 'Maternal nutrition and birth outcomes' (2010) 32(1) Epidemiol Rev 5

Adhikari, R. and Sawangdee, Y., 'Influence of women's autonomy on infant mortality in Nepal' (2011) 8 Reprod 1

Aikin, R., and others, 'Biomarkers of doping: uses discovery and validation' (2020) 12(11) Bioanalysis 791

Al-Gailani, S., and Davis A., 'Introduction to "Transforming pregnancy since 1900"' (2014) 47 Stud Hist Philos Biol Biomed Sci 229.

Al-Othman, H. and Al-Khalaf, L., 'Women still on trial over abortions' *Sunday Times* (London, 17 July 2022)

Alghrani, A. and Brazier, M., 'What is it? Whose it? Re-positioning the Foetus in the Context of Research?' (2011) 70 CLJ 51

Allard, K., 'HIV – still a death sentence?' (*Kingsley Napley*, 20 November 2015) <https://www.kingsleynapley.co.uk/insights/blogs/medical-negligence-and-personal-injury-blog/hiv-still-a-death-sentence> accessed 28 March 2022

Allen, F. and others, 'The effectiveness of interventions targeting major potentially modifiable risk factors for infant mortality: A user's guide to the systematic review evidence' (National Perinatal Epidemiology Unit: University of Oxford, 2009)

Allen, M., *Criminal Law* (13th edn, Oxford University Press 2015)

Allen, M., *Textbook on Criminal Law* (13th edn, Oxford University Press 2015)

Allen, N., 'A human right to smoke?' [2008] 158 New Law J 886

Altintas, E., 'Are British parents investing less time in their children?' Centre for Social Investigation Briefing Note 27 (Oxford Nuffield College, 2016) <http://csi.nuff.ox.ac.uk/wp-content/uploads/2016/09/CSI-27-Are-British-Parents-investing-less-time.pdf> accessed 19 November 2021

Amnesty International, 'Key Facts on Abortion' <https://www.amnesty.org/en/what-we-do/sexual-and-reproductive-rights/abortion-facts/> accessed 16 August 2022

Anon, 'Ethics of Down's syndrome screening test questioned' (2015) 18(10) J Learning Disability Practice 7

Arkell R. and Lee, E., 'Using meconium to establish prenatal alcohol exposure in the UK: ethical, legal and social considerations' (2022) J Med Ethics <https://jme.bmj.com/content/early/2022/07/22/jme-2022-108170> accessed 25 July 2022.

Armstrong, E. and Abel, E., 'Fetal Alcohol Syndrome: The Origins of a Moral Panic' (2000) 35(13) Alcohol Alcohol 276

Armstrong, E., 'Making Sense of Advice About Drinking During Pregnancy: Does Evidence Even Matter?' (2017) 26(2) J Perinat Educ 65

Arras, J., 'Theory and Bioethics' in Zalta E. N. (ed), *The Stanford Encyclopedia of Philosophy* (Winter 2019 Edition) <https://plato.stanford.edu/archives/win2019/entries/theory-bioethics/> accessed 20 April 2022

Ashwin, C., Marshall, J., and Standen, P., 'Exploring women's experiences of smoking during pregnancy and the postpartum' (2012) 10(4) EBM 112

Ashworth, A., *Sentencing and Criminal Justice* (2nd ed, Cambridge University Press 1995)

Bartie, S., 'The lingering core of legal scholarship' (2010) 30 Legal Studies 345

BBC News, 'Baby destruction woman sentenced' (24 May 2007) <http://news.bbc.co.uk/1/hi/england/manchester/6687893.stm> accessed 19 August 2020

BBC News, 'Moderate drinking in pregnancy 'harms IQ'' (15 November 2012) <https://www.bbc.co.uk/news/health-20325000> accessed 10 August 2022

BBC News, 'No alcohol in pregnancy advised' (*BBC News online*, 25 May 2007) <http://news.bbc.co.uk/1/hi/health/6687761.stm> accessed 18 January 2022

Bean P., and others, ‘Alcohol Biomarkers as Tools to Guide and Support Decisions About Intoxicated Driver Risk’ (2009) 10(6) Traffic Inj Prev 519

Beauchamp, T. L. and Childress, J. F., *Principles of Biomedical Ethics* (8th edn, Oxford University Press 2019)

Bell, K., McNaughton, D., and Salmon, A., ‘Medicine, Morality and Mothering: Public Health Discourses on Foetal Alcohol Exposure, Smoking Around Children and Childhood Overnutrition’ (2009) 19(2) Crit Public Health 155

Bennett, R., ‘Antenatal genetic testing and the right to remain in ignorance’ (2001) 22(5) Theor Med Bioeth 461

Bennett, R., ‘Routine antenatal HIV testing and informed consent: an unworkable marriage?’ (2007) 33(8) J Med Ethics 446

Bennett, R. and Bowden, C., ‘Why we must resist proposals for routine screening for alcohol in pregnancy’ (Journal of Medical Ethics Blog, 28 March 2022) <https://blogs.bmj.com/medical-ethics/2022/03/28/why-we-must-resist-proposals-for-routine-screening-for-alcohol-in-pregnancy/> accessed 6 September 2022

Bennett, R., Draper, H., and Frith, L., ‘Ignorance is bliss? HIV and moral duties and legal duties to forewarn’ [2000] 26(1) J Med Ethics 9

Bewley, S., ‘Restricting the freedom of pregnant women’ (2002) Matern Fetal Med 131

Bille, C. and Andersen, A-M. N., ‘Preconception care’ (2009) BMJ 338

Bingol, N. and others, ‘The influence of socioeconomic factors on the occurrence of fetal alcohol syndrome’ (1987) 6(4) Adv Alcohol Subst Abuse 105

Blair, P. S. and others, ‘Smoking and the sudden infant death syndrome: Results from 1993–5 case-control study for confidential inquiry into stillbirths and deaths in infancy. Confidential enquiry into stillbirths and deaths regional coordinators and researchers’ (1996) 313(7051) BMJ 195

Blaylock, R., and others, ‘WRISK voices: A mixed-methods study of women's experiences of pregnancy-related public health advice and risk messages in the UK’ (2022) 113 Midwifery

Bloch, M. and Parascandola, M., ‘Tobacco use in pregnancy: A window of opportunity for prevention’ (2014) 2(9) Lancet Glob Health 489

Boehmer, U. and Williamson, J. B., 'The impact of women's status on infant mortality rate: A cross-national analysis' (1996) 37 Soc Indic Res 333

Borry, P., Schotsmans, P., and Dierickx, K., ‘The birth of the empirical turn in bioethics’ (2005) 19(1) Bioethics 49

Boutwell, B. B. and Beaver, K., ‘Maternal cigarette smoking during pregnancy and offspring externalizing behavioral problems: A propensity score matching analysis’ (2010) 7(1) Int J Environ Res Public Health 146

Bowden, C., ‘Are we justified in introducing carbon monoxide testing to encourage smoking cessation in pregnant women?’ (2019) 2(1) J Med Law Ethics 3

Brazier, M. and Cave, E., *Medicine, Patients and the Law* (6th edn, Manchester University Press 2020)

Brazier, M., ‘Liberty, Responsibility, Maternity' (1999) 52 Curr Leg Probl 359

Brazier, M., ‘Parental Responsibilities: Foetal Welfare and Children’s Health’ in Bridge C. (ed), *Family Law Towards the Millennium: Essays for P M Bromley* (Butterworth-Heinemann Ltd 1997)

Brenick, A. and others, ‘Understanding the Influence of Stigma and Medical Mistrust on Engagement in Routine Healthcare Among Black Women Who Have Sex with Women’ (2017) 4(1) LGBT Health 4

Bressan, J., de Carvalho Vidigal, F., and Hermsdorff, H. H. M., ‘Social components of the obesity epidemic’ (2013) 2 Curr Obes Rep 32

Brewis, A. and Wutich, A., *Lazy, crazy, and disgusting: stigma and the undoing of global health* (Johns Hopkins University Press 2019)

Brione, R., ‘To what extent does or should a woman’s autonomy overrule the interests of her baby? A study of autonomy-related issues in the context of caesarean section’ (2015) 21(1) New Bioeth 71

Brown, R. C. H., ‘Resisting Moralisation in Health Promotion’ (2018) 21 *Ethic Theory Moral Prac* 997.

Bryce, A. and others, 'CATCH: Development of a home-based midwifery intervention to support young pregnant smokers to quit' (2009) 25(5) Midwifery 473

Button, T. M. M., Maughan, B., and McGuffin, P., 'The relationship of maternal smoking to psychological problems in the offspring' (2007) 83(11) Early Hum Dev 727

Campbell, A. V., 'Viability and the moral status of the fetus' in *Abortion: Medical Progress and Social Implications* (Pitman 2009).

Campbell, D., 'Test all pregnant women for smoking, say NHS chiefs' *The Guardian* (Sunday 26 February)

Cattapan, A., 'Perpetually, Potentially, Pregnant' <https://www.perpetuallypotentiallypregnant.com> accessed 11 July 2022.

Cave, E. and Stanton C., 'Maternal responsibility to the child not yet born' in Stanton, C., Devaney, S., Farrell, A-M., and Mullock, A. (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015)

Cave, E., *Mother of All Crimes* (Routledge 2018)

Center for Reproductive Rights 'Punishing women for their behaviour during pregnancy; an approach that undermines women's health and children's interests' (Briefing paper, September 200) <https://reproductiverights.org/sites/default/files/documents/pub_bp_punishingwomen.pdf> accessed 25 July 2022

Centers for Disease Control and Prevention, 'Achievements in public health. Reduction in perinatal transmission of HIV infection – United States, 1985–2005' [2006] 55 MMWR Morb Mortal Wkly Rep 592

Chamberlain, C. and others, 'Psychosocial interventions for supporting women to stop smoking in pregnancy' (2017) 2(2) Cochrane Database Syst Rev CD001055

Chick, J., 'Can light or moderate drinking benefit mental health?' (1999) 5(2) Eur Addict Res 74

Clark, T. and Nolan, D., 'A critique of *Chester v Afshar*' 34 (4) [2014] Oxf J Leg Stud, 664

Coggon, J., 'Public Health, Responsibility and English Law: Are There Such Things as No Smoke without IRE or Needless Clean Needles' [2009] 17 Med L Rev 127

Cohen Cramer Solicitors, 'Catching a sexually transmitted disease' <https://www.cohencramerpi.co.uk/cica-claims/claims-for-victims-of-rape-and-sexual-assault/claim-for-sexually-transmitted-disease/> accessed 28 March 2022

Coke, E., *The third part of the Institutes of the laws of England: concerning high treason, and other pleas of the crown, and criminal causes*, vol 1 (W. Clarke and Sons 1809)

Collier, R. and Sheldon, S., *Fragmenting Fatherhood: A socio-legal study* (Bloomsbury Publishing 2008)

Cooper, E. R. and others, 'Combination antiretroviral strategies for the treatment of pregnant HIV-1-infected women and prevention of perinatal HIV-1 transmission' [2002] 29 J Acquir Immune Defic Syndr 484

Coulter, A. and Ellins, J., 'Effectiveness of strategies for informing, educating, and involving patients' (2007) 335(7609) BMJ 24

Cownie, F., *Legal Academics: Cultures and Identities* (Hart 2004)

Criminal Injuries Compensation Calculator <https://criminal-injuries-compensation.co.uk/how-much-compensation-will-i-receive/> accessed 5 August 2021

Criminal Injuries Compensation Scheme 2012, Annex B <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808343/criminal-injuries-compensation-scheme-2012.pdf> accessed 5 August 2021

Crown Prosecution Service, 'The Code for Crown Prosecutors' 2018 <https://www.cps.gov.uk/publication/code-crown-prosecutors > accessed 20 August 2020

Daniels, C., 'Fathers, mothers and fetal harm' in Morgan L. M. and Michaels M. W. (eds), *Fetal subjects: Feminist positions* (Pennsylvania University Press 1999) 83

Daniels, C., *Exposing men: The science and politics of male reproduction* (Oxford University Press 2008)

Day, J. and others, 'Influence of paternal preconception exposures on their offspring: Through epigenetics to phenotype' (2016) 5(1) Am J Stem Cells 11

Department of Health and Social Care, *Fetal alcohol spectrum disorder: health needs assessment* (9 September 2021)

Department of Health, *Review of the Health Inequalities Infant Mortality PSA Target* (London 2007)

Devlin, P. Baron, *The Enforcement of Morals* (Oxford University Press 1965)

Donovan, B. M. and others, 'Intimate partner violence during pregnancy and the risk for adverse infant outcomes: a systematic review and meta-analysis' [2016] 123 BJOG 1289

Dworkin, G., *The theory and practice of autonomy* (Cambridge University Press 1991)

Dworkin, R., *Life's Dominion: An Argument about Abortion and Euthanasia* (HarperCollins 1993)

Ebner, N., and others, 'Management of neonatal abstinence syndrome in neonates born to opioid maintained women' (2007) 87(2-3) Drug Alcohol Depend 131.

Editorial, 'A woman's rights: parts 1-7' *New York Times* (New York, 28 December 2018) <https://www.nytimes.com/interactive/2018/12/28/opinion/pregnancy-women-pro-life-abortion.html> accessed 16 June 2022.

Entwistle, V., Cribb, A., and Owens, J., 'Why health and social care support for people with long-term conditions should be oriented towards enabling them to live well' (2018) 26(1) Health Care Anal 48

European Collaborative Study, 'HIV-infected pregnant women and vertical transmission in Europe since 1986' [2001] 15 AIDS 761

European Collaborative Study, 'Mother-to-child transmission of HIV infection in the era of highly active antiretroviral therapy' [2005] 40 Clin Infect Dis 458

Feinberg, J., *Freedom and Fulfillment* (Princeton University Press 1994) ch 2

Finnis, J., 'The Rights and Wrongs of Abortion: A reply to Judith Thomson' (1973) 2(2) Philos Public Aff 117

Fletcher, R., 'On care, coercion, and childbirth in the Court of Protection.' (*Open Justice Court of Protection Project,* 5 July 2021) <https://openjusticecourtofprotection.org/2021/07/05/on-care-coercion-and-childbirth-in-the-court-of-protection/> accessed 21 September 2021

Fortin, J. E. S., 'Legal Protection for the Unborn Child' (1988) Mod L Rev 54

Fortin, J., 'Is the "Wrongful Life" Action Really Dead?' (1987) J Soc Wel L 306

Foster, C. and Savulescu, J., 'Should pregnant mothers owe a duty to their unborn children?' (2018) New Law J

Fovargue, S. and Miola, J., 'Are we still policing pregnancy?' in Stanton, C., Devaney, S., Farrell, A-M., and Mullock, A. (eds), *Pioneering Healthcare Law: Essays in Honour of Margaret Brazier* (Routledge 2015)

Fovargue, S. and Miola, J., 'Policing pregnancy: implications of the Attorney-General's Reference (No. 3 of 1994)' (1998) 6 MLR 265

Fovargue, S., 'Anticipating Issues with Capacitous Pregnant Women: *United Lincolnshire NHS Hospitals Trust v CD* [2019] EWCOP 24 and *Guys and St Thomas' NHS Foundation Trust (GSTT) and South London and Maudsley NHS Foundation Trust (SLAM) v R* [2020] EWCOP 4' (2020) 28(4) MLR 781

Fresh NE, 'Major initiative to protect unborn babies from smoking in the North East' (2017) <http://www.freshne.com/in-the-news/pr/item/1974-major-initiative-to-protect-unborn-babies-from-smoki ng-in-the-north-east> accessed 8 November 2017

Friedman, M., 'Feminism and modern friendship: Dislocating the community' (1989) 99 Ethics 275

Friesen, P., 'Personal responsibility within health policy: Unethical and ineffective' (2016) 44(1) Journal Med Ethics 53

Garcia-Broncano, P. and others, 'Early antiretroviral therapy in neonates with HIV-1 infection restricts viral reservoir size and induces a distinct innate immune profile' [2019] 11 Sci Transl Med

Gavaghan, C., ' "You can't *handle* the truth"; medical paternalism and prenatal alcohol use' (2009) 35 J Med Eth 300

General Medical Council, *Decision making and consent* (2020) para 25 <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent> accessed 18 January 2022

Gillon, R., ‘Ethics needs principles—four can encompass the rest—and respect for autonomy should be “first among equals”’ (2003) 29 J Med Ethics 307

Goodwin, M., *Policing the womb: Invisible women and the criminalization of motherhood. (Cambridge University Press 2020).*

Gray, R. and Henderson, J., *Review of the fetal effects of prenatal alcohol exposure* (Report to the Department of Health, University of Oxford 2006)

Gray, R. and Rutter, M., ‘Alcohol consumption during pregnancy and its effects on neurodevelopment: What is known and what remains uncertain’ (2009) 104(8) Addiction 1270

Green, N. and others, ‘Research agenda for preterm birth: Recommendations from the March of Dimes’ (2005) 193(3) Am J Obstet Gynecol 626

Greenway, J. C., Entwistle, V. A., and terMeulen, R., ‘Ethical tensions associated with the promotion of public health policy in health visiting: a qualitative investigation of health visitors’ views’ (2013) 14(2) Prim Health Care Res Dev 200

Gross, H., *A Theory of Criminal Justice* (Oxford University Press 1979)

Hansard Debate 06 (February 1976, volume 904) 1593 <https://api.parliament.uk/historic-hansard/commons/1976/feb/06/congenital-disabilities-civil-liability> accessed 25 August 2020

Harris, J., *The value of life: an introduction to medical ethics* (Routledge & Kegan Paul 1985)

Hart, H. L. A., ‘Prolegomenon to the principles of punishment’ in *Punishment and Responsibility: Essays in the Philosophy of Law* (2nd ed, Oxford University Press 2008) <https://oxford-universitypressscholarship-com.manchester.idm.oclc.org/view/10.1093/acprof:oso/9780199534777.001.0001/acprof-9780199534777-chapter-1> accessed 12 May 12 2022

Herring, J., *Medical Law and Ethics* (4th edn, Oxford University Press 2012)

HM Government, *Consultation on proposes changes to the Mental Capacity Act 2005 Code of Practice and Implementation of the Liberty Protection Safeguards* <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1084096/changes-to-the-MCA-code-and-implementation-of-the-LPS-consultation-document-extension.pdf> accessed 16 August 2022

HM Government, *Mental Capacity Act 2005 Code of Practice* (Draft) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1080137/draft-mental-capacity-act-code-of-practice.pdf> accessed 16 August 2022

Holm, S., ‘Not just autonomy--the principles of American biomedical ethics’ (1995) 21(6) J Med Ethics 332

Honoré, T *Responsibility and Fault* (Bloomsbury 2002)

Howlett, H. and others, ‘Assessing prevalence of alcohol consumption in early pregnancy: Self-report compared to blood biomarker analysis’ (2018) 61(9) Eur J Med Genet 531

Hulme, A. V., ‘An Emerging Pattern? A Further Case of Anticipated Capacity Loss in Pregnancy: North Middlesex University Hospital NHS Trust V SR [2021] EWCOP 58’ (2022) MLR <https://academic.oup.com/medlaw/advance-article-abstract/doi/10.1093/medlaw/fwac021/6617970?login=false> accessed 24 July 2022

Hutchinson, T., 'The Doctrinal Method: Incorporating Interdisciplinary Methods in Reforming the Law' (2015) 8 Erasmus L Rev 130

Huxtable, R. and Ives, J., ‘Mapping, framing, shaping: a framework for empirical bioethics research projects’ (2019) 20(86) BMC Med Ethics <https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-019-0428-0.pdf> accessed 3 August 2022

Jackson, E., ‘Challenging the comparison in Montgomery between patients and ‘consumers exercising choices’’ (2021) 29(4) MLR 595

Jackson, E., *Regulating reproduction: Law, technology and autonomy* (Bloomsbury Publishing 2001)

Jarvis-Thomson, J., ‘A Defense of Abortion’ (1971) 1 Philos Public Aff 47

Jefferson, M., *Criminal Law* (11th edn, Pearson Education 2013)

JJ Way, <http://www.commonsensechildbirth.org/jjway/> accessed 27 April 2018

Josephs, L. and Brown, S., *The JJ Way: Community-based Maternity Center Final Evaluation Report* (Visionary Vanguard Group Inc, 2017) <https://secureservercdn.net/198.71.233.72/qj7.106.myftpupload.com/wp-content/uploads/2022/03/The-JJ-Way%C2%AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf > accessed 6 September 2022

Juárez, S. P. and Merlo, J., 'Revisiting the effect of maternal smoking during pregnancy on offspring birthweight: A quasi-experimental sibling analysis in Sweden' (2013) 8(4) PLoS ONE e61734

Kabir, Z. and others, 'Declining maternal smoking prevalence did not change low birthweight prevalence in Massachusetts from 1989 to 2004' (2009) 19(1) Eur J Public Health 65

Kant, I., *Groundwork for the Metaphysic of Morals,* Gregor, M. and Timmermann, J. (eds), (Cambridge Texts in the History of Philosophy, revised edition, Cambridge University Press 2012)

Kater-Kuipers, A. and others, 'Ethics of routine: a critical analysis of the concept of 'routinisation' in prenatal screening (2018) 44 J Med Ethics 626

Kelly, Y. and others, 'Light drinking in pregnancy, a risk for behavioural problems and cognitive deficits at 3 years of age?' (2009) 38 Int J Epidemiol 129

Kitzinger, C., 'Refusing blood products during pregnancy and labour' (*Open Justice Court of Protection Project*, 21 September 2021) <https://openjusticecourtofprotection.org/2021/09/21/refusing-blood-products-during-pregnancy-and-labour/?fbclid=IwAR2a2vlBesq6aPlgJXpNiB5Y_rHd-PnJGQKjnFU4YzjPtQKBWGeF7pHEvRY> accessed 22 September 2021

Kuhse, H. and Singer, P. D., 'What is Bioethics? A historical introduction' in Kuhse, H. and Singer, P. (eds), *A Companion to Bioethics* (Wiley-Blackwell 1998)

Kukla, R., 'Measuring mothering' (2008) 1(1) Int J Fem Approaches to Bioethics 67

Kukla, R., *Mass Hysteria: Medicine, Culture, and Mothers' Bodies* (Rowman & Littlefield Publishers 2005)

Lane Powell PC, 'Liability for transmission of HIV and other sexually transmitted diseases in Washington' Lexology, (*Lexology*, 5 May 2011) <https://www.lexology.com/library/detail.aspx?g=617851df-13a5-4e31-9d81-2773c133f75e> accessed 28 March 2022

Laurance, J., 'Even Moderate Drinking During Pregnancy can Affect Child's IQ' *The Independent* (15 November 2012) <https://www.independent.co.uk/life-style/health-and-families/health-news/even-moderate-drinking-during-pregnancy-can-affect-child-s-iq-8317300.html> accessed 10 August 2022

Law Commission, *Injuries to Unborn Children* (Law Com. No. 60, 1974)

Law Commission, *Reform of Offences Against the Person* (Law Com No 361, 2015)

Lee, E. and others, 'Beyond 'the choice to drink' in a UK guideline on FASD: the precautionary principle, pregnancy surveillance, and the managed woman' (2022) 24(1-2) Health Risk Soc 17

Lee, E., Sutton, R. M., and Hartley, B. L., 'From scientific article to press release to media coverage: advocating alcohol abstinence and democratising risk in a story about alcohol and pregnancy' (2016) Health Risk Soc 18(5-6) 247

Levy, J. K., 'Jehovah's witnesses, pregnancy, and blood transfusions: a paradigm for the autonomy rights of all pregnant women' (1999) 27 JL Med & Ethics 171.

Lewis, S. and others, 'Fetal alcohol exposure and IQ at age 8: Evidence from a population-based birth cohort study' (2012) 7(11) PLoS One e49407

Liptak, A., 'People who pass on AIDS virus may be sued', (*New York Times*, 4 July 2006) <https://www.nytimes.com/2006/07/04/health/people-who-pass-on-aids-virus-may-be-sued.html> accessed 28 March 2022

Lowe, P. K. and Lee, E. J., 'Advocating alcohol abstinence to pregnant women: Some observations about British policy' (2010) 12(4) Health Risk Soc 301

Lumley, J. and others, 'Interventions for promoting smoking cessation during pregnancy' (2009) 8(3) Cochrane Database of Syst Rev: CD001055

MacIntyre, A., *After virtue* (A&C Black 2013)

Mackenzie, C., 'Abortion and embodiment' (1992) 70 Australas J Philos 136

Mackenzie, C., and Stoljar, N., 'Introduction: autonomy refigured' in Mackenzie, C. and Stoljar, N. (eds), *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self* (Oxford University Press 2000)

Marcellus, L., 'Is Meconium Screening Appropriate for Universal Use?' (2007) 7(4) Adv Neonatal Care 207.

Matas, A., 'Liability and the sexually transmitted disease' (*The Lawyers Weekly*, 7 February 2014) <https://lernerspersonalinjury.ca/wp-content/uploads/Liability-and-the-sexually-transmitted-disease.pdf> accessed 28 March 2022

Mather, M., Wiles, K., and O'Brien, P., 'Should women abstain from alcohol throughout pregnancy?' (2015) BMJ 351 :h5232

McCarthy, N., 'Stabbed mum's unborn baby is refused criminal injuries compensation' *Birmingham Mail* (24 November 2016) <https://www.birminghammail.co.uk/news/midlands-news/stabbed-mums-unborn-baby-refused-12225378> accessed 5 August 2021

McGowan, A. and others, ''Breathe': The stop smoking service for pregnant women in Glasgow' (2010) 26(3) Midwifery e1–e13

McLean, S., *Autonomy, consent and the law* (Routledge, 2009)

McMillan, J., *The Methods of Bioethics: An Essay in Meta-Bioethics* (Oxford University Press 2018) ch 8

McQuire, C. and others, 'Screening prevalence of fetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study' (2019) 118 Prev Med 344

Miguel, A. R., 'Equality before the Law and Precedent' (1997) 10 Ratio Juris 372

Mill, J. S., *On Liberty* (Longman, Roberts and Green Co. 1859)

Milne, E., 'Concealment of Birth: Time to Repeal a 200-Year-Old "Convenient Stop-Gap"?' (2019) 27 Fem Leg Stud 139

Milne, E., 'Putting the fetus first – legal regulation, motherhood, and pregnancy' (2020) 27 Mich J Gend Law 149

Miola, J., 'The relationship between medical law and ethics' (2006) 1(1) Clin Ethics 22

Morgan, H. and others, 'An interview study of pregnant women who were provided with indoor air quality measurements of second hand smoke to help them quit smoking' (2016) 16(1) BMC Pregnancy Childbirth 305

Moss, R. 'Two women in UK are facing criminal charges for abortion. Here's why' (*Huffington Post*, 18 July 2022) <https://www.huffingtonpost.co.uk/entry/why-women-in-uk-face-criminal-charges-for-abortion_uk_62d5689ee4b0116f21be6fe1> accessed 23 July 2022

Mulheron, R., *Principles of Tort Law* (2nd edn, Cambridge University Press 2020)

Murugan, S. and Anburajan, R., 'Father to child transmission of human immunodeficiency virus disease while sero-discordant status of the mother is maintained' [2013] 34(1) Indian J Sex Transm Dis AIDS 60

Nakou, P., 'Is routine prenatal screening and testing fundamentally incompatible with a commitment to reproductive choice? Learning from the historical context' (2021) 24(1) Med Health Care Philos 73

National Institute for Health and Care Excellence (NICE), *Antenatal care* (NG201,2021) <https://www.nice.org.uk/guidance/cg62>accessed 24 May 2022

National Institute for Health and Care Excellence (NICE), *Antenatal Care* (NICE Guideline, NG201, 2021) <https://www.nice.org.uk/guidance/ng201> accessed 11 July 2022.

National Institute for Health and Care Excellence (NICE), *Fetal Alcohol Spectrum Disorder: NICE quality standard draft for consultation* (March 2020) <https://www.nice.org.uk/guidance/indevelopment/gid-qs10139/documents> accessed 3 November 2021

National Institute for Health and Clinical Excellence (NICE), *Smoking: Stopping in pregnancy and after childbirth* (NICE Guideline PH26, 2010)

National Institute for Health and Clinical Excellence (NICE), *Weight management before, during and after pregnancy* (NICE Guideline PH27, 2010)

Nelson, E., *Law, policy and reproductive autonomy* (Bloomsbury Publishing 2013)

Neureiter, A. and others, 'Trust in Science, Perceived Media Exaggeration About COVID-19, and Social Distancing Behavior' (2021) 9 Front Public Health article 670485 <https://www.frontiersin.org/articles/10.3389/fpubh.2021.670485/full> accessed 5 August 2022

Neurotoxicol Teratol 437

NHS England, *Screening tests for you and your baby* (NHS Guidance, 2019) <https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby> accessed 11 July 2022.

NHS Health Scotland, 'Ready Steady Baby! Tests and checks you may have' <http://www.ready steadybaby.org.uk/you-and-your-pregnancy/antenatal-care/tests-and-checks-you-may-have.aspx> accessed 15 November 2018

NHS Website, 'Foetal Alcohol Syndrome' <https://www.nhs.uk/conditions/foetal-alcohol-syndrome/> accessed 16 March 2022

NHS, 'Passive Smoking' <https://www.nhs.uk/live-well/quit-smoking/passive-smoking-protect-your-family-and-friends/> accessed 20 May 2021

NHS, 'Your antenatal appointments' (2019) <https://www.nhs.uk/pregnancy/your-pregnancy-care/your-antenatal-appointments/> accessed 24 May 2022.

NHS, Health Education England, *Making Every Contact Count* <http://www.makingeverycontactcount.co.uk> accessed 29th September 2021

NHS, *Smokefree* <https://www.nhs.uk/smokefree/help-and-advice> accessed 8 November 2017

NHS, *Your antenatal appointments* (2019) <https://www.nhs.uk/pregnancy/your-pregnancy-care/your-antenatal-appointments/> accessed 24 May 2022

Nicita, F. and others, 'Seizures in Fetal Alcohol Spectrum Disorders: Evaluation of Clinical, Electroencephalographic, and Neuroradiologic Features in a Pediatric Case Series' (2014) 55(6) Epilepsia e60-e66

Noonan Jr, J. T., 'Abortion and the Catholic Church: A Summary History' (1967) Nat LF 12

Noonan, J. T. Jr, 'An almost absolute value in history' in *The Morality of Abortion: Legal and Historical Perspectives* John T. Noonan Jr. (ed) (Harvard University Press 2013)

O'Brien, P., 'Is it all right for women to drink small amounts of alcohol in pregnancy? Yes' (2007) 335(7625) BMJ 856

O'Connell, R., 'A Dialogue on Discrimination and Equality: The UK Supreme Court and Article 14 ECHR' in Dickson, B., and McCormick, C. (eds), *The Judicial Mind: A Festschrift for Lord Kerr of Tonaghmore* (Hart Publishing 2022)

O'Connell, M. and Duaso, M., 'Barriers and facilitators of midwives' use of the carbon monoxide breath test for smoking cessation in practice: a qualitative study' (2014) 24(4) Midirs Midwifery Digest 453

Oppenheim, M., 'Postcode lottery preventing women in Northern Ireland accessing abortion services' (*Independent,* 21 October 2020) <https://www.independent.co.uk/news/uk/home-news/northern-ireland-abortions-women-postcode-lottery-b1205000.html> accessed 24 July 2022

Oshana, M., 'Personal autonomy and society' (1998) 29 J Soc Philos 81

Paltrow, L. M. and Flavin, J., 'Arrests of and forced interventions on pregnant women in the United States, 1973–2005: Implications for women's legal status and public health' (2013) 38 J Health Polit Policy Law 299.

Park, A. and others (eds), British Social Attitudes: the 30th Report (London, NatCen Social Research 2013) 126 <https://www.bsa.natcen.ac.uk/media/38457/bsa30_gender_roles_final.pdf> accessed 19 November 2021

Parkes, T. and others, *Double exposure: a better practices review on alcohol interventions during pregnancy* <https://bccewh.bc.ca/wp-content/uploads/2014/08/Double-Exposure.pdf> accessed 13 April 2021

Pickett, K. E. and Wilkinson, R. G., 'Income inequality and health: A causal review' (2015) 128 Soc Sci Med 316

Public Health England (PHE), *Maternity High Impact Area: Reducing the incidence of harms caused by alcohol in pregnancy* (December 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Mat

ernity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf> (accessed 3 November 2021)

Public Health Wales NHS Trust, 'Models for access to maternal smoking cessation support' (2015) <http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20MAMSS%20Report%20E%2003.17.pdf> accessed 15 November 2018

Pugh, J., 'The United Kingdom's Coronavirus Act, deprivations of liberty, and the right to liberty and security of the person' (2020) 7(1) J Law Biosci <https://academic.oup.com/jlb/article/7/1/lsaa011/5826792> accessed 3 August 2022

Purshouse, C., 'Review: Against Autonomy: Justifying Coercive Paternalism by Sarah Conly' (2014) 89 Philos 367

Raz, J., 'Liberalism, Autonomy, and the Politics of Neutral Concern' (1982) 7 Midwest Stud Philos 89

Richardson, S., *Maternal Imprint: The Contested Science of Maternal-Fetal Effects* (University of Chicago Press 2021).

Robertson, J., 'Procreative liberty and the control of conception, pregnancy, and childbirth' (1983) 69(3) VA Law Rev 405

Robertson, J., *Children of Choice: Freedom and the new reproductive technologies* (Princeton University Press 1994)

Romanis, E. C., 'Challenging the "Born Alive" Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood' (2020) 28 MLR 93

Royal College of Obstetricians and Gynaecologists and Faculty of Sexual and Reproductive Healthcare 'RCOG and FSRH statement on decriminalisation of abortion' (July 2022) <https://www.fsrh.org/documents/fsrh-rcog-statement-decriminalisation-of-abortion-2022/> accessed 16 August 2022

Salihu, H. M. and others, 'Levels of excess infant deaths attributable to maternal smoking during pregnancy in the United States' (2003) 7(4) Matern Child Health J 219

Sandel, M. J., *Liberalism and the Limits of Justice* (Cambridge University Press 1998)

Savasi, V. and others, 'Safety of sperm washing and ART outcome in 741 HIV-1-serodiscordant couples' [2007] 22(3) Hum Reprod 772

Savell, K., 'The Mother of the Legal Person', in James, S. and Palmer, S. (eds), *Visible Women: Essays on Feminist Legal Theory and Political Philosophy* (Hart Publishing 2002)

Savitz, D. A. and others, 'Influence of paternal age, smoking, and alcohol consumption on congenital anomalies' (1991) 44(4) Teratology 429

Schiff, D. N., 'Socio-Legal Theory: Social Structure and Law' (1976) 39(3) Mod L Rev 287

Schmitz, D., Netzer, C. and Henn, W., 'An offer you can't refuse? Ethical implications of non-invasive prenatal diagnosis' (2009) 10 Nat Rev Genet 515

Scott, R., 'Maternal duties toward the unborn? Soundings from the law of tort' (2000) 8(1) MLR 1

Scott, R., *Rights, duties and the body: law and ethics of the maternal-fetal conflict* (Hart Publishing 2002)

Scottish Intercollegiate Guidelines Network, *Guideline 156: Children and Young People Exposed Prenatally to Alcohol* (SIGN 156, 2019)

Seymour, J., *Childbirth and the Law* (Oxford University Press, 2000)

Sharma, A. and Kader, M., 'Effect of women's decision-making autonomy on infant's birth weight in rural Bangladesh' (2013) ISRN Pediat 159542

Sheldon, S. and Wellings, K. (eds), *Decriminalising Abortion in the UK: What would it mean?* (Policy Press 2020) <https://www.oapen.org/search?identifier=1007882> accessed 6 April 2020

Sheldon, S., 'Reconceiving masculinity: imagining men's reproductive bodies in law' [1999] 2 J Law Soc 129, 132

Sherr, L. and Barry, N., (2004) 'Fatherhood and HIV-positive heterosexual men' 5 [2004] HIV Med 258, 260

Shouse, N., ‘Can I sue someone for giving me herpes?’ (*Shouse Injury Law Group*, 8 July 2021) <https://www.shouselaw.com/ca/blog/personal-injury/can-i-sue-someone-for-giving-me-herpes/> accessed 28 March 2022

Siddique, H., ‘Doctors to breathalyse smokers before allowing them NHS surgery’ *The Guardian* (Wednesday 18 October 2017)

Sikorski C., and others, ‘The stigma of obesity in the general public and its implications for public health - a systematic review’ (2011) 11 BMC Pub Health 661

Smits, J., ‘What Is Legal Doctrine?: On The Aims and Methods of Legal-Dogmatic Research’ in van Gestel, R., Micklitz, H., and Rubin E. (eds), *Rethinking Legal Scholarship: A Transatlantic Dialogue* (Cambridge University Press 2017)

South Tees Hospitals NHS Foundation Trust, ‘Major initiative to tackle smoking in pregnancy underway’ (2013) <https://www.southtees.nhs.uk/news/health-improvement/major-initiative-tackle-smoking-pregnancy-underway/pregnancy-underway/> accessed 15 November 2018

South Warwickshire NHS Foundation Trust, ‘NHS Warwickshire Stop Smoking in Pregnancy Service’ <https://www.swft.nhs.uk/our-services/adult-hospital-services/maternity/nhs-warwickshire-stop-smoking-pregnancy-service> accessed 15 November 2018

Stanton, C., ‘Genetic transmission of disease: a legal harm?’ (2016) 24 Health Care Anal 228

Stapleton, G., ‘Qualifying choice: ethical reflection on the scope of prenatal screening’ (2017) 20 Med Health Care Philos 195

Steinbock, B., *Life Before Birth – The Moral and Legal Status of Embryos and Fetuses* (Oxford University Press 1992) ch 2, 36-107

Suter, A. M., ‘The Routinization of Prenatal Testing’ (2002) 28 Am J Law Med 233

Teff, H. and Munro, C., *Thalidomide: The Legal Aftermath* (Saxon House, 1976)

Tengland, P-A., ‘Behavior change or empowerment: On the ethics of health-promotion goals’ (2016) 24(1) Health Care Anal 24

The Royal College of Midwives, *High Quality Midwifery Care* (London 2014)

Thom, B., Herring, R., and Milne, E., ‘Drinking in pregnancy: shifting towards the 'precautionary principle'’ in MacGregor, S. and Thom, B. (eds), *Risk and Substance Use: Framing Dangerous People and Dangerous Places* (Routledge 2020)

Tolmie, J., ‘Alcoholism and Criminal Liability’ (2001) 64 Mod Law Rev 688

Tominey, E., ‘Maternal smoking during pregnancy and early child outcomes’ (2007) CEP Discussion Paper No 828: Centre for Economic Performance, London School of Economics

Townsend, C. L. and others, ‘Low rates of mother-to-child transmission of HIV following effective pregnancy interventions in the United Kingdom and Ireland, 2000–2006’ [2008] 22 AIDS 973

Turner-Warwick, M., ‘Smoking and the young: A report of a working party of the Royal College of Physicians’ (1992) 1(3) Tob Control 231

UK Chief Medical Officers, *Low Risk Drinking Guidelines* (August 2016) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf > accessed 27 October 2021

van der Eijk, Y. and Porter, G., ‘Human rights and ethical considerations for a tobacco-free generation’ [2015] 24(3) Tob Control 238

Viterna, J. and Bautista, J. S. G., ‘Pregnancy and the 40-year prison sentence: how “abortion is murder” became institutionalized in the Salvadoran judicial system’ (2017) 19 Health Hum Rights 81

Wang, D. W. L., ‘Mental Capacity Act, Anorexia, and the Choice Between Life-Prolonging Treatment and Palliative Care: A NHS Foundation Trust v Ms X’ (2015) 78(5) Mod L Rev 871

Warren, M. A., ‘On the moral and legal status of abortion’ (1973) Monist 43

Warren, M. A., ‘The Moral Significance of Birth’ in Bequaert Holmes, H. and Purdy, l. M., (eds), *Feminist Perspectives in Medical Ethics* (Indiana University Press 1992)

Welch-Carre, E., ‘The neurodevelopmental consequences of prenatal alcohol exposure’ (2005) 5 Adv Neonatal Care 217

Wells, C., and Quick, O., *Reconstructing Criminal Law: Text and Materials* (4th edn, Cambridge University Press 2010)

Wilkinson, D. and others, ‘Protecting future children from in-utero harm’ (2016) 30(6) Bioethics 425

Woollard, F., Responses to Alcohol and Pregnancy Policy (University of Southampton, 2022) <https://www.southampton.ac.uk/publicpolicy/support-for-researchers/New%20Things%20Fund/202122/fiona-woollard.page> accessed 25 July 2022

World Health Organisation, *Global alcohol action plan 2022-2030* < https://cdn.who.int/media/docs/default-source/alcohol/alcohol-action-plan/first-draft/global_alcohol_acion_plan_first-draft_july_2021.pdf?sfvrsn=fcdab456_3&download=true> accessed 25 July 2022

Zhao, L. and others, ‘Parental smoking and the risk of congenital heart defects in offspring: An updated meta-analysis of observational studies’ [2020] 27 Eur J Prev Cardiol 1284

APPENDIX

Thesis Papers in Published Form

1. **Catherine Bowden**, 'Are we justified in introducing carbon monoxide testing to encourage smoking cessation in pregnant women?' (2019) 27(2) Health Care Analysis 128.

2. Rebecca Bennett and **Catherine Bowden**, 'Can routine screening for alcohol consumption in pregnancy be ethically and legally justified?' (2022) 48 Journal of Medical Ethics 512, Feature Article.

3. **Catherine Bowden**, 'Is a relational approach required to close the door on criminal liability for maternal prenatal conduct?' (2020) 2(1) Journal of Medical Law and Ethics 3.

4. **Catherine Bowden**, 'Is the Unequal Treatment of Maternal and Paternal Liability Under the Congenital Disabilities (Civil Liability) Act 1976 Justified? (2022) 30(3) Medical Law Review 457.

Health Care Analysis (2019) 27:128–145
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ORIGINAL ARTICLE

Are We Justified in Introducing Carbon Monoxide Testing to Encourage Smoking Cessation in Pregnant Women?

Catherine Bowden[1]

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Abstract
Smoking is frequently presented as being particularly problematic when the smoker is a pregnant woman because of the potential harm to the future child. This premise is used to justify targeting pregnant women with a unique approach to smoking cessation including policies such as the routine testing of all pregnant women for carbon monoxide at every antenatal appointment. This paper examines the evidence that such policies are justified by the aim of harm prevention and argues that targeting pregnant women in this way is likely to do more harm than good. Routine carbon monoxide testing is particularly problematic as it sends a message to pregnant women that they cannot be trusted either to truthfully answer questions as to whether or not they smoke, or to make decisions in the best interests of themselves and their future children in the way that non-pregnant individuals are. Further, if the aim is to reduce rates of prenatal harm, the evidence suggests that adopting a supportive and empowering approach to prenatal care is the most effective way to achieve this, something that the current policies aimed at pregnant women are in conflict with.

Keywords Pregnancy · Smoking cessation · Reproductive autonomy · Prenatal care · Public health · Harm reduction · Autonomy

Introduction

It is normally assumed that pregnant women not only want their future children to be born as healthy as possible, but that they are also under a moral obligation to protect those future children during their fetal stage if they are intending to bring them to birth [12, 49]. This assumption underlies public health policies advocating interventions in pregnancy including those that aim to persuade women to limit their alcohol consumption, control their weight and stop smoking [37, 38, 59]. This paper focuses

✉ Catherine Bowden
Catherine.Bowden@Manchester.ac.uk

[1] School of Law, The University of Manchester, Oxford Road, Manchester M13 9PL, UK

on a particular public health intervention, routinely testing pregnant women for carbon monoxide to encourage smoking cessation, and asks whether such measures are justified.

While there has been a great deal of discussion around what moral obligations pregnant women might have to their fetuses and the children their fetuses might become, and how this should affect law and policy in this area [6, 12, 13, 39, 45, 48, 49, 54, 56], this paper seeks to explore a different but equally important question. It seeks to avoid the intractable nature of the debate concerning what moral obligations pregnant women might have, by starting from the assumption that a convincing case has been made that pregnant women have a moral obligation to take reasonable steps to avoid causing their future children harm. By making this assumption, I am then able to focus on the fundamental question of whether the evidence suggests that public health measures such as routine carbon monoxide testing in pregnancy are likely to achieve their aim of preventing harm to future children. This question has received little attention despite its significance for policy making, as well as the ethical and legal issues it raises. Without strong evidence of harm prevention, such interventions and their implications for the lives of pregnant women cannot be justified.

Smoking Cessation Interventions in Pregnancy

Non-pregnant smokers are frequently offered support to quit, including nicotine replacement therapies, support groups and counseling [41].[1] However, in England it is only pregnant women who, irrespective of whether they say they are smokers or not, are now to be routinely screened and monitored using carbon monoxide tests at all prenatal care appointments [16].[2] As the majority of routine face-to-face antenatal care in the UK is delivered by midwives, the task of performing the carbon monoxide tests falls to them, although some auxiliary staff have been involved where resources allow [35]. The implementation of this policy is therefore significant for the relationship between pregnant women and midwives. The policy was trialled in the North East of England in the Babyclear programme [22] and following the 2010 NICE Guidelines, 'Smoking: stopping in pregnancy and after childbirth' (the NICE Guidelines) [38] has been adopted by a number of NHS Trusts across England, Scotland and Wales.[3] The test involves the midwife holding a doll connected

[1] Carbon monoxide tests have been used on non-pregnant smokers in Hertfordshire but this has so far been limited to individuals who say they are smokers and are required to quit before being permitted surgery on the NHS. While this is also problematic, it is not the same as testing all patients regardless of whether they say they smoke or not. See [51].

[2] Other measures include, the promotion of smoke free homes during pregnancy and beyond. Such measures could potentially avoid some of the problems associated with the policy of singling out pregnant women for routine carbon monoxide screening [36].

[3] There is currently no evidence regarding the extent to which NICE Guidelines on smoking cessation during pregnancy have been implemented nationally but the policy has been adopted by a number of NHS Trusts including South Tees NHS Foundation Trust [52], South Warwickshire NHS Foundation Trust [53], NHS Scotland [40] and NHS Wales [44] among others.

to a model placenta, informing the pregnant woman that when you have a cigarette "…it is as if someone gets hold of your baby's cord and squeezes it really really hard and you can see that if that was held really tightly and squeezed really tightly, that stops the oxygen getting to your baby." [23] The woman is told that this will mean it will be a smaller, weaker baby, likely to need special care and she is likely to need a caesarean section [23]. The midwife then states that if it is alright with the woman she would like to do the test [23]. It is possible for a pregnant woman to refuse the test, but the fact that it is to be offered routinely at all antenatal appointments and given the emotive language used; presenting it as a test to see if someone is taking hold of the umbilical cord and squeezing it tightly, it seems inevitable that pregnant women will feel pressurised to take it. The pregnant woman then gives a breath sample connected to a computer screen displaying a picture of a fetus which changes from green to amber, to flashing red with an alarm sounding depending on the level of carbon monoxide in the woman's breath. If a high level of carbon monoxide is detected the woman is informed that her baby "…is in danger" and is struggling [23].

This goes beyond the support to quit offered to non-pregnant smokers, with a lack of trust inherent in testing all pregnant women for carbon monoxide levels regardless of whether they say they smoke or not. It could be argued that the test detects the presence of carbon monoxide rather than whether the woman smokes, as some level of carbon monoxide could be present from other sources. However, the purpose of the test is to discover if a pregnant woman smokes or not, as stated in the NICE Guidelines [38]. If a carbon monoxide test is needed to determine whether a pregnant woman smokes rather than relying on whether she says she does, this indicates that a pregnant woman cannot be trusted to answer this question truthfully.

It could be argued that targeting pregnant smokers is justified on the basis of preventing harm to the pregnant women themselves, utilising the window of opportunity that the close contact with health services provides [7, 10]. However, this would only justify such measures if a similar approach was taken to other windows of opportunity, including the partners of pregnant women, parents of existing children and patients receiving treatment for other conditions. While these individuals may be offered smoking cessation services, they are not being routinely tested to determine if they smoke or not. Further, if this were the justification for targeting pregnant smokers the emotional presentation connected to the future child's wellbeing would not be justified. It is clear that pregnant women are being treated differently because of the potential health risks to their future children.

Therefore, the question is, is singling pregnant women out for such pressurised interventions justified in order to prevent harm to future children?[4]

This paper suggests that for this to be the case four things would need to be established:

[4] As the policy under consideration is a public health measure, this paper assesses harm on the basis of rates of children born classified as being of low birthweight, stillborn or born preterm.

1. that smoking during pregnancy causes significant prenatal harm to future children;
2. that carbon monoxide testing reduces rates of smoking during pregnancy;
3. that such interventions do not cause more harm to future children than they prevent; *and*
4. that there is no alternative, less problematic way to reduce prenatal harm.

It argues that these things cannot be established and therefore carbon monoxide testing in pregnancy cannot be justified on the grounds of preventing harm to future children.

1. Does Smoking During Pregnancy Cause Significant Prenatal Harm to Future Children?

This condition must be satisfied if the potential harm to future children is to justify the uniquely pressurised approach to smoking cessation during pregnancy. After all, if smoking during pregnancy is no more harmful than at other times, there would be no reason to single out pregnant women for these measures.

Although there is a significant amount of evidence linking smoking during pregnancy to low birthweight, stillbirth and premature delivery, this is not the only factor linked to such harms [34, 43] and the issue of causation beyond correlation remains unclear.[5] Significantly, the majority of studies linking smoking during pregnancy to these harms have not looked in depth at the role of social factors such as education and poverty. The evidence suggests that such harms could be reduced in a number of ways including reducing inequality [43], improving nutrition [2], increasing education [57], encouraging men not to smoke [9, 19, 47], or encouraging pregnant women not to smoke [17]. Therefore, the choice to view these harms as primarily a problem of individual behaviour during pregnancy requires justification.

The assertions about the health risks of smoking during pregnancy contained in the NICE Guidelines are based on a 1992 report of the Royal College of Physicians [58] and a claim in The Department of Health's 'Review of the health inequalities infant mortality PSA target' (the DOH Review) [20], that smoking during pregnancy increases the risk of infant mortality by an estimated 40% [38]. The DOH Review states that babies born to women who smoke are more likely to be born prematurely, are twice as likely to have a low birthweight and are up to 3 times more likely to die from sudden infant death syndrome (SIDS) [20]. This is based on research which

[5] This weakness in supporting evidence can similarly be seen for the causal link between alcohol consumption during pregnancy and Fetal Alcohol Syndrome. One study found that "women who consumed at least three alcoholic drinks a day but ate balanced diets experienced a rate of Fetal Alcohol Syndrome (FAS) of only 4.5 percent, while women who drank the same amount and were malnourished had an FAS rate of 71 percent [8] (It was also found that the rate of FAS in children born to chronic alcoholic mothers in lower socioeconomic classes (defined as labourers and unskilled workers) was 70.9% compared to 4.5% in those born to mothers in higher socioeconomic classes such as clerical and sales workers [8] See also [1].

states that the causal mechanisms by which smoking and other risk factors influence the likelihood of preterm birth remain unknown and highlights the fact that many factors are associated with an increased risk of preterm birth [25]. Further, it states that infections are implicated in at least 40% of preterm births and as much as 70% for births prior to 32 weeks gestation [25]. The claim in the DOH Review that the likelihood of infant mortality is increased by about 40% is a finding of correlation as a result of a statistical analysis [46]. Similarly, the 1992 report of the Royal College of Physicians establishes a correlation between smoking during pregnancy and outcomes such as low birthweight but not a direct causal link [58]. One Swedish study has attempted to isolate the effects of smoking during pregnancy from other maternal characteristics by comparing the birthweights of siblings born to mothers who smoked in one pregnancy but not another [31]. This study found that maternal smoking during pregnancy did reduce birthweight but not by as much as was predicted by conventional analysis. Further, as its authors acknowledge this study still does not establish a causal link as other factors linked to the change in the mother's smoking behaviour such as stress, relationship breakdown and nutrition have not been accounted for [31].

Another study which sought to look beyond correlation is that conducted by Emma Tominey in 2007 which analysed data on the lives of 6500 children and their mothers, considering in detail the lifestyles of the mothers [57]. By controlling for variables including grandparent smoking habits during adolescence, maternal birthweight and paternal smoking habits, it was able to establish that the harm often attributed to smoking during pregnancy varies according to the education of the mother, and unobservable traits of the mother such as nutrition and knowledge of healthy behaviour. The study concluded that:

> …around one-third of the harm from smoking is explained by unobservable traits of the mother. Smoking tends to reduce birthweight by 1.7% but has no significant effect on the probability of having a low birthweight child, pre-term gestation or weeks of gestation [57].

A further claim is made in the NICE Guidelines that "exposure to smoke in the womb is associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour." [38][6] However, the link between prenatal smoking and childhood behavioural problems has been questioned in a study which concluded that once compounding factors such as maternal antisocial behaviour were taken into account, prenatal smoking was no longer associated with antisocial behaviour in children [11].

Establishing a causal link beyond correlation between smoking during pregnancy and harms such as low birthweight is problematic given the difficulties in isolating smoking from other potentially causal factors. However, a strong indication of a causal link would be if reducing smoking rates during pregnancy led to reduced rates of prenatal harm.

[6] Based on [15].

Does Reducing Smoking Rates During Pregnancy Reduce Prenatal Harm?

Although most reviews of the effectiveness of smoking cessation interventions in pregnancy focus on their ability to reduce smoking rates rather than their ability to reduce harm to future children, there is evidence that smoking cessation interventions can reduce low birthweight and preterm birth [4]. However, the link between reducing smoking rates and prenatal harm is not a straightforward one.

This is illustrated by a study which considered the impact of declining rates of maternal smoking during pregnancy on the number of low birthweight babies in Massachusetts from 1989 to 2004 [32]. During this period there was a significant yearly decline of at least 6% in maternal smoking prevalence during pregnancy. However, over the same period a significant *increase* of up to 1% in the prevalence of low birthweight babies occurred. The report concluded that factors other than maternal smoking had reversed the potential gains attributable to reductions in maternal smoking. However, it seems equally possible that the link between smoking and low birthweight is one of correlation rather than causation and other factors such as poverty and low education which are aligned with smoking rates could be more significant causes of low birthweight. Similarly, it could be that at least some of the positive effects of smoking cessation interventions could be explained by side effects of the specific delivery of the interventions, such as increased contact with healthcare professionals or other simultaneous interventions regarding nutrition and lifestyle.

Particularly significant is the conclusion of Emma Tominey's study that only up to 13% of the babies classified as low birthweight, born to mothers who smoked during pregnancy could have been classified as being of healthy weight had their mothers not smoked [57]. Such a low prevention rate seems insufficient to justify presenting such prenatal harm as solely a problem of the individual behaviour of pregnant women. After all, in 87% of cases the prenatal harm associated with maternal smoking (low birthweight), would have occurred even if the mother did not smoke during pregnancy. Further, the impact of smoking is much greater for mothers of low education, even controlling for the quantity of cigarettes they smoke, clearly indicating that factors other than the woman's smoking are at play [57]. Therefore, while reducing smoking rates during pregnancy might lead to some reduction in prenatal harm, it is not clear that a more significant reduction could not be achieved by focussing on a different factor.

Assuming that condition 1 is fulfilled and reducing smoking rates during pregnancy has some beneficial impact on the rates of prenatal harm, for the policy of routine carbon monoxide testing in pregnancy to be justified, it must still be established that this specific smoking cessation measure is likely to be effective.

2. Does Routine Carbon Monoxide Testing Reduce Rates of Smoking During Pregnancy?

The NICE Guidelines, recommend that a carbon monoxide test be used to identify pregnant women who smoke as "some women find it difficult to say that they smoke because the pressure not to smoke during pregnancy is so intense." [38] Targeting the behaviour of pregnant women with carbon monoxide testing is unlikely to alleviate this pressure, particularly as pregnant smokers might find it difficult to admit they smoke because they fear they will be judged and emotionally blamed for something they feel they have little control over. If pregnant women are treated with distrust by their midwives and emotional, coercive language is used, they are unlikely to be encouraged to engage with smoking cessation services and prenatal care more generally. An alternative would be to make pregnant women feel respected and trusted and support them in what they feel is best for them and their future children. Indeed, the NICE Guidelines state that because some pregnant women find it difficult to say that they smoke it is important to communicate in a sensitive, client-centred manner [38]. It is difficult to see how the lack of trust displayed by the policy to routinely test pregnant women for carbon monoxide fulfils this requirement.

Further, it is equally plausible that a non-pregnant smoker might not admit to smoking in order to avoid feelings of judgment and pressure to quit, yet it is only pregnant women who are to be routinely screened for carbon monoxide levels. This policy sends out a message to pregnant women that they cannot be trusted either to truthfully answer questions about whether or not they smoke, or to make the right decisions in the interests of themselves and their future children in the way non-pregnant individuals can. Not only does this raise ethical concerns because it involves unequal respect for the autonomy of pregnant women compared to individuals who are not pregnant, but it is also likely to have a negative impact on the health outcomes for pregnant women and their future children as research suggests that respecting the autonomy of pregnant women is linked to better outcomes for mother and babies [3, 50].

One problem with evaluating the effectiveness of routine carbon monoxide testing is that instead of asking whether the policy reduces rates of prenatal harm, the policy is frequently assessed on the percentage of pregnant smokers that it identifies. This not only fails to take account of the possibility that smokers identified in this way might be less likely to engage with smoking cessation measures and go on to quit, but it also ignores the possibility that such policies might lead to increased prenatal harm in other ways. For example, one study trialled the use of routine carbon monoxide testing as part of a smoking cessation programme targeting pregnant women across three maternity units serving Glasgow in Scotland [35]. While it suggested that utilising carbon monoxide testing alongside self-reporting could increase identification of pregnant smokers from 80 to 94%, it found that booking midwives found it difficult to approach all pregnant women to talk about smoking and this was not made easier by the requirement that all pregnant women should be tested for

carbon monoxide at the initial booking appointment.[7] This indicates that a policy of routine carbon monoxide testing might actually hinder midwives from raising smoking cessation with pregnant women and even decrease rates of pregnant women who successfully quit smoking. The CATCH programme also operated in Glasgow, employing a similar approach to smoking cessation using motivational interviews to engage pregnant smokers during telephone contact and withdrawal orientated therapy including nicotine replacement therapy [14]. However, it differed from the 'breathe' programme in that it delivered care in a home setting rather than a clinic; it operated a holistic approach, helping women to solve more pressing problems such as housing, before smoking; the referral model was opt-in rather than opt-out; and smokers were not initially identified by routine carbon monoxide testing. While no data was collected as to whether CATCH identified fewer smokers than 'breathe', the data suggests that CATCH achieved a better quit rate than 'breathe'.

While pregnant smokers need to be identified to be supported to quit, the goal of reducing prenatal harm to future children should not be reduced to identifying pregnant smokers. No information was collected as part of this study on the rates of low birth weight or premature delivery as a result of these interventions. Further, it does not support the claim that routine carbon monoxide testing itself leads to better rates of smoking cessation. It is possible, if not probable, that those smokers who would only be identified as smokers by carbon monoxide testing rather than self-reporting, would be less likely to be motivated to quit and engage with smoking cessation measures. Treating them with distrust is unlikely to change this. Therefore, while the evidence indicates that carbon monoxide testing could increase the number of pregnant smokers identified, it does not allow the conclusion to be made that a policy of routine carbon monoxide testing of pregnant women would reduce rates of smoking during pregnancy and so condition 2 is not satisfied.

However, even if conditions 1 and 2 were met, the policy of singling out pregnant women for routine carbon monoxide testing would only be justified on the basis that it reduces prenatal harm to future children, if it could be shown that such measures do not cause more harm to future children than they prevent.

3. Do Such Interventions Cause More Harm to Future Children than They Prevent?

It could be argued that even if smoking during pregnancy is not as harmful as other factors such as poverty, a lack of education, genetic factors, poor nutrition, or a lack of good quality prenatal care, smoking during pregnancy is harmful to some extent and therefore it is still a good thing to reduce smoking rates among pregnant women.

[7] This study also found that in one hospital where auxiliary nurses were responsible for performing the test, 89% of women provided a breath sample at the initial booking appointment, whereas in a hospital where midwives were responsible for carbon monoxide testing, only 35% of women provided a sample. This indicates that the policy is unlikely to achieve its potential of identifying 94% of pregnant smokers when the test is the responsibility of midwives, perhaps due to time constraints or other priorities for midwives delivering antenatal care. [35].

It is likely that it would be of some benefit to future children and to others, including the women themselves, if women did not smoke during pregnancy.[8] It is also possible that some pregnant smokers may quit smoking having been identified as smokers through carbon monoxide testing and therefore, a policy of routine testing might prevent some prenatal harm. The problem with justifying the policy on the basis that it could prevent some prenatal harm is that it assumes that targeting the behaviour of pregnant women in this way is not in itself, harmful to future children.

There are three ways in which the policy to routinely test pregnant women for carbon monoxide has the potential to cause harm to future children. Firstly, by focussing on the behaviour of pregnant women other more significant causes of prenatal harm such as poverty and poor prenatal care are obscured and overlooked [28]. This can occur on both a public health level and an individual level. On a public health level, if responsibility for these harms lies with the pregnant women themselves then the calls for the state to address social factors such as poverty and education are weakened, resulting in a missed opportunity to improve the welfare of future children to a much greater extent. On an individual level, policies which require health professionals to focus on certain factors such as smoking cessation to the extent of testing every pregnant woman for carbon monoxide at every antenatal appointment has the potential to interfere with the professional's own assessment of the individual patient's health needs, requiring them to use the limited contact time they have with patients pursuing public health priorities rather than the health priorities of the individuals. As studies into the ethical issues raised by health visitors delivering public health measures have shown, this can lead to health professionals feeling that they are wasting time, inadequately addressing more pressing needs of the individual and eroding their ability to form relationships of trust with their patients [26].

Similarly, as Kukla has argued, healthcare policies which focus on maternal behaviour at signal moments surrounding pregnancy and birth fail to take account of the extended narrative of motherhood (and indeed parenthood) and so miss the opportunity to genuinely improve the welfare of future children by supporting their parents to be "good parents" in the long term. This reductive view of motherhood focuses on individual responsibility rather than fostering the conditions which enable individuals to make good choices in the longer narrative of motherhood [33]. The welfare of future children depends on a wide range of factors and focusing narrowly on individual behaviour such as smoking during pregnancy oversimplifies the issue and prevents what are likely to be more significant factors from being addressed by obscuring their importance and restricting healthcare professionals' ability to deliver individualised patient-centred care.

Secondly, the feeling of judgment and blame connected with such individualisation, could act as a deterrent to engaging with prenatal care. This is supported by recent studies in the context of support for self-management of long-term health

[8] While there may be potential consequential harms to pregnant women in employing policies such as routine carbon monoxide screening, the question being considered is whether such policies are justified on the basis that they reduce prenatal harm to future children. Therefore, this section will focus on the potential harms to the future children they seek to protect.

conditions which have found that focusing on behavioural deficits and emphasising biomedical and clinical epidemiological research reinforces the position of healthcare professionals as experts and this hierarchical view of the patient-professional relationship prevents patients from acting as effective partners in their own care [21]. Thus, presenting the problem of prenatal harm as one of pregnant women choosing not to conform to what medical science tells them is best for their babies, is likely to disempower pregnant women from taking an active role in their care. Further, as has been noted in connection with personal responsibility in other forms of healthcare there is likely to be a significant reduction in trust between health professionals and patients if judgment and blame is perceived [24]. This seems a particular risk in routine screening for carbon monoxide for all mothers regardless of whether they say they smoke and would like help to stop or not. This impact on the relationship between pregnant women and healthcare professionals means that not only are the most significant causes of prenatal harm obscured by the individualisation of the problem, but they are actually exacerbated by it. The most vulnerable women who would benefit most from good quality prenatal care may disengage with that care due to fear of judgment and blame and their future children are therefore more likely to suffer prenatal harm.

One study looking at the experiences of midwives administering the carbon monoxide test found that, despite initial concerns, midwives have not found carbon monoxide testing to be problematic [42]. The midwives interviewed reported that although they had initially been concerned about the lack of research and evidence base for using carbon monoxide testing as well as concerns about the potential for such testing to negatively impact on their relationships with their patients if the test was used as a 'lie detector', the test had quickly become an accepted part of routine care. While these findings are initially encouraging, as its authors recognise, this study is limited in a number of ways. Firstly, at the time of the study it was difficult to find midwives who were routinely using the test at the initial booking appointment, as currently advised. This prevents it being an accurate assessment of the impact of the policy to routinely test all women at all antenatal appointments. Secondly, most of the participants were recruited from an area with a low-smoking prevalence. It seems likely that the test would be most problematic in areas of high smoking prevalence as it is smokers who will potentially feel judged and blamed for their behaviour rather than non-smokers. Finally, the study only considered whether the midwives had found the use of carbon monoxide screening problematic and did not speak to the pregnant women regarding their experiences. Even if midwives did not feel the test significantly altered their interactions with pregnant women, the pregnant women might have experienced the test differently.

Thirdly, it is likely that outcomes for future children are improved when the autonomy of their mothers is respected during pregnancy [3, 50]. In this context, respecting autonomy requires that women are encouraged to pay an active role in their own care and that they are trusted to be the ultimate decision makers, with health professionals supporting their decisions. In other aspects of healthcare this patient engagement has been shown to produce better outcomes for individual patients [18]. Due to the interconnected nature of the interests of a woman and her future child, something that is in the interests of pregnant women will most likely be

in the interests of future children. If, as the evidence suggests, outcomes for patients are improved when they take an active role in their own care and are empowered to do so by healthcare professionals, it seems logical that outcomes for future children will improve when the individuals most connected to and invested in their wellbeing are empowered in this way. This is supported by studies in Bangladesh and Nepal which indicate that children born to mothers who have more power to make decisions in their everyday lives and regarding their medical care, have better outcomes than those born to women whose autonomy is less respected [3, 50]. This is to be expected once the pregnant woman is recognised as a protector rather than a threat to the future child.

Pressurising pregnant women to stop smoking using routine carbon monoxide testing and emotional coercion as opposed to presenting information and offering support if desired, assumes that pregnant women are either unable or unwilling to make the best choices for themselves and their future children in the way that other individuals are. There is no evidence that this is the case and policies based on this assumption in turn, contribute to the undermining of the autonomy of pregnant women. As argued by Entwistle et al in relation to support for self-management of long term health conditions, negative judgmental attitudes towards patients, including using tests to suggest that the patients' claims about their behaviour are false, can cause patients to feel anxious, hopeless and disrespected which can be understood as undermining their autonomy [21]. Even when looking narrowly at the issue of smoking, research has shown that the more confident and capable a woman considered herself to be at the transition to motherhood, the less likely she is to relapse into smoking [5]. Therefore, there is a very real possibility that routine carbon monoxide testing could cause pregnant smokers to feel undermined and so decrease the chances of them quitting in the long term.

The narrow focus on reducing harms to future children such as low birthweight and pre-term delivery has meant that harms to autonomy and the general wellbeing of pregnant woman and future child have not been taken into account. It is not part of the purpose of policies such as routine carbon monoxide testing to enhance or protect the autonomy of pregnant women and thus this potential negative impact on the welfare of future children is not part of the cost-benefit analysis undertaken. Therefore, such policies are potentially harmful to future children as well as to the women who bear them.

It could be argued that placing extra pressure to quit smoking on pregnant women is justified because it is a case of one individual (the pregnant woman) harming another individual (the future child) rather than an individual harming *themselves* by smoking, or that there is something specific about it being a future child that is harmed and the pregnant woman's relationship to it, that makes smoking while pregnant more problematic than smoking at other times. While it seems likely that a pregnant woman who chooses to bring a child to birth has a moral duty to take the interests of the future child into account it is difficult to see why this should be any greater than the duty owed by a parent of an existing child. [12] Given the risks of passive smoking, if it is not necessary to screen parents of existing children for carbon monoxide, it is difficult to see why this would justify targeting pregnant women in this way. In any event, if the policy was to be justified on the grounds that it prevented an especially significant type of harm,

i.e. harm to a future child by its mother during pregnancy, it would still be necessary to show that the policy did indeed prevent such harm.

Arguments could also be made against such policies on the basis that they are harmful to pregnant women. However, such arguments are problematic as they involve balancing harms and benefits to one individual (the future child) with those caused to another individual (the pregnant woman). It could be argued that preventing harm to one at the cost of another is justified either because one is more deserving of protection or because of some sense of culpability on the part of the other. In this case the argument would be that it is acceptable for pregnant women to be harmed by measures taken to protect future children because pregnant women are not as vulnerable as future children, and they are the ones creating the risk. However, there are several problems with this argument. First, policies such as carbon monoxide testing all pregnant women at every antenatal appointment have the potential to harm pregnant smokers and non-smokers and even women in general. The message of distrust is communicated to all women. Second, if such policies are to be based on the culpability of pregnant smokers, the argument to support this has not been made. There are clear issues surrounding the degree of choice exercised by women who do not give up smoking during pregnancy due to the addictive nature of smoking and it is not clear why a pregnant smoker should be considered more culpable for any resulting harm than a parent of an existing child or any other smoker. Finally, there is an inherent problem with balancing potential harms to pregnant women with those to future children because they are not two separate individuals; their welfare is uniquely interconnected because of their physical and emotional connection. Harming pregnant women will also harm future children. This illustrates the problematic nature of the traditional maternal-fetal conflict model which presents the interests of the pregnant woman as conflicting with those of the future child and therefore, the pregnant woman as a threat to her future child rather than the person who is most invested in its welfare. In any event, any argument supporting smoking cessation measures in pregnancy to address prenatal harm to future children requires evidence that such measures will reduce harm to future children before this can be considered alongside any potential harms to pregnant women.

It is clear that even if smoking during pregnancy causes significant prenatal harm and routine carbon monoxide testing has some positive effect on smoking rates during pregnancy fulfilling conditions 1 and 2, it is extremely unlikely that condition 3 will be met. Not only are there other causal factors which could be addressed to greater effect, but pressurising pregnant women to quit smoking in this way is harmful in itself. The policy is likely to obscure more significant causes of prenatal harm, have a negative effect on engagement with antenatal care and reduce rather than strengthen women's autonomy and their role in their own care.

4. Is There an Alternative, Less Problematic Way to Reduce Prenatal Harm?

An alternative strategy for improving outcomes for future children is to move away from presenting the needs of a developing fetus as being in conflict with those of the pregnant woman. Once we accept that in the vast majority of cases,

a pregnant woman wants to do what is best for her future child and will do whatever she can to protect that future child, it becomes clear that far from smoking during pregnancy warranting a more pressurised approach, if anything, given her additional motivation, less pressure is required and we should look instead to providing the woman with support.

It seems likely from the evidence discussed above that there would be some improvement in the outcomes for future children and their mothers if fewer women smoked during pregnancy. Similarly, there are lifestyle changes the wider population could take to improve their health. However, the assumption underlying pressurised interventions such as routine carbon monoxide testing is that pregnant women are not making these changes because they require additional motivation to do so. The policy ignores the very premise it is based on. The NICE Guidelines state that women feel intense pressure to quit smoking during pregnancy and this is preventing them from engaging with measures aimed at improving their health and the health of their future children [38]. This indicates that the way to help women make healthy lifestyle choices during pregnancy is to alleviate this pressure. This would make them more likely to feel able to be open and honest with healthcare professionals and engage in a more supportive method of ensuring the best outcomes for their future children.

This is supported by evidence from a prenatal care programme founded by Jennie Joseph in America known as the JJ Way [30]. This programme aims to achieve positive pregnancy outcomes for all with particular efforts to reach low-income and marginalised people who are at risk of a poor birth outcome due to the social determinants of health and institutional and structural discrimination inherent in the health care system. The key to this approach to prenatal care is the empowerment of pregnant women:

> Empowerment results from having access to high quality, cost efficient services, and a connection with supportive culturally-responsive services and natural supports which lead to an increase in knowledge, agency and self-determination [30].

This programme emphasises the importance of access to and engagement with, quality prenatal care. It seeks to move away from the paternalism evident in traditional maternity care where the pregnant woman is encouraged to trust the medical experts. The JJ Way encourages the pregnant woman to play an active role in her care, providing her with knowledge and support through peer educators and fluid group classes. Instead of viewing the pregnant woman and her future child as separate individuals whose interests may or may not align, the pregnant woman and her future child are viewed as a unit, with the understanding that the pregnant woman is the decision maker and has the full support of her care team [29].

As a result of this approach, the rate of preterm births in Orange County fell from 10% in 2015 to 4.3% in 2016 and the rate of low birthweight was reduced from 8.9% in 2015 to 5% in 2016/2017. By delivering prenatal care in this way the racial disparities in preterm birth outcomes were eliminated and there were significant reductions in low birthweight babies in at-risk populations [30].

In choosing how best to reduce prenatal harm the options presented here are (1) to target pregnant smokers with pressurised smoking cessation interventions and (2) to employ a supportive and empowering approach to prenatal care. The evidence suggests that even assuming that smoking cessation interventions stopped every pregnant woman smoking, the rates of prenatal harm would be reduced by 13% [57]. However, a supportive and empowering approach to prenatal care appears to reduce such harm by around 50% based on the evaluation of the JJ Way. This is even before we take into account the potential harms of pressurising pregnant women to stop smoking discussed above.[9] Therefore, if we are interested in harm reduction, this is a much more effective option.

Even though a greater reduction in prenatal harm could be achieved by addressing factors other than the behaviour of pregnant women, it could be argued that addressing factors such as social inequality and education are far more difficult and costlier than getting individuals to stop smoking. After all, smoking cessation measures are already part of our health service. However, this argument would not justify policies such as carbon monoxide screening as opposed to offering supportive, empowering prenatal care as prenatal care is already part of our health service. Placing a greater emphasis in that prenatal care on empowering pregnant women and supporting them to make decisions rather than policing their behaviour in a distrustful manner, would not be a particularly difficult or costly change. Indeed, it is in line with how many midwives already see their role [27].

It is not possible to employ both of these approaches simultaneously as the pressurised smoking cessation interventions would not fit within a supportive and empowering approach to prenatal care. However, employing a supportive and empowering approach to prenatal care has the added advantage of achieving the stated aim of carbon monoxide screening policy. If pregnant women are unlikely to admit that they smoke because of the extreme pressure they feel to stop smoking, it would be reasonable to expect that a supportive, non-judgmental approach to prenatal care would alleviate that pressure and thus remove the need for carbon monoxide screening. Therefore, it is clear that targeting the behaviour of pregnant women with pressurised smoking cessation interventions is not justified on the grounds of harm reduction, as more effective measures which are no more difficult to put into practice are available. Even if conditions 1, 2 and 3 had been met, the fact that an alternative, less problematic approach is available, would be sufficient to prevent the policy of routine carbon monoxide testing in pregnancy being justified on the ground of preventing prenatal harm to future children.

[9] Pers-Anders Tengland has argued that there are moral reasons for preferring the empowerment approach to health promotion rather than the behaviour change approach [55].

Conclusion

Does the evidence suggest that public health measures such as carbon monoxide testing in pregnancy are likely to achieve their aim of preventing harm to future children?

Despite the fact that smoking when not pregnant is harmful to the smokers and those around them, pregnant women are being singled out for a particular level of pressure to quit including being routinely tested for carbon monoxide at every antenatal appointment regardless of whether they say they smoke or not. Pressurising pregnant women to quit smoking is presented as necessary and proportionate in the interests of protecting future children from prenatal harm. This paper has examined the justification for such measures on the grounds of harm reduction. As stated above, for this to be the case four things would have to be established: (1) that smoking during pregnancy causes significant prenatal harm to future children; (2) that carbon monoxide testing reduces rates of smoking during pregnancy; (3) that such interventions do not cause more harm to future children than they prevent; *and* (4) that there is no other, less problematic way to reduce prenatal harm.

This paper has argued that while there is evidence connecting smoking during pregnancy to prenatal harm, there are other factors at play which prevent a clear causal link from being established. While reducing smoking during pregnancy is likely to have some beneficial impact on rates of prenatal harm, this is not the only way to achieve such a reduction. In fact, addressing other factors, such as social inequality, education, nutrition and the quality of prenatal care, would lead to a more significant reduction in rates of prenatal harm. Targeting pregnant women with pressurised smoking cessation measures such as carbon monoxide screening might help some women to quit smoking during pregnancy. However, even if carbon monoxide testing was 100% successful in getting women to quit smoking during pregnancy, the rates of prenatal harm would only fall by 13% [57] (compared to around 50% achieved by the JJ Way [30]) and this is without taking into account the potential harms of such interventions, for example, from women disengaging with prenatal care. Current discussions of the potential benefits of smoking cessation measures in pregnancy have not sufficiently taken into account the potential harms of such measures. As argued above, constructing the problem of prenatal harm as one of individual behaviour and targeting this behaviour with routine carbon monoxide testing has the potential to cause harm as it obscures other more significant causes of prenatal harm, risks women disengaging with prenatal care and does not promote the autonomy of pregnant women. Perhaps the most troubling aspect is that routine carbon monoxide testing sends a message to pregnant women that they cannot be trusted either to truthfully answer questions as to whether or not they smoke, or to make decisions in the best interests of themselves and their future children in the way that non-pregnant individuals are. Extra pressure is thought to be required for pregnant women to quit smoking as they will not be able to make an appropriate decision when presented with information about the risks and appropriate support if requested. This distrust is defended on the basis of the extra pressure pregnant women face, but instead of alleviating this pressure, the policy exacerbates it,

risking alienating pregnant women from their prenatal care team. Crucially, as such a policy is incompatible with a supportive and empowering approach to prenatal care, it is an obstacle to measures being put into place which the evidence suggests would significantly reduce prenatal harm. Far from being justified on the grounds of harm reduction, the policy to routinely test pregnant women for carbon monoxide has the potential to do more harm than good and there are other, more effective, less problematic ways to reduce harm to future children.

Compliance with Ethical Standards

Conflict of interest The author declares that she has no conflict of interest.

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References

1. Abel, E. L. (1995). An update on incidence of FAS: FAS is not an equal opportunity birth defect. *Neurotoxicology and Teratology, 17*(4), 437–443.
2. Abu-Saad, K., & Fraser, D. (2010). Maternal nutrition and birth outcomes. *Epidemiologic Reviews, 32*(1), 5–25.
3. Adhikari, R., & Sawangdee, Y. (2011). Influence of women's autonomy on infant mortality in Nepal. *Reproductive Health, 8*(1), 1.
4. Allen, F., Gray, R., Oakley, L., Kurinczuk, J. J., Brocklehurst, P., & Hollowell, J. (2009). *The effectiveness of interventions targeting major potentially modifiable risk factors for infant mortality: A user's guide to the systematic review evidence*. National Perinatal Epidemiology Unit: University of Oxford.
5. Ashwin, C., Marshall, J., & Standen, P. (2012). Exploring women's experiences of smoking during pregnancy and the postpartum. *Evidence Based Midwifery, 10*(4), 112.
6. Bewley, S. (2002). Restricting the freedom of pregnant women. *maternal–fetal medicine*, 131.
7. Bille, C., & Andersen, A.-M. N. (2009). Preconception care. *British Medical Journal (Online), 338.*
8. Bingol, N., Schuster, C., Fuchs, M., Iosub, S., Turner, G., Stone, R. K., et al. (1987). The influence of socioeconomic factors on the occurrence of fetal alcohol syndrome. *Advances in Alcohol and Substance Abuse, 6*(4), 105–118.
9. Blair, P. S., Fleming, P. J., Bensley, D., Smith, I., Bacon, C., Taylor, E., et al. (1996). Smoking and the sudden infant death syndrome: Results from 1993–5 case-control study for confidential inquiry into stillbirths and deaths in infancy. Confidential enquiry into stillbirths and deaths regional coordinators and researchers. *British Medical Journal, 313*(7051), 195–198.
10. Bloch, M., & Parascandola, M. (2014). Tobacco use in pregnancy: A window of opportunity for prevention. *The Lancet Global Health, 2*(9), 489–490.
11. Boutwell, B. B., & Beaver, K. M. (2010). Maternal cigarette smoking during pregnancy and offspring externalizing behavioral problems: A propensity score matching analysis. *International Journal of Environmental Research and Public Health, 7*(1), 146–163.
12. Brazier, M. (1999). Liberty, maternity, responsibility. *Current Legal Problems, 52,* 359.
13. Brione, R. (2015). To what extent does or should a woman's autonomy overrule the interests of her baby? A study of autonomy-related issues in the context of caesarean section. *The New Bioethics, 21*(1), 71–86.

14. Bryce, A., Butler, C., Gnich, W., Sheehy, C., & Tappin, D. M. (2009). CATCH: Development of a home-based midwifery intervention to support young pregnant smokers to quit. *Midwifery, 25*(5), 473–482. https://doi.org/10.1016/j.midw.2007.10.006.
15. Button, T. M. M., Maughan, B., & McGuffin, P. (2007). The relationship of maternal smoking to psychological problems in the offspring. *Early Human Development, 83*(11), 727–732.
16. Campbell, D. (Sunday 26 February, 2017 00.03 GMT). Test all pregnant women for smoking, say NHS chiefs. *The Guardian*,
17. Chamberlain, C., O'Mara-Eves, A., Porter, J., Coleman, T., Perlen, S. M., Thomas, J., et al. (2017). Psychosocial interventions for supporting women to stop smoking in pregnancy. *Cochrane Database of Systematic Reviews* (2).
18. Coulter, A., & Ellins, J. (2007). Effectiveness of strategies for informing, educating, and involving patients. *British Medical Journal, 335*(7609), 24–27.
19. Day, J., Savani, S., Krempley, B. D., Nguyen, M., & Kitlinska, J. B. (2016). Influence of paternal preconception exposures on their offspring: Through epigenetics to phenotype. *American Journal of Stem Cells, 5*(1), 11–18.
20. Department of Health. (2007). *Review of the Health Inequalities Infant Mortality PSA Target*. London: Department of Health.
21. Entwistle, V. A., Cribb, A., & Owens, J. (2018). Why health and social care support for people with long-term conditions should be oriented towards enabling them to live well. *Health Care Analysis, 26*(1), 48–65.
22. Fresh NE (2017). Major initiative to protect unborn babies from smoking in the North East. http://www.freshne.com/in-the-news/pr/item/1974-major-initiative-to-protect-unborn-babies-from-smoking-in-the-north-east. Accessed 8 November 2017.
23. FreshSFNE (2017). Smoking in pregnancy. https://www.youtube.com/watch?v=0Icc3NwPgU&list=UU2lnzX6fEhIckkzI1amNs2Q&index=9. Accessed 8 November 2017.
24. Friesen, P. (2016). Personal responsibility within health policy: Unethical and ineffective. *Journal of Medical Ethics, 44,* 53–58.
25. Green, N. S., Damus, K., Simpson, J. L., Iams, J., Reece, E. A., Hobel, C. J., et al. (2005). Research agenda for preterm birth: Recommendations from the March of Dimes. *American Journal of Obstetrics and Gynecology, 193*(3), 626–635.
26. Greenway, J. C., & Entwistle, V. A. (2013). Ethical tensions associated with the promotion of public health policy in health visiting: a qualitative investigation of health visitors' views. *Primary Health Care Research and Development, 14*(2), 200–211.
27. High Quality Midwifery Care (2014). London: The Royal College of Midwives.
28. Jackson, E. (2001). *Regulating reproduction: Law, technology and autonomy*. Bloomsbury: Bloomsbury Publishing.
29. JJ Way - Commonsense Childbirth Inc. http://www.commonsensechildbirth.org/jjway/. Accessed 27 April 2018.
30. Josephs, L., & Brown, S. E. (2017). The JJ Way: Community-based Maternity Center Final Evaluation Report. Visionary Vanguard Group Inc.
31. Juárez, S. P., & Merlo, J. (2013). Revisiting the effect of maternal smoking during pregnancy on offspring birthweight: A quasi-experimental sibling analysis in Sweden. *PLoS ONE, 8*(4), e61734.
32. Kabir, Z., Connolly, G. N., Clancy, L., Cohen, B. B., & Koh, H. K. (2009). Declining maternal smoking prevalence did not change low birthweight prevalence in Massachusetts from 1989 to 2004. *The European Journal of Public Health, 19*(1), 65–68.
33. Kukla, R. (2008). Measuring mothering. *International Journal of Feminist Approaches to Bioethics, 1*(1), 67–90.
34. Lumley, J., Chamberlain, C., Dowswell, T., Oliver, S., Oakley, L., & Watson, L. (2009). Interventions for promoting smoking cessation during pregnancy. *Cochrane Database of Systematic Reviews* (3).
35. McGowan, A., Hamilton, S., Barnett, D., Nsofor, M., Proudfoot, J., & Tappin, D. M. (2010). 'Breathe': The stop smoking service for pregnant women in Glasgow. *Midwifery, 26*(3), e1–e13.
36. Morgan, H., Treasure, E., Tabib, M., Johnston, M., Dunkley, C., Ritchie, D., et al. (2016). An interview study of pregnant women who were provided with indoor air quality measurements of second hand smoke to help them quit smoking. *Bmc Pregnancy and Childbirth, 16*(1), 305.
37. National Institute for Health and Clinical Excellence (2010). Weight management before, during and after pregnancy. NICE Guideline PH27.

38. National Institute for Heath and Clinical Excellence (2010). Smoking: Stopping in pregnancy and after childbirth. NICE Guideline PH26.
39. Nelson, E. (2013). *Law, policy and reproductive autonomy*. Bloomsbury: Bloomsbury Publishing.
40. NHS Health Scotland Ready Steady Baby! Tests and checks you may have. http://www.readysteadybaby.org.uk/you-and-your-pregnancy/antenatal-care/tests-and-checks-you-may-have.aspx. Accessed 15 November 2018.
41. NHS Smokefree NHS. https://www.nhs.uk/smokefree/help-and-advice. Accessed 8 November 2017.
42. O'Connell, M., & Duaso, M. (2014). Barriers and facilitators of midwives' use of the carbon monoxide breath test for smoking cessation in practice: a qualitative study. *Midirs Midwifery Digest, 24*(4), 453–458.
43. Pickett, K. E., & Wilkinson, R. G. (2015). Income inequality and health: A causal review. *Social Science and Medicine, 128,* 316–326.
44. Public Health Wales NHS Trust (2015). Models for access to maternal smoking cessation support. http://www.wales.nhs.uk/sitesplus/documents/888/PHW%20MAMSS%20Report%20E%2003.17.pdf. Accessed 15 November 2018.
45. Robertson, J. A. (1983). Procreative Liberty and the control of conception, pregnancy, and childbirth. *Virginia Law Review, 69*(3), 405–464.
46. Salihu, H. M., Aliyu, M. H., Pierre-Louis, B. J., & Alexander, G. R. (2003). Levels of excess infant deaths attributable to maternal smoking during pregnancy in the United States. *Maternal and Child Health Journal, 7*(4), 219–227.
47. Savitz, D. A., Schwingl, P. J., & Keels, M. A. (1991). Influence of paternal age, smoking, and alcohol consumption on congenital anomalies. *Teratology, 44*(4), 429–440.
48. Scott, R. (2000). Maternal duties toward the unborn? Soundings from the law of tort. *Medical Law Review, 8*(1), 1–68.
49. Scott, R. (2002). *Rights, duties and the body: law and ethics of the maternal-fetal conflict*. Oxford: Hart Publishing.
50. Sharma, A., & Kader, M. (2013). *Effect of women's decision-making autonomy on infant's birth weight in rural*. Bangladesh: ISRN Pediatrics.
51. Siddique, H. (Wednesday 18 October, 2017). Doctors to breathalyse smokers before allowing them NHS surgery. *The Guardian*,
52. South Tees Hospitals NHS Foundation Trust (2013). Major initiative to tackle smoking in pregnancy underway. https://www.southtees.nhs.uk/news/health-improvement/major-initiative-tackle-smoking-pregnancy-underway/. Accessed 15 November 2018.
53. South Warwickshire NHS Foundation Trust NHS Warwickshire Stop Smoking in Pregnancy Service. https://www.swft.nhs.uk/our-services/adult-hospital-services/maternity/nhs-warwickshire-stop-smoking-pregnancy-service. Accessed 15 November 2018.
54. Stanton, C., & Cave, E. (2015). Maternal responsibility to the child not yet born. In C. Stanton, S. Devaney, A.-M. Farrell, A. Mullock, & M. Brazier (Eds.), *Pioneering healthcare law: Essays in honour of Margaret Brazier*. London: Routledge.
55. Tengland, P.-A. (2016). Behavior change or empowerment: On the ethics of health-promotion goals. *Health Care Analysis, 24*(1), 24–46.
56. The Law Commission (1974). Report on Injuries to Unborn Children (Law Com. No. 60). *Advice to the Lord Chancellor under section 3(1)(E) of the Law Commissions Act 1965, 20th Century House of Commons Sessional Papers, 1974, Vol. VII, 1021*.
57. Tominey, E. (2007). Maternal smoking during pregnancy and early child outcomes. *CEP Discussion Paper No 828*: Centre for Economic Performance, London School of Economics.
58. Turner-Warwick, M. (1992). Smoking and the young: A report of a working party of the Royal College of Physicians. *Tobacco Control, 1*(3), 231–235.
59. UK Chief Medical Officer (2016). *UK Chief Medical Officers' Low Risk Drinking Guidelines*.

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Can routine screening for alcohol consumption in pregnancy be ethically and legally justified?

Rebecca Bennett, Catherine Bowden

Department of Law, Centre for Social Ethics and Policy, The University of Manchester, Manchester, UK

Correspondence to
Professor Rebecca Bennett, Department of Law, The University of Manchester, Manchester M13 9PL, UK; rebecca.bennett@manchester.ac.uk

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ABSTRACT

In the UK, it has been proposed that alongside the current advice to abstain from alcohol completely in pregnancy, there should be increased screening of pregnant women for alcohol consumption in order to prevent instances of fetal alcohol spectrum disorder. The Scottish Intercollegiate Guidelines Network published guidelines in 2019 recommending that standardised screening questionnaires and associated use of biomarkers should be considered to identify alcohol exposure in pregnancy. This was followed in 2020 by the National Institute for Health and Care Excellence Draft Quality Standard, which recommended that pregnant women should have information on their alcohol consumption recorded throughout their pregnancy and this information transferred to the child's health records. Most recently, Public Health England has stated that the alcohol intake of all women should be recorded throughout pregnancy, not just at the initial booking appointment and that tools such as blood biomarkers and meconium testing should be researched in order to determine true prevalence rates of alcohol in pregnancy. We argue that this proposed enhanced screening undermines women's autonomy and their legal right to be sufficiently informed to consent to screening. We argue that there is no evidence that this kind of screening will result in a reduction of fetal harm and there is a danger that undermining the autonomy of women and the trust relationship between women and healthcare professionals may even increase harm to future children.

INTRODUCTION

Concerns have been raised about the effects of alcohol consumption in pregnancy since the 1970s. In more recent years, the publication of studies that show correlation between alcohol exposure and low IQ[1 2] has resulted in a proliferation of media coverage[3] sending the message that 'Even moderate drinking during pregnancy can affect a child's IQ.'[4 5] In the last few years, it has been reported[6] that the prevalence of fetal alcohol spectrum disorders (FASD) in the UK is significantly underestimated and there have been calls for urgent action to clarify and address this.

While the evidence regarding light or moderate drinking is not nearly as clear as the headlines might have us believe, there is evidence that *heavy* alcohol consumption in pregnancy can lead to miscarriage and FASD[7] (a spectrum of conditions including growth issues, distinctive facial features and learning difficulties).[8] As a result, a so-called 'precautionary approach'[9] has been adopted 'clarifying' the advice to women[i] before conception and during pregnancy to abstain from alcohol all together.[10–12]

This 'abstinence only approach' now forms the basis for all policies on alcohol consumption in pregnancy in the UK and is increasingly linked to recommendations for monitoring women during pregnancy.[13–15] Guidance on addressing alcohol consumption during pregnancy in England and Wales is currently in draft form and is expected to be finalised in the next year.[14] Although pregnant women are currently routinely asked by their midwives about their alcohol intake at the initial booking appointment, it is proposed that this should be increased to all women being screened using standard questionnaires at *every* antenatal appointment. In addition, there is an evident appetite for the development of biomarker screening tools, testing blood, urine and even meconium to establish if a pregnancy is 'alcohol exposed'.[16 17] The Scottish Intercollegiate Guidelines Network (SIGN) published guidelines in 2019 recommending that standardised screening questionnaires and associated use of biomarkers should be considered to identify alcohol exposure in pregnancy.[17] This was followed in 2020 by the National Institute for Health and Care Excellence Draft Quality Standard, which recommended that pregnant women should have information on their alcohol consumption recorded throughout their pregnancy and this information transferred to the child's health records.[18] Most recently, Public Health England (PHE) has stated that the alcohol intake of all women should be recorded throughout pregnancy, not just at the initial booking appointment[19] and that tools such as blood biomarkers and meconium testing should be researched in order to determine true prevalence rates of alcohol in pregnancy.[19] The intention is to identify women who do not currently reveal their alcohol consumption to their healthcare professionals including those who have consumed even a small amount of alcohol during pregnancy, rather than only heavy drinkers. The reason that biomarker screening has not yet been introduced as part of this screening policy is because currently available tests are not sensitive enough to accurately detect low and moderate alcohol consumption in pregnancy.

In this paper, we examine this proposed approach to screening for alcohol consumption in pregnancy and ask 'Can this kind of routine screening for alcohol use in pregnancy be ethically and legally

[i]While we do refer to pregnant 'women' throughout this paper, we recognise that it is important to acknowledge that not all pregnant people identify as women.

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justified?'. Routine screening in pregnancy is usually justified based on either prevention of fetal harm or on empowering women with information to make more informed choices about their lives, or both. We argue that this move towards systematic and extensive routine screening of this population cannot be justified on either of these bases. First, we argue that it is unlikely that this approach will achieve the public health and social aims that are the goals of this policy and may well be counterproductive, resulting in more fetal harm. Second, we argue that unlike other screening policies that may arguably be justified in order to empower women with information about their pregnancy, screening for alcohol consumption will not result in women being better informed than they already were because the information gained about individual alcohol consumption is information these women already have, and the information given to women on which this policy is based is inconclusive and often contradictory.

ALCOHOL SCREENING AND CONSENT ISSUES

It is a central ethical and legal principle in modern healthcare that we should respect the autonomy of individuals accessing healthcare. This is seen as important to allow individuals control over their own lives and their own bodies, to avoid the medical paternalism of the past and develop a relationship of trust between healthcare professional and patient. As a result, all those able to make a sufficiently autonomous, informed choice have the right, under law, to make an uncoerced decision about whether they wish to provide any information or have any treatment or tests. In order to enable this kind of voluntary, informed consent, we usually require that balanced information is given to patients in a non-directive way to foster a society where individuals are able to make the choices that they believe are the right ones for themselves.

An obvious exception to this rule is where there is strong evidence that providing treatment will prevent serious harm to others, for example, mandatory treatment or quarantine for serious infectious disease. Here, it is argued that overriding individual autonomy is justified in these cases to protect the interests of others from serious harm.

However, there is a slightly less obvious exception to this rule of voluntary, informed consent for testing and treatment. This example is any routine programme, for example, for screening or vaccination. Here, instead of an intervention as an option that individuals can opt-in for, this intervention is introduced as a routine part of care with an inherent expectation that this intervention will be accepted. There is usually the option of refusing these interventions, but the routine nature of this offer arguably changes the usual non-directive nature of consent as making this part of routine care sends a message that this intervention is encouraged or recommended.[20] The fundamental aim of making an intervention routine is to improve the uptake of these interventions to encourage the participation of not only those who would have elected to be tested or vaccinated but also those who may not have chosen this option if it was offered in the usual, non-directive, opt-in way that other tests and treatments are usually offered in.

This is the rationale behind all routine vaccination programmes and routine screening programmes for serious and treatable conditions such as breast, cervical and bowel cancer. There are, of course, a number of established routine screening programmes in pregnancy. Some of these screening programmes aim to protect the welfare of the resulting child by preventing HIV infection, or treating syphilis or other preventable or treatable conditions. Other screening programmes aim to empower women with information that it is thought will be useful to them in order to make informed decisions about their pregnancies, eg, screening for Down's syndrome. While these screening programmes are not without controversy,[21] the justification here is that this deviation from the 'gold standard' of non-directive informed consent for treatment is justified in order to either prevent harm to future children or to give women information that they may find important when making choices about their pregnancies.

We argue that this proposal for extensive screening for alcohol use raises these challenges to respect for autonomy in the same way as other routine screening programmes and also has some additional features that intensify these challenges, which we will come to later.

JUSTIFICATION FOR ROUTINE ALCOHOL SCREENING

The rationale for this proposed routine and regular screening of pregnant women for alcohol consumption is to increase the information that healthcare professionals have regarding how much pregnant women are drinking before and throughout their pregnancies. Information about alcohol intake is patchy with alcohol usage only being recorded for 60% of women at the initial booking appointment.[22] It is argued that this increased information about alcohol consumption will be helpful for two main reasons. First, it is claimed that this systematic and routine screening approach 'supports the drive to improve wellbeing, reduce risk and tackle inequalities…and ensure every woman is fit for and during pregnancy and supported to give children the best start in life'.[23] Second, it is argued that keeping a record of the alcohol consumption of these women, even if this is moderate, will help to later diagnose FASD in any resulting children.[14,24] Thus, the justification here for this deviation from the usual approach to respect for autonomy is based on an attempt to enhance the well-being of pregnant women and the children they bring to birth and to further enable accurate diagnosis and support of children affected by alcohol consumption in pregnancy. While these are, of course, laudable aims, if a strong case is to be made to justify this intervention based on these aims, then evidence needs to be available to convince that undermining the autonomy of women in this way is likely to have the public health and welfare gains that are sought.

Harm prevention?

Underlying the argument that the welfare of future children justifies the interference with women's autonomy is the assumption that the policy will maximise the welfare of future children by preventing harm to them. If evidence does exist that screening for alcohol use in pregnancy is likely to prevent serious harm to future children then this may provide a justification for this routine screening.

What is the evidence here?

The guidance of the UK Chief Medical Officers (CMOs) that forms the basis of the approach of PHE adopts an abstinence only approach.[25] The rationale for this approach is that the evidence on issue this is complex particularly when it comes to light or moderate drinking, where evidence is at best inconclusive and at worst contradictory with some studies, indicating that light and moderate drinking could be associated with better outcomes than abstinence[2]. It is thought that providing the detail of this information may be confusing to women and, thus, in order to prevent fetal harm (from heavy drinking), the conclusion arrived at is to remove this uncertainty and to advocate abstinence.[26]

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Given this lack of evidence of correlation between light and moderate drinking and fetal harm, if undermining women's autonomy is to be justified on the grounds that it is necessary in order to prevent harm to future children, it would be logical for the intervention to be targeted at the pregnancies most at risk of harm. However, the policy is not directed at those women who are believed to be drinking heavily during pregnancy, but at *all* women even though it is thought that only around 2.9% of pregnant women drink more than one alcohol unit a week.[27] Nor is the policy aimed at detecting high levels of alcohol consumption, but *any* level of alcohol exposure, despite the lack of evidence that low to moderate alcohol consumption is harmful. Therefore, we argue that this policy cannot be justified as a proportionate interference with women's autonomy in order to prevent harm to future children.

Better diagnosis of FASD?

It is also claimed that this policy will improve the welfare of future children because it will assist with the diagnosis of FASD.[13] The hope here is that this, often difficult to diagnose, condition might be more easily identified with the use of information about the alcohol use of the child's mother. However, it appears that while evidence that the child's mother consumed alcohol during pregnancy might assist in linking these conditions to the mother's behaviour, it is not necessary in order to diagnose the conditions themselves and determine the appropriate treatment and support.[28] In fact, the SIGN 156 document itself notes concerns that there was '...no evidence identified which directly links a maternal history that has involved alcohol use to improved rates of diagnosis and better outcomes for a woman or her children'.[29] Despite this, the same document recommends that routine screening be intensified with the use of biomarkers in addition to screening questionnaires.[29]

The use of routine biomarker analysis?

There is little evidence to suggest that the inclusion of biomarker analysis will lead to a more accurate record of maternal alcohol consumption. The PHE document draws on a 2018 study that compared the prevalence of alcohol consumption in the first trimester of pregnancy revealed by self-reporting and blood biomarker analysis.[30] This study concluded that the prevalence of alcohol consumption estimated from blood biomarker analysis did not significantly differ from that revealed by self-reporting. Similarly, the SIGN 156 document notes that testing of meconium and placental tissues shows the greatest promise as blood biomarkers have been shown to be of limited use in screening for low and moderate alcohol consumption in pregnancy compared with self-reporting.[31] If biomarker analysis is no better than self-reporting, what is the justification for using it? Meconium and placental tissue testing might be more accurate in revealing low and moderate alcohol consumption, but this would not be justified for two reasons. First, given the lack of evidence that low to moderate level alcohol consumption during pregnancy is likely to harm the future child, it is not clear what testing for this level of consumption would achieve. Second, testing of meconium and placental tissues is retrospective and cannot be used to identify women who might benefit from specialist support services to reduce their alcohol consumption during pregnancy and so could only be of use in making a retrospective link between the child's conditions and the mother's alcohol intake during pregnancy. A policy of routine screening using blood biomarker analysis or meconium and placental tissue testing would be even more of an infringement on women's autonomy than routine alcohol questionnaires, given the physically invasive nature of this screening. The absence of evidence that these measures would improve the welfare of either the resulting child or the woman means that justification for this infringement is lacking.[32]

Counter productive?

Not only is there no evidence that the use of routine questionnaires and blood biomarkers would be likely to improve the welfare of children born, but there are also concerns that this more extensive investigation of alcohol use in pregnancy might actually prove harmful to the welfare of these future children. The pregnancies that are most at risk from harm associated with alcohol consumption are those where women are drinking heavily throughout their pregnancies. Given that these women are already reluctant to disclose their alcohol consumption to their healthcare team,[33] most likely through fear of judgement and even of having their children removed from their care, it seems unlikely that a routine questionnaires and biomarker blood tests implemented to identify even low levels of alcohol will encourage these women to engage with antenatal care. This added level of surveillance and the distrust inherent in it has the potential to cause the women who would benefit most from good, supportive antenatal care, to disengage from that care, leading to far worse outcomes for them and their future children.[34] The SIGN 156 document states that 'no evidence was identified to suggest that asking about alcohol history had a detrimental effect on attendance for care',[17] but this could easily change with the increased pressure of being asked at every antenatal appointment, having this recorded on the woman's (and potentially the child's) health records and the use of biomarker screening. In addition, the proposed use of meconium and placental tissue testing might conceivably lead to women choosing to conceal births in fear of such testing revealing that they have consumed alcohol during pregnancy and the very real possibility that this could be used in care proceedings to remove the child from the mother's care.[35]

The SIGN 156 document notes that some members of the development group reported that in their experience screening tools do not necessarily ensure that alcohol consumption is discussed effectively and that other issues such as experiences of violence and abuse need to be discussed.[17] Indeed, it states that 'To enable health behaviour change, including reduction in alcohol consumption during pregnancy, supportive relationships between patients and caregivers are key'.[17] Despite the potential benefits, no recommendations are made relating to enhancing this supportive relationship and encouraging wider discussions of other issues in the woman's life. Instead, it is recommended that use of biomarkers alongside screening questionnaires should be considered.[17]

FURTHER CHALLENGES TO RESPECTING WOMEN'S AUTONOMY

In the face of this evidence, however, those proposing this change of approach may still insist that the *chance* that we might prevent fetal harm in this very small minority of pregnant women who do drink heavily is enough to justify, what they would argue is a minor infringement of autonomy. However, we argue that the infringement of autonomy is not inconsiderable.

While it is true that women can refuse to provide information and refuse to consent to blood biomarker testing, arguing that this ability to refuse makes this screening voluntary seems a stretch. If you are still doubting this consider the information that women will be given as part of the consent process to this screening. Accurate information is a prerequisite of voluntary informed consent. This screening is presented as necessary on

the basis that total abstinence is the only safe approach during pregnancy. However, as we have seen, evidence linking light or moderate drinking to fetal harm is not available and this approach is taken on the basis that women might be confused by an accurate account of the risks involved.[17 25 36] This 'simplification' of the evidence calls into question whether participation in such screening can be considered to be voluntary and informed.

This approach misrepresents the evidence behind this request for engagement with screening and presents the evidence in a way that we argue is unjustifiably directive to the point of coercion. In the face of this version of the evidence, midwives may even feel it is their duty to persuade women to participate in screening adding to directiveness of this interaction. This is, of course, not only ethically challenging but also potentially legally problematic in that not providing accurate and clear information when asking a patient to consent to screening may well render the consent given legally invalid.

Finally, it is important to recognise that this type of screening is very different from other routine screening programmes in that the participation in screening cannot be justified in order to empower those screened with information. This is for the simple reason that the participants already know the information that is being screened for. Women are already aware of the amount they are using alcohol. What could empower women is to be provided with accurate information of the risk of alcohol consumption in an environment where they feel able to discuss this issue freely. However, the proposed screening does not provide this.

CONCLUSION

In this paper, we have argued that proposals to enhance routine screening of all pregnant women for alcohol consumption using regular questionnaires and blood biomarkers are problematic, not only ethically and legally but also when we consider the public health aims these screening programmes aim to address. We have argued that 'simplifying' the complexity of the evidence when it comes to FASD undermines women's autonomy and their legal rights to be sufficiently informed to consent to screening. We have also argued that this proposed routine screening cannot be justified by appealing to the harm that is prevented to the fetus or the woman as the evidence just does not back this up. As a result, such proposals are not only ethically and legally problematic but also likely to be at best ineffective, and at worst counterproductive as a result of undermining the trust relationship between women and healthcare professionals.

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REFERENCES

1 Lewis SJ, Zuccolo L, Davey Smith G, *et al*. Fetal alcohol exposure and IQ at age 8: evidence from a population-based birth-cohort study. *PLoS One* 2012;7(11):e49407.
2 Kelly Y, Sacker A, Gray R, *et al*. Light drinking in pregnancy, a risk for behavioural problems and cognitive deficits at 3 years of age? *Int J Epidemiol* 2009;38(1):129–40.
3 Lee E, Sutton RM, Hartley BL. From scientific article to press release to media coverage: advocating alcohol abstinence and democratising risk in a story about alcohol and pregnancy. *Health Risk Soc* 2016;18(5-6):247–69.
4 See for example Jeremy Laurance, 'Even Moderate Drinking During Pregnancy can Affect Child's IQ' The Independent, 2012. Available: https://www.independent.co.uk/life-style/health-and-families/health-news/even-moderate-drinking-during-pregnancy-can-affect-child-s-iq-8317300.html; https://www.bbc.co.uk/news/health-20325000
5 BBC News. 'Moderate drinking in pregnancy 'harms IQ', 2012. Available: https://www.bbc.co.uk/news/health-20325000
6 McQuire C, Mukherjee R, Hurt L, *et al*. Screening prevalence of fetal alcohol spectrum disorders in a region of the United Kingdom: a population-based birth-cohort study. *Prev Med* 2019;118:344–51.
7 Mather M, Wiles K, O'Brien P. Should women abstain from alcohol throughout pregnancy? *BMJ* 2015;351.
8 NHS Website. Foetal alcohol syndrome. Available: https://www.nhs.uk/conditions/foetal-alcohol-syndrome/
9 Significantly in the UK Chief Medical Officers' Low Risk Drinking Guidelines, 2016. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf [Accessed 27th Oct 2021].
10 For a critique of this approach see Gavaghan C 'You can't handle the truth'; medical paternalism and prenatal alcohol use. *Journal of Medical Ethics* 2009;35:300–3.
11 Lowe PK, Lee EJ. Advocating alcohol abstinence to pregnant women: some observations about British policy. *Health Risk Soc* 2010;12(4):301–11.
12 Milne E, Thom B, Herring R. Drinking in pregnancy: shifting towards the 'precautionary principle'. In: MacGregor S, Thom B, eds. *Risk and Substance Use: Framing Dangerous People and Dangerous Places*. Routledge, 2020.
13 Scottish Intercollegiate Guidelines Network (SIGN). Children and young people exposed prenatally to alcohol: national guideline 156, 2019. Available: https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
14 National Institute for Health and Care Excellence (NICE). Fetal alcohol spectrum disorder: NICE quality standard draft for consultation, 2020. Available: https://www.nice.org.uk/guidance/indevelopment/gid-qs10139/documents [Accessed 3 Nov 2021].
15 Public Health England (PHE). Maternity high impact area: reducing the incidence of harms caused by alcohol in pregnancy, 2020. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf [Accessed 3 Nov 2021].
16 Public Health England (PHE). Maternity high impact area: reducing the incidence of harms caused by alcohol in pregnancy: p12, 2020. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf [Accessed 3 Nov 2021].
17 Scottish Intercollegiate Guidelines Network (SIGN). Children and young people exposed prenatally to alcohol: national guideline 156: p13, 2019. Available: https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
18 National Institute for Health and Care Excellence (NICE). Fetal alcohol spectrum disorder: NICE quality standard draft for consultation: p9, 2020. Available: https://www.nice.org.uk/guidance/indevelopment/gid-qs10139/documents [Accessed 3 Nov 2021].
19 Public Health England (PHE). Maternity high impact area: reducing the incidence of harms caused by alcohol in pregnancy: p10, 2020. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf [Accessed 3 Nov 2021].
20 Bennett R. Routine antenatal HIV testing and informed consent: an unworkable marriage? *J Med Ethics* 2007;33(8):446–8.
21 See for example Anon, A NEW screening test for Down's syndrome that was due to be introduced in the NHS as Learning Disability Practice went to press has been criticised by the group Saving Down Syndrome. *Learning Disability Practice* 2015;18(10).
22 Public Health England (PHE). Maternity high impact area: reducing the incidence of harms caused by alcohol in pregnancy: p9, 2020. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf [Accessed 3 Nov 2021].
23 Public Health England (PHE). Maternity high impact area: reducing the incidence of harms caused by alcohol in pregnancy: p3, 2020. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf [Accessed 3 Nov 2021].
24 Scottish Intercollegiate Guidelines Network (SIGN). Children and young people exposed prenatally to alcohol: national guideline 156: p10-14, 2019. Available: https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
25 UK Chief Medical Officers' Low Risk Drinking Guidelines, 2016. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf [Accessed 27th Oct 2021].
26 Mather M, Wiles K, O'Brien P. Should women abstain from alcohol throughout pregnancy? *BMJ* 2015;351.
27 Public Health England. *Health of women before and during pregnancy: health behaviours, risk factors and inequalities*. Public Health England, 2019: 8.
28 It appears that the main reason for recording a woman's alcohol exposure is to assist in diagnosing whether the child's condition is due to alcohol consumption during pregnancy or genetic factors. Scottish Intercollegiate Guidelines Network (SIGN). Children and Young People Exposed Prenatally to Alcohol: National Guideline 156.

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January 2019:11. Available. Available: https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
29 Scottish Intercollegiate Guidelines Network (SIGN). Children and young people exposed prenatally to alcohol: national guideline 156: p14, 2019. Available: https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
30 Howlett H, Mackenzie S, Gray WK, *et al*. Assessing prevalence of alcohol consumption in early pregnancy: self-report compared to blood biomarker analysis. *Eur J Med Genet* 2018;61(9):531–8.
31 Scottish Intercollegiate Guidelines Network (SIGN). Children and young people exposed prenatally to alcohol: national guideline 156: p12-13, 2019. Available: https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
32 Marcellus L. Is meconium screening appropriate for universal use? *Advances in Neonatal Care* 2007;7(4):207–14.
33 As noted in Scottish Intercollegiate Guidelines Network (SIGN). Children and young people exposed to alcohol: national guideline 156, 2019. Available: https: //www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021] (referring to Parkes T, Poole N, Salmon A, Greaves L, Urquhart C. Double exposure: a better practices review on alcohol interventions during pregnancy Vancouver: British Columbia Centre of Excellence for Women's Health 2008), 2019https://www.sign.ac.uk/media/1092/sign156.pdf [Accessed 3 Nov 2021].
34 Brenick A, Romano K, Kegler C, *et al*. Understanding the influence of stigma and medical Mistrust on engagement in routine healthcare among black women who have sex with women. *LGBT Health* 2017;4(1):4–10.
35 As we have already seen in cases such as *D (a minor) v. Berkshire County Council and others* [1987] 1 All E.R. 20, a woman's behaviour during pregnancy can be used against her in care proceedings concerning her children.
36 Gavaghan C. "You can't handle the truth"; medical paternalism and prenatal alcohol use. *J Med Ethics* 2009;35(5):300–3.

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Is a Relational Approach Required to Close the Door on Criminal Liability for Maternal Prenatal Conduct?

Catherine Bowden*

Centre for Social Ethics and Policy, School of Law, University of Manchester

Abstract

Calls for women who drink heavily during pregnancy to face criminal liability for the subsequent harm to their future children are driven by notions of the 'bad mother' and the view that such behaviour represents a serious moral wrong, worthy of criminal penalties. If we are to avoid the erosion of women's autonomy and extensive scrutiny of women's lives such maternal criminal liability would precipitate, a new approach is needed in the criminal law. Until now, questions regarding criminal liability for conduct at the prenatal stage have focussed on the status of the victim at the relevant time; taking little account of whether the harm was caused by the pregnant woman or a third party. This has resulted in the woman who drinks heavily during pregnancy being presented as equally blameworthy as the man who stabs his pregnant partner. I argue that a relational approach; accurately reflecting the different nature of the relationship between a pregnant woman and her foetus, to that of a third party and a foetus, is vital for the law to capture the moral blameworthiness of conduct which unintentionally causes harm to future children. Only when the law is able to do this can arguments in favour of maternal criminal liability based on notions of the 'bad mother' be addressed and the door firmly closed on criminal liability for maternal prenatal conduct.

1. Introduction

Women have not yet faced criminal liability in the UK for their prenatal conduct such as heavy drinking or drug taking during pregnancy which results in harm to their future children.[1] However, the criminal law has not expressly excluded pregnant women from liability for such harm in the way

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1 I use the terms 'prenatal conduct' and 'harm to a future child' to refer to harm due to events which occur prenatally. This includes prenatal events that cause harm to the foetus that is subsequently born alive and prenatal events which cause harm to the child *after* she is born alive. Where I refer to only one of these two types of prenatal events I make that distinction clear.

that the civil law has[2] and although such criminal liability seems unlikely at present, it remains a possibility.[3] Powerful arguments have been made by others as to why maternal criminal liability for prenatal conduct should be resisted on the ground that it would be ineffective at preventing harm and highly problematic for the lives of women, leading to calls for an exclusion of maternal liability in the criminal as well as the civil law.[4] However, those calls have so far gone unheeded and the door has not been firmly closed on maternal criminal liability.

In this paper I seek to establish three things: that maternal criminal liability for unintentional prenatal harm remains a possibility, that a relational approach could close the door on such liability, and that it would be appropriate for the criminal law to adopt such an approach.

Women who drink alcohol during pregnancy are commonly viewed as having committed a serious moral wrong, driving the argument that such behaviour should be criminalised.[5] This argument cannot be addressed until the criminal law captures the particular moral nature of how a pregnant woman might cause harm to her future child. Under the current law a woman who drinks heavily during pregnancy leading to the death of her child following its birth could be guilty of manslaughter in the same way as a man who stabs his pregnant partner unintentionally causing the death of the child after it is born.[6] The woman who drinks heavily during pregnancy is ingesting alcohol into her own body which is far from unusual in our society whereas someone who stabs a pregnant woman is acting in a violent manner towards another person which would attract criminal liability even where no harm occurred to a future child. To treat these individuals as equally blameworthy for the harm caused to the child after its birth fails to take account of the different reasons and interests pregnant women

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2 With the exception of harm due to negligent driving, the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) is intended to exclude maternal civil liability for prenatal conduct. See ss 1(1) and 2 CDCLA.

3 For a discussion of how the offence of concealment has been used to punish women for their conduct during pregnancy beyond the scope of the offence see E Milne, 'Concealment of Birth: Time to Repeal a 200-Year-Old "Convenient Stop-Gap"?' (2019) 27 Feminist Legal Studies 139.

4 E Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Oxford and Portland Oregon: Hart Publishing, 2001); M Brazier, 'Liberty, Responsibility, Maternity' (1999) 52 Current Legal Problems 359; E Cave & C Stanton, 'Maternal Responsibility to the Child Not yet Born' in A Farrell, A Mullock, C Stanton & S Devaney (eds), *Pioneering Healthcare Law* (London: Routledge, 2015) 306; S Fovargue & J Miola, 'Policing Pregnancy: Implications of the Attorney General's Reference (No. 3 of 1994)' (1998) 6(3) Medical Law Review 265.

5 E Armstrong & E Abel, 'Fetal Alcohol Syndrome: The Origins of a Moral Panic' (2000) 35(13) Alcohol and Alcoholism 276; K Bell, D McNaughton & A Salmon, 'Medicine, Morality and Mothering: Public Health Discourses on Foetal Alcohol Exposure, Smoking Around Children and Childhood Overnutrition' (2009) 19(2) Critical Public Health 155; D Wilkinson, L Skene, L De crespigny & J Savulescu, 'Protecting Future Children from In-Utero Harm'(2016) 30 Bioethics 425; E Milne, 'Putting the Fetus First – Legal Regulation, Motherhood, and Pregnancy' (2020) 27(1) Michigan Journal of Gender and Law 149.

6 *Attorney-General's Reference (No 3 of 1994)* [1997] All ER 936, [1998] AC 245.

might have for acting towards their own bodies compared to third parties acting towards another individual. The right to make choices about one's own body is an important factor in assessing whether behaviour is morally problematic and is an important legal principle.[7] It is therefore unsatisfactory for the law not to take account of the unique way in which this right is engaged in the unintentionally harmful conduct of pregnant women.

I argue that the solution lies in adopting what Seymour refers to as a 'relational approach' to cases of this kind, taking into account how the relationship between a pregnant woman and her foetus differs to that of a third party and a foetus, as well as the characteristics of the foetus.[8] This would capture the different moral nature of the harmful actions and thus the argument that women whose behaviour during pregnancy unintentionally harms their future children should face criminal liability because they have committed a serious moral wrong in the same way as a third party who causes such harm by attacking a pregnant woman, can be shown to be inaccurate. This has the potential to finally close the door to maternal criminal liability for unintentionally harmful prenatal conduct.

In order to answer the question of whether the criminal law should adopt a relational approach to prenatal conduct I must first explain the approach the law currently takes before going on to establish how this leaves the door open to maternal criminal liability.

2. The current law

The civil and criminal law in England and Wales currently take different approaches to liability for harmful prenatal conduct. While a child who is born disabled as a result of events which occur while it is in utero or even prior to its conception can bring a civil claim against other individuals responsible for those events,[9] the child cannot bring such a claim against his own mother except in relation to negligent driving.[10] Under the criminal law individuals – potentially including the woman pregnant with the future child[11] –

7 For a detailed discussion of this see R Scott, *Rights, Duties and the Body* (Oxford and Portland Oregon: Hart Publishing, 2002).

8 J Seymour, *Childbirth and the Law* (Oxford: Oxford University Press, 2000) 159-164.

9 Such a claim is derivative from a breach of a duty of care owed to the affected parent s 1(3) CDCLA.

10 ss 1(1) and (2) CDCLA. This is a policy decision due to the requirement for all drivers to have insurance, meaning that it would be the woman's insurer meeting any judgment in respect of her negligent driving, rather than the woman herself.

11 See Fovargue & Miola; Cave & Stanton; Brazier, 'Liberty, Responsibility, Maternity'; E Cave, *The Mother of All Crimes: Human Rights, Criminalization and the Child Born Alive* (Aldershot: Ashgate, 2004) 61-62.

can commit an offence if their actions which occur when the victim is in utero cause harm to the child after she is born alive.[12]

2.1. Civil law

The civil law in this area is dominated by the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) brought into law following the thalidomide tragedy.[13] The CDCLA stipulates that a child born disabled as a result of an occurrence before or during its birth can bring a civil claim against the person whose wrongful act caused that disability.[14] However, the child's mother is expressly excluded from such liability except in relation to negligent driving.[15] Maternal liability is excluded in this way because of the extent of the liability women would otherwise face and the potential for such liability to be used against women in matrimonial disputes.[16] As Jackson argues, there are three further reasons why this exclusion is required in civil law.[17] First, without such exclusion there would be practical implications on women's freedom to make choices about their bodies rendering them second class citizens in terms of autonomy and bodily integrity and subjecting them to continual surveillance.[18] For example, a pregnant woman would not be free to refuse a medical procedure such as a caesarean section without the prospect of being held liable for the consequences of that decision for her future child. Second, there would be practical difficulties in determining the standard of the 'reasonable person' used to determine standards of behaviour in the tort of negligence in relation to women's conduct during pregnancy.[19] Given the all-encompassing nature of pregnancy for nine months (as well as the potential for preconception care to impact on the health of a future child) and the extensive list of factors which can impact on the welfare of a future child, applying such a standard to pregnancy would permit judicial scrutiny of every aspect of women's lives. Third, judicial reasoning is primarily based on analogy and precedent which cannot easily be applied in the unique biological relationship of pregnancy.[20] In law, a foetus is not a legal person and so the pregnant women and foetus are not analogous to two individuals. However, the foetus is also 'not nothing' and what

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12 *Attorney-General's Reference (No 3 of 1994).*
13 See H Teff and C. Munro, *Thalidomide: The Legal Aftermath* (Chichester: Saxon House, 1976).
14 S 1(1) CDCLA
15 S 1(2) CDCLA
16 Law Commission, *Report on Injuries to Unborn Children* Law Comm No 60 (London: HMSO, 1974) 24-25.
17 Jackson, 142-147.
18 ibid 143.
19 ibid 143-144.
20 ibid 144.

is thought to be in its interests can be considered, meaning that the pregnant woman and foetus are considered not one but not two.[21] This makes analogy to other relationships between individuals problematic.[22] For all of these reasons a relational approach differentiating maternal liability from third party liability is adopted by the civil law.

2.2. Criminal law

In contrast to the civil law described above, the criminal law on prenatal conduct does not clearly differentiate between harm caused by the pregnant woman carrying the foetus and harm caused by third parties. Instead, the focus of the criminal law is on the status of the victim and so the criminal law can be seen to take a definitional approach, leaving the door open to maternal criminal liability for unintentional prenatal harm. This definitional approach can be seen in the following criminal offences.

Section 1 of the Infant Life (Preservation) Act 1929 (ILPA) makes it a criminal offence punishable by life imprisonment, to intentionally destroy the life of a child capable of being born alive before it has an existence independent of its mother.[23] Overlooking the troubling language of this provision and indeed the problematic title of the legislation,[24] it is notable that this section is only concerned with the *destruction* of the foetus capable of being born alive; it is not relevant to prenatal conduct which causes harm short of destruction to a future child (i.e. one that is later born alive). Further, no distinction is drawn between a pregnant woman who destroys the foetus she is carrying and a third party who destroys a foetus being carried by someone else.[25] This offence reflects the definitional approach of the criminal law; focussing on the status of the foetus rather than who has caused the harm and how. This definitional approach is illustrated by the family law case of *C v S*[26] in which the father of a foetus sought a court order preventing his ex-partner from terminating her pregnancy on the grounds that a termination at the stage of 18–21 weeks would be an offence under section 1 ILPA, in that it would be destroying a foetus capable of being

21 *Attorney-General's Reference (No 3 of 1994)* 687.

22 Jackson, 146.

23 Unless it is done only to preserve the life of the mother (s 1 ILPA) or the termination is in accordance with the provisions of the Abortion Act 1967 (s 5(1) Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990).

24 It is troubling and inaccurate to refer to a foetus of any stage gestation as a child or an infant.

25 Although the pregnant woman is a potential perpetrator of this offence, there appears to have been only one expectant mother convicted under this 90-year-old law. Maisha Mohamed was convicted despite no evidence as to what happened to the foetus. See Anonymous, 'Baby destruction woman sentenced', *BBC News* 24 May 2007 < http://news.bbc.co.uk/1/hi/england/manchester/6687893.stm> accessed 19 August 2020.

26 [1987] 1 All ER 1230.

born alive. The father sought to bring the claim in his own name but also to join the future child as a party to the action. However, the Court of Appeal followed the reasoning in *Paton v Trustees of the British Pregnancy Advisory Service*[27] and held that a foetus could not be a party to an action, and that a foetus born at 18-21 weeks that might show some discernible signs of life but would never be capable of breathing either naturally or with artificial assistance, could not be considered a 'child capable of being born alive' within the meaning of section 1 ILPA and so rejected the father's claim.[28] It can be seen that in focussing solely on the status of the 'victim', the foetus capable of being born alive, this offence reflects a definitional approach to harmful prenatal actions, rather than a relational approach which would distinguish between the actions of the pregnant woman and those of third parties.

In section 58 Offences Against the Person Act 1861 (OAPA) the actions of a pregnant woman and a third party who intentionally destroy a foetus of any gestation are described separately but both constitute the same offence:

Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for life.[29]

Under this provision, a pregnant woman who intentionally attempts (whether successfully or not) to abort her pregnancy or a third party who intentionally attempts to abort a woman's pregnancy can be guilty of a criminal offence and sentenced to life imprisonment.[30] It is this legislation (together with section1 ILPA and section 59 OAPA) that makes abortion a crime in England and Wales unless one of the exceptions set out in the Abortion Act 1967 apply.[31] The language used in section 58 OAPA hints at the distinction a relational ap-

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27 [1978] 2 All ER 987.

28 *C v S*, 151-152.

29 S 58 OAPA 1861.

30 For example, a woman was convicted of an offence under s 58 OAPA after she took a drug, misoprostol, in order to bring about an abortion towards the end of her pregnancy in *R v Catt* [2013] EWCA Crim 1187.

31 In summary, abortion is not an offence if the pregnancy is no more than 24 weeks of gestation and two medical practitioners certify that the continuance of the pregnancy poses a greater risk to the woman's physical or mental health than a termination, or after 24 weeks, two medical practitioners certify that the abortion is necessary to prevent a risk to the life of the pregnant woman or grave permanent harm to the woman's health, or there is a substantial risk that the child would be seriously handicapped if born. S 1(1) Abortion Act 1967

proach seeks to draw in that it talks about a pregnant woman administering a noxious substance *to herself* while a third party administers the noxious substance to the pregnant woman. However, this distinction has little significance in section 58 OAPA as the pregnant woman faces the same liability as a third party.

There are strong arguments against imposing criminal liability on a pregnant woman acting to abort her own pregnancy that are beyond the scope of this paper.[32] However, while this remains a criminal act it less problematic for the pregnant woman who intentionally brings about her own abortion and a third party who intentionally brings it about on her behalf to be guilty of the same offence than in the case of unintentional prenatal harm. Provided that the third party is bringing about the abortion at the woman's request it is the woman's right to bodily integrity that is engaged regardless of whether she is the defendant or the third party. However, when we are dealing with unintentional prenatal harm, because of the bodily relationship of pregnancy, the interests of a pregnant woman are engaged in a way that they are not when the harm is caused by a third party. It is this that necessitates a relational approach in the criminal law.

Having now established that the criminal law takes a definitional approach to intentional prenatal harm, in the next section I will show that a similar approach is taken to unintentional harm, leaving the door open to maternal criminal liability for conduct such as heavy drinking during pregnancy.

2.3. The Potential for Maternal Criminal Liability for Unintentional Harm

It is a well-established principle in English law that a foetus cannot be considered a legal person until it has a separate existence to its mother.[33] Therefore, actions that are not intended to destroy the foetus which cause harm short of destruction to individuals in their foetal stage cannot attract criminal liability.[34] However, events which happen during an individual's foetal

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32 For a detailed discussion of the arguments against criminal liability for abortion see S Sheldon & K Wellings (eds), *Decriminalising Abortion in the UK: What would it mean?* (Bristol: Policy Press, 2020) <https://www.oapen.org/search?identifier=1007882> accessed 6 April 2020.

33 *Paton v BPAS* [1978] 2 All ER 987 in which it was held that a foetus cannot be considered a legal person until it has a separate existence to its mother; *Re F (In Utero)* [1988] Fam 122 in which it was held that the court had no jurisdiction to make an unborn child a ward of court in order to protect it from harm as a result of its pregnant mother's drug abuse; and *Re MB (an adult: medical treatment)* [1997] 8 Med LR 217 which stated that as a foetus cannot be a legal person, a pregnant woman has the same right to refuse medical treatment as any other competent adult.

34 However, actions intended to cause the destruction of the foetus which fail to destroy the foetus but instead cause harm, or even no harm at all, could be subject to criminal liability under s 58 OAPA, discussed above.

stage can attract criminal liability if they result in harm occurring to that individual *following birth* as the victim is then a legal person.[35] As explained below, the principle of legal personhood has dominated the law on unintentionally harmful prenatal conduct leading to the courts adopting a purely definitional approach leaving maternal criminal liability a possibility.

In the criminal law the leading case on prenatal conduct is *Attorney-General's Reference (No 3 of 1994)*[36] in which the defendant was found guilty of the 'dangerous act manslaughter' of a child after he stabbed his pregnant girlfriend in the abdomen causing her to deliver her baby prematurely. Although the foetus was not directly injured by the stabbing the baby was born alive but subsequently died 121 days later as a complication of its prematurity.[37] The defendant had committed an unlawful act which any sober and reasonable person would recognise as creating a risk of harm to some other person in stabbing the pregnant woman. It was not necessary to establish that the risk of harm to the ultimate victim (the future child) was obvious; only that the risk to someone, in this case the pregnant woman, was obvious.[38] It is clear that the status of the victim was central to the decision in this case. If the victim had died *in utero* a charge of manslaughter could not have been made out. It was the fact that the baby had been born alive and therefore the death had been of a legal person that enabled the charge to succeed.

It could be argued that this definitional approach, focussing on the status of the victim, is appropriate given that the case was not addressing the actions of a pregnant woman; the defendant in the case was not in the unique biological relationship of pregnancy with the victim. Therefore, his actions were towards another separate being; he had stabbed his pregnant girlfriend. However, this definitional approach means that there is nothing in the judgment precluding a pregnant woman facing criminal liability for her actions during pregnancy which cause the death or other harm to her own child following its birth.[39] As Cave and Stanton have pointed out, the ruling in *Attorney-General's Ref (No 3 of 1994)* and the subsequent case of *CP v Criminal Injuries Compensation Authority*[40] discussed below leave open the possibility that a pregnant woman could be prosecuted for gross negligence manslaughter if she takes heroin during pregnancy and her child is born alive but later dies of Sudden Infant Death Syndrome (SIDS) as a result of her heroin use.[41] In this scenario although

35 *Attorney-General's Reference (No 3 of 1994)*.
36 ibid.
37 *ibid* 250-251.
38 *ibid* 246.
39 M Brazier & E Cave, *Medicine Patients and the Law* ((6th edn, Manchester: Manchester University Press, 2016) 346.
40 [2014] EWCA Civ 1554.
41 E Cave & C Stanton, 290.

the heroin would be taken while the 'victim' is in its foetal stage the subsequent death would be of a child that had been born alive bringing it within the reasoning in *Attorney-General's Ref (No 3 of 1994)*.

It could be argued that the door to maternal criminal liability is not left open in this way as such a scenario could not constitute the offence of gross negligence manslaughter because that requires the existence of a duty of care between the pregnant woman and her future child, something excluded in the civil law by the CDCLA. A duty of care in the criminal law appears unlikely given the exclusion of maternal liability expressed in the CDCLA and the opinion of Lord Dyson MR in the case of *CP v CICA* that the criminal law should reflect the civil law in these circumstances:

> Since the relationship between a pregnant woman and her foetus is an area in which Parliament has made a (limited) intervention, I consider that the court should be slow to interpret general criminal legislation as applying to it.[42]
>
> The law would be incoherent if a child were unable to claim compensation from her mother for breach of a duty of care owed during pregnancy, but the mother was criminally liable for causing the harm which gave rise to damage and a right to compensation (...).[43]

However, it appears that despite the exclusion of maternal liability under section 1(1) CDCLA a woman could still owe a civil duty of care to her future child in respect of heavy drinking during pregnancy in some circumstances. The CDCLA applies to a child 'born disabled' as a result of an occurrence before its birth bringing a claim in respect of those disabilities.[44] Further, section 1(2) states that:

> An occurrence to which this section applies is one which –
>
> *a.* affected either parent of the child in his or her ability to have a normal, healthy child; or
>
> *b.* affected the mother during her pregnancy, or affected her or the child in the course of its birth, *so that the child is born with disabilities* which would not otherwise have been present. (emphasis added)

Therefore, the CDCLA is not applicable to harm which occurs *after* the child is born alive as a consequence of something that happened prior to its birth. For example, if a woman drinks heavily during pregnancy and her child is born with FASD, the CDCLA would exclude her child from bringing a claim against her in respect of the FASD itself, but if the woman's drinking caused the child to suffer seizures after its birth resulting in brain damage, this could be construed as falling outside of the CDCLA. The child would be bringing a claim

42 *CP v CICA* [65] (Lord Dyson).
43 ibid [66] (Lord Dyson).
44 S 1(1) CDCLA 1976.

in respect of disabilities it was not born with and which were due to an occurrence after its birth.

If such a duty of care is not excluded under the CDCLA it is possible that one could be found to exist by applying the normal criteria set out in *Caparo v Dickman*:[45] it is foreseeable that a pregnant woman's future child could be harmed by her heavy drinking given the current understanding of the impact of the prenatal environment on the health of future children; there is likely to be sufficient proximity between a pregnant woman (who is aware she is pregnant) and her future child as there is a clear relationship distinguishing this from a duty owed to the world at large; and although there are strong public policy reasons why a duty in negligence should not exist (discussed above), these could be threatened by arguments that it would be fair, just and reasonable for a duty of care to exist because of the seriousness of the moral wrong that has been committed.

Therefore, returning to Cave and Stanton's example above, a woman who takes heroin during pregnancy, whose child is born alive but later dies from SIDS associated with her drug taking during pregnancy, could be said to owe a duty of care sufficient for the offence of gross negligence manslaughter as a civil duty of care in relation to post-birth harm caused by pre-birth events is not prohibited by the CDCLA and could be found applying the principles in *Caparo v Dickman*. Therefore, criminal maternal liability for prenatal conduct remains a possibility.

Even assuming that the CDCLA does exclude a duty of care in civil law, despite the comments of Lord Dyson MR, a lack of a duty of care in civil law does not necessarily preclude the existence of a duty of care in criminal law. The purposes of the two branches of law are distinct and therefore where it might be considered inappropriate for a duty of care to exist in one, it could be entirely appropriate in the other.[46] The purpose of a duty of care in civil law is to distribute loss in a manner necessary for the functioning of society, whereas a duty of care in criminal law is centred on protecting individuals from harm caused in a blameworthy manner.[47] Indeed, in order to protect individuals it might be more necessary for the criminal law to act where the civil law does not.[48] Consequently, not all of the arguments against a duty of care in civil law apply equally against a duty of care in criminal law and so it should not be assumed that the civil law exclusion is sufficient to rule out a duty of care in criminal law.

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45 [1990] 2 AC 605.

46 It was acknowledged in *CP v CICA* that the public interests in play in tort and the criminal law are different. *CP v CICA* [47] (Lord Treacy).

47 See M Jefferson, *Criminal Law* (11th edn, Harlow: Pearson Education, 2013) 463 and *Wacker* [2003] QB 1207 (CA).

48 M Allen, *Criminal Law* (13th edn, Oxford: Oxford University Press, 2015) 368.

The possibility of criminal maternal liability for harmful prenatal conduct is further increased by the language used in *Attorney-General's Ref (No 3 of 1994)*. As Fovargue and Miola have argued, in finding that a third party could be liable in manslaughter in these circumstances, and further holding that the pregnant woman and foetus are 'two distinct organisms living symbiotically, not a single organism with two aspects',[49] the House of Lords took a step towards personalising the foetus despite rejecting the possibility that the foetus could be a separate legal personality.[50] This step towards personalisation is based on the assumption that while the State has a duty to protect the rights of women, it also has an interest, or perhaps even a duty, to protect foetuses not only from harm by third parties, which would reflect their value to their parents, but also from harm *by their parents*, because they have their own intrinsic value. Further, the pregnant woman was objectified as the 'maternal environment of the foetus'[51] in Lord Mustil's comments:

The unlawful and dangerous act of B *changed the maternal environment of the foetus* in such a way that when born the child died when she would otherwise have lived.'[52] (emphasis added)

This reflects a separation of mother and foetus to an extent that it treats pregnant women in the same way as other potential defendants. Further, the conception of the pregnant woman as 'maternal environment' raises the possibility that such liability may be extended beyond intentionally harmful actions to the woman's failure to maintain that environment to the standard acceptable to the law.[53]

In addition, the harm that the woman could be liable for is not limited to the *death* of the child born alive. One of the five rules Lord Mustill considers to have been established is that:

Violence towards a foetus which results in *harm* suffered after the baby has been born alive can give rise to criminal responsibility even if the harm would not have been criminal (apart from statute) if it had been suffered in utero.[54] (emphasis added)

Therefore, a woman could be criminally liable for disabilities suffered by her child as a result of her conduct during pregnancy provided that the harm occurred to the child after it was born alive.[55]

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49 *Attorney-General's Reference (No 3 of 1994)* 255 (Lord Mustill).
50 Fovargue & Miola, 287-290.
51 *Attorney-General's Reference (No 3 of 1994)* 264 (Lord Mustill).
52 ibid.
53 K Savell, 'The Mother of the Legal Person' in S James & S Palmer (eds) *Visible Women: Essays on Feminist Legal Theory and Political Philosophy* (Oxford and Portland Oregon: Hart Publishing, 2002) 46.
54 *Attorney-General's Reference (No 3 of 1994)* 254 (Lord Mustill).
55 Brazier, 'Liberty, Responsibility, Maternity' 382.

The above discussion shows that the definitional approach taken in *Attorney-General's Ref (No 3 of 1994),* which fails to distinguish between the harmful conduct of a third party and a pregnant woman, together with the step it took towards the personalisation of the foetus means that maternal criminal liability for unintentional prenatal harm remains a possibility. This approach is problematic as it does not permit the law to take account of the unique way in which a pregnant woman might harm her future child and the interests she may have in acting in that way. As I will explain in the next section, the door to maternal criminal liability was more recently left ajar by the definitional approach taken in the case of *CP v CICA* which considered the specific question of whether the actions of a pregnant woman which unintentionally harm her future child could constitute a crime.

2.4. CP v CICA

In *CP v CICA* the Court of Appeal was asked to consider whether heavy alcohol consumption during pregnancy resulting in a child born with Foetal Alcohol Spectrum Disorder (FASD) could amount to a crime of violence under section 23 OAPA 1861 and therefore form the basis of a claim for compensation from the Criminal Injuries Compensation Authority (CICA).[56] Compensation had been previously granted under CICA for similar injuries before the scheme was reformed in November 2012 to exclude children damaged by alcohol in the womb.[57] The action brought on behalf of CP was governed by the 2008 CICA scheme and had the potential to cast doubt on the legitimacy of this exclusion by seeking a ruling that heavy drinking during pregnancy could be considered a crime of violence and thus worthy of compensation under the scheme.

The offence states that:

Whosoever shall unlawfully and maliciously administer to or cause to be administered to or taken by *any other person* any poison or other destructive or noxious thing, so as thereby to endanger the life of *such person*, or so as thereby to inflict upon *such person* any grievous bodily harm, shall be guilty of felony, and being convicted thereof shall be liable to be kept in penal servitude for any term not exceeding ten years.'[58] (emphasis added)

The Court of Appeal unanimously ruled that the harm had occurred while CP was a foetus and a foetus could not be 'any other person' for the purposes

56 The biological mother in this case did not face criminal investigation or charges. *CP v CICA* [11] (Lord Treacy).

57 ibid [1] (Lord Treacy).

58 S 23 OAPA 1861.

of section 23 OAPA. Therefore, CP was not entitled to compensation on the basis of this offence.[59]

This definitional approach is clearly illustrated in the remarks of Lord Dyson MR who stated that:

If s 23 [OAPA] had expressly included a foetus as well as "any other person", EQ [CP's mother] would have committed the *actus reus* of the offence during pregnancy.[60]

Thus, the case hinged on the definition of the required victim.

It could be argued that as a foetus lacks legal personhood and cannot be the victim of a section 23 offence, nor any other offence drafted to protect legal persons, maternal criminal liability for unintentionally harmful prenatal acts is only possible if new legislation was passed to make a foetus a specific victim of such an offence. However, the reasoning in *CP v CICA* does not alter the potential for maternal liability on the basis of the invocation of the born-alive rule in *Attorney-General's Ref (No 3 of 1994)* where the victim is the child following its birth as explained above.

Further, it is not only liability for gross negligence manslaughter that remains a possibility for women in relation to their conduct during pregnancy, but liability for harm short of death such as under section 20 OAPA. This statutory provision makes it an offence to maliciously (ie intentionally, or recklessly) wound or inflict grievous bodily harm upon any other person.[61] Following the ruling in *CP*, harm done at the foetal stage would not be sufficient for this offence for the same reason it was not sufficient for a section 23 offence; the foetus cannot be 'any other person'. However, a section 20 offence could be committed if the heavy alcohol consumption during pregnancy causes harm *after* the child is born alive such as seizures[62] which result in brain damage. It could be argued that in that scenario the brain damage is connected to the harm suffered at the foetal stage and so is not harm to the child born alive but merely the child born alive suffering the effects of the harm done to it at its foetal

59 It is worth noting that if the Court of Appeal had ruled that heavy drinking during pregnancy is capable of being a crime of violence for the purposes of the CICA scheme, it would not automatically follow that pregnant women could face criminal liability for such actions; it would be for the courts to consider whether this amounted to a criminal act if and when such as case was brought by the Crown Prosecution Service (CPS) and this would have to also pass the initial hurdle of being considered to be in the public interest. Crown Prosecution Service, 'The Code for Crown Prosecutors' 2018 < https://www.cps.gov.uk/publication/code-crown-prosecutors> accessed 20 August 2020, para 4.9.

60 *CP v CICA* [64] (Lord Dyson MR).

61 S.20 OAPA.

62 F Nicita et al, 'Seizures in Fetal Alcohol Spectrum Disorders: Evaluation of Clinical, Electroencephalographic, and Neuroradiologic Features in a Pediatric Case Series' (2014) 55(6) Epiliepsia e60-e66.

stage.[63] However, this is not the view taken by the House of Lords in *Attorney-General's Ref (No 3 of 1994)*. In that case the death of the child born alive was held to be harm *to the child* caused by the attack on the child's mother during pregnancy rather than merely an effect of the prenatal harm. If prenatal events which cause the death of a child later born alive can be considered to be sufficient for manslaughter, there is no reason why brain damage due to a seizure could not be sufficient for section 20 OAPA on the same basis.

A further argument as to why maternal criminal liability is unlikely following the case of *CP v CICA* is that in that case the Court of Appeal expressed an intention for the criminal law to reflect the approach of the civil law and to 'be slow to interpret general criminal legislation as applying to [the relationship between a pregnant woman and her foetus].'[64] However, this reluctance to impose criminal liability on women for their conduct during pregnancy is not the exclusion that commentators such as Fovargue and Miola have called for.[65] *CP v CICA* was decided on the basis of the status of the victim at the time the harm occurred leaving the born-alive rule from *Attorney-General's Ref (No 3 of 1994)* in operation and reinforcing the definitional approach of the criminal law. Conceptual reasons as to why the civil law exclusion should be followed were not given. There was no explanation of why the relationship between the potential victim and the potential defendant should mean that criminal liability would be inappropriate in these circumstances. Therefore, while the Court of Appeal has expressed an intention for the criminal law to follow the relational approach of the civil law, without a robust conceptual basis it is not certain that this intention will be followed in all circumstances that come before the courts. Further, while this is a decision of the Court of Appeal the ruling in *Attorney-General's Ref (No 3 of 1994)* which did not adopt a relational approach to prenatal conduct came from the House of Lords and so takes precedence indicating that a purely definitional approach to harmful prenatal conduct is likely to prevail at least where the harm occurs after the child is born alive. Therefore, the intention expressed by the Court of Appeal to follow the civil law is not sufficient to close the door firmly on maternal criminal liability.

If a woman was found guilty of an offence such as gross negligence manslaughter, or inflicting grievous bodily harm under section 20 OAPA, in relation to her conduct during pregnancy which caused harm to her child after he was born alive, it is unlikely that this would be the end of the matter. Those who believe that a woman who drinks heavily during pregnancy has committed a serious moral wrong in the same way as the man who stabs his pregnant partner

63 CP's disabilities were held to be the effects of the harm done to her *in utero* rather than harm occurring following her birth, as the harm had already occurred, but in the case of seizures, new, post-birth harm would be occurring. *CP v CICA* [42] (Lord Treacy).

64 ibid [65] (Lord Dyson MR).

65 Fovargue & Miola, 292-293.

are unlikely to be satisfied by maternal criminal liability only when some additional harm associated with the alcohol consumption occurs after birth.[66] Arguments will continue to be made for the law to reformed to hold women legally responsible for harm caused to their future children at the foetal stage. After all, there appears to be little to distinguish the conduct of a pregnant woman which results in harm to her child after he is born alive from the same conduct which causes harm to a foetus that is later born alive. Therefore, the potential for maternal criminal liability for prenatal conduct remains under the born alive rule and could lead to prenatal conduct that causes harm at the foetal stage.

Having now established that the door remains ajar to criminal maternal liability for prenatal conduct I will now consider how the intuitive moral judgment of the conduct of pregnant women has the potential to push that door wide open and how a relational approach, which reflects who has caused the harm and how, could address this.

3. The moral judgment of the conduct of pregnant women

If we accept that parents are under a moral duty to do what they can to protect their children from unreasonable and avoidable harm then it seems to follow that women who intend to bring a foetus to birth have a moral duty to protect their child from harm even if this harm is due to events before its birth. The fact that the child is a foetus rather than a legal person at the time the harmful events occur is irrelevant as the duty is owed to the future child not the foetus.[67] Indeed, as Brazier has argued, a pregnant woman can be seen to be under a particularly strong moral duty not to injure her future child due to the future child's total dependency on the pregnant woman.[68] The argument is that this total dependency, coupled with the woman's intention to bring this future child to birth, mean that the pregnant woman should at least take that future child's interests into account when making decisions. Her conduct during pregnancy will affect the welfare of an individual; that cannot be disregarded on the grounds that that individual is not yet born.[69]

Strong arguments have been made by Brazier and other commentators that it would be inappropriate for this moral duty to be translated into a legal one

66 A man who stabs his pregnant partner causing harm to the foetus, rather than to the child after it is born alive, would still face criminal liability for the infliction of grievous bodily harm on the woman.

67 B Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses,* 2nd ed. (2nd edn, New York: Oxford University Press, 1992) Chapter 4.

68 Brazier, 'Liberty, Responsibility, Maternity'367.

69 ibid 369.

on the basis that it would be ineffective in preventing harm to future children and it would be an unjustified trespass on women's autonomy.[70] Unfortunately, these arguments have not been sufficient to prevent cases such as *CP v CICA* being pursued in the courts. I argue that it is the interpretation of this moral duty that lies behind cases such as *CP v CICA* and has the potential to push the door to criminal maternal liability for prenatal conduct wide open.[71] The influence of the moral view of pregnancy can be seen in cases such as *Attorney-General's Ref (No.3 of 1994)* itself. As Fovargue and Miola argued:

The decision in [*Attorney-General's Ref (No.3 of 1994)*] suggests that the courts are willing to interpret the law in such a way as to provide a morally 'correct' outcome. In crossing the gap between moral and legal culpability where a foetus is concerned, the courts have opened up a range of possibilities which have the potential to extend even further than at present.[72]

The courts' desire to interpret the law to achieve a morally 'correct' outcome could therefore lead to the perceived moral duty associated with pregnancy being translated into criminal maternal liability for harmful prenatal conduct at least in circumstances where the harm occurs after the child is born alive.[73] Indeed, as Milne argues, the assumption that a 'good mother' will always act to prioritise the needs of her future child in front of her own (what Milne refers to as the 'foetus-first' mentality) already influences the courts' interpretation of offences such as Concealing the Birth of a Child[74] to punish women for their behaviour during pregnancy.[75] The moral judgment of pregnant women will continue to push on the door to maternal criminal liability while the law is unable to address the argument that a woman whose conduct during pregnancy unintentionally causes harm to her future child has committed a serious moral wrong in the same way as a man who stabs his pregnant partner. Therefore, if we are to avoid the trespass on women's autonomy that criminal liability for behaviour during pregnancy would represent, an approach is needed that distinguishes between a woman whose conduct during pregnancy unintentionally causes harm to her future child and a third party who unintentionally causes such harm. Having established that the door to maternal criminal liability for unintentional prenatal harm remains open, and the potential for the moral judgment of the conduct of pregnant women to push it wide open, in the next section I will explain why

70 ibid, Jackson; Fovargue and Miola; Cave and Stanton.
71 Something which Fovargue and Miola argue lies behind many of the court ordered caesarean section cases, Fovargue & Miola, 280-281.
72 Fovargue & Miola, 280-281.
73 Brazier argues strongly that this would be inappropriate, Brazier, 'Liberty, Responsibility, Maternity'.
74 S 60 OAPA.
75 E Milne, 'Putting the Fetus First'.

it would be appropriate for the criminal law to adopt a relational approach to finally close that door.

4. Why a relational approach is appropriate

The significance of a relational approach, distinguishing between a pregnant woman and a third party who unintentionally cause harm to a future child, lies in its ability to account for the interests that a woman might have in conduct directed towards her own body which would not be engaged in the case of a third party. Although this distinction is missing in the definitional approach taken by the courts in *Attorney-General's Ref (No 3 of 1994)* and *CP v CICA*, I argue that it can be seen in the statutory offences under sections 23 and 58 OAPA.

Starting with the offence considered in *CP v CICA* of administering a poison or noxious substance under section 23 OAPA, we can compare a third party who administers a noxious substance to a foetus *in utero* with a woman who indirectly administers the noxious substance to the foetus by consuming the substance herself. Both of these scenarios are likely to involve indirect administration as the third party would have to administer the substance through the woman's body. Indirect administration has been held to be included in the meaning of 'administered' in English law.[76] However, in the pregnant woman's case the 'administration' is not only indirect but is through the defendant's own body. The defendant administers the alcohol *to herself* and as a consequence it is administered to the foetus: her actions are towards her own body. Even in circumstances where alcohol consumed during the latter stages of pregnancy passes to the baby after it is born alive while the umbilical cord is still intact,[77] the pregnant woman should not be considered to have simply administered the alcohol to another person (her baby) but rather to herself.

If a woman drank heavily with the intent of procuring a miscarriage, this would be an offence under section 58 OAPA as she would have administered to herself a noxious substance for the purpose of procuring her own miscarriage. Despite it being noted in *CP v CICA* that the 'focus of section 58 is on the administration of drugs or the use of instruments on the woman rather than the child',[78] the Court of Appeal was of the opinion that the only thing that distin-

76 The meaning of 'administered' was defined in the case of *Gillard* (1988) 87 Cr App R 189 which considered it to mean 'takes, postulates some, ingestion' by the victim. Bringing a noxious thing into contact with the body, directly or indirectly, was enough, therefore, spraying with CS gas was included.

77 This has been the basis for criminalising drug taking in pregnancy in some American States. See for example *Johnson v State 578* So.2d 419 Ct App FL 5th Dist (1991).

78 *CP v CICA* [47] (Lord Treacy).

guishes a section 58 offence from a section 23 offence is that the former requires an intention to bring about a miscarriage.[79] The *actus rei* of the two offences were viewed as the same. This ignores the fact that section 58 OAPA refers to 'administering to herself' while section 23 OAPA refers to 'administering to another'. This conflation of the *actus reus* of section 23 OAPA with that of section 58 OAPA misses the significance of Parliament, in enacting section 58 OAPA, only seeing fit to criminalise a pregnant woman's actions towards her own body where she intends to destroy the foetus.

The unique manner in which a pregnant woman may cause prenatal harm is reflected in the construction of the CDCLA. The fact that a pregnant woman's harmful prenatal acts are towards her own body means that maternal civil liability would be impossible under the CDCLA even if the express exclusion in section 1(1) CDCLA had not been included. Liability to a child under the CDCLA is dependent on a duty of care being owed to the parent whose reproductive health is affected.[80] For example, an employer who exposes workers to radiation which causes genetic mutations in his employee's gametes will only be liable to the child born disabled as a result if the employer owes a duty of care to the employee in respect of such exposure. A person cannot be liable in tort to herself and so a pregnant woman could not be liable to her future child for what was referred to in the parliamentary debate putting forward the legislation for its second reading as 'self-inflicted injury'.[81] Therefore, the CDCLA can be seen to reflect the indirect manner in which a pregnant woman may cause prenatal harm. Something that the potential for liability under the principle in *Attorney-General's Ref (No 3 of 1994)* and the definitional approach taken in *CP v CICA*, do not.

The above consideration of the *actus rei* of section 23 and section 58 OAPA demonstrates that the criminal law does recognise that a pregnant woman can cause harm to her future child by acting towards her own body and Parliament has only seen fit to expressly criminalise this when those actions are intended to destroy the foetus. However, the approach of the common law in *Attorney-General's Ref (No 3 of 1994)* and *CP v CICA* does not recognise the unique way in which a pregnant woman might unintentionally harm her future child. This is problematic because it fails to account for the interests that a woman might have in conduct directed towards her own body which would not be engaged in the case of a third party. In order to illustrate this I will now consider the

79 CP's mother could not be charged with a s 58 offence as she did not have the requisite intention to procure her own miscarriage.

80 S 1(3) CDCLA 1976.

81 Hansard Debate 06 (February 1976, volume 904) 1593 < https://api.parliament.uk/historic-hansard/commons/1976/feb/06/congenital-disabilities-civil-liability> accessed 25 August 2020. However, an exception to this was permitted in the case of negligent driving as noted above.

currently hypothetical scenario of ectogenesis in which a foetus develops outside of the woman's body. Ectogenesis is a useful thought experiment as it removes the physical relationship between a woman and her developing foetus so that the ways in which she can cause harm to that foetus are akin to those of a third party. By comparing this to a bodily pregnancy I will show why it would be appropriate for the criminal law to adopt a relational approach to unintentional prenatal harm.

4.1. Ectogenesis

Brazier has set out three considerations for determining the extent to which the law should interfere with a pregnant woman's conduct during pregnancy in the name of protecting the interests of her future child:

1. We cannot demand a woman 'subordinate her interests to the potential child's, where in the case of a child already born no such demand could be made';
2. A woman's obligation is to make judgements based on what is best for herself, her child and any other children; and
3. It must be proportionate and practical and able to be defined within agreed limits.[82]

In the case of ectogenesis, where a foetus gestates in an artificial womb outside of the woman's body,[83] Brazier's three considerations are clearly less likely to be problematic when considering criminal liability for harmful prenatal acts than when the foetus is within the woman's body. The woman's interests in health, privacy and liberty are not engaged in the same way. Imposing criminal liability on a woman who administered alcohol to an externally gestating foetus would be akin to the demand made in respect of a child already born.[84] The obligation on her in making decisions about the care of the externally gestating foetus is likely still to be to take the interests of her future child into account and weigh these against her own interests and those of her other dependants. However, whatever course of action is in the interests of her externally

82 Brazier, 'Liberty, Responsibility, Maternity', 375-376.

83 For the purposes of this thought experiment, I use the term 'ectogenesis' to refer to complete ectogenesis, where the foetus is not inside the woman's uterus at any time. I also make the assumption that the externally gestating foetus would not be considered a legal person as it has not been 'born alive' *(Paton v British Pregnancy Advisory Service Trustees* [1978] 2 All ER 987). See A Alghrani and M Brazier, 'What is it? Whose it? Re-positioning the Foetus in the Context of Research?' (2011) 70 Cambridge Law Journal 51 and E Romanis, 'Challenging the "Born Alive" Threshold: Fetal Surgery, Artificial Wombs, and the English Approach to Legal Personhood' (2020) 28 Medical Law Review 93.

84 It is an offence to give a child under 5 alcohol unless in an emergency or under medical supervision, Children and Young Persons Act 1933.

gestating future child, it is unlikely to represent a significant impact on her own interests in the same way as for a bodily pregnancy.

As others have discussed this is not the case in the current reality of pregnancy.[85] It is the fact that the foetus is developing inside the woman's body that necessitates a different approach by the law rather than the status of the foetus in isolation. The location of the foetus is not simply a matter of geography but a factor which engages the interests of the pregnant woman in a unique way. Further, the location of the foetus changes the nature of the prenatal conduct which might be harmful. For example, FASD could in theory be caused in ectogenesis by the expectant mother administering alcohol to the external foetus but in a bodily pregnancy it could be caused by the pregnant woman administering alcohol to herself. Similarly, avoiding causing such harm in the case of ectogenesis would require the woman not to administer alcohol to another being (even if not another person) something which other individuals are also required to do in instances where that could result in harm. For example, even administering alcohol to an animal can be a criminal offence under section 7 Animal Welfare Act 2006.

In the scenario of ectogenesis the actions of a woman who administers alcohol to the external foetus are akin to those of the third party in *Attorney-General's Ref (No 3 of 1994)* in that her actions are directed towards another being rather than herself.[86] If that caused harm either to the external foetus or to the resulting child later 'born' alive, there would be a strong argument in favour of criminal liability for that harm. After all, the woman would have administered a noxious substance to another being resulting in harm to that being.[87] This might mean that a definitional rather than a relational approach would be appropriate in the scenario of ectogenesis, however, this is not the case with a bodily pregnancy.

4.2. A relational approach to prenatal harm

We need to be clear about what behaviour would be criminalised in the case of unintentionally harmful prenatal conduct of pregnant women. Take the example of FASD linked to heavy drinking during pregnancy. Avoiding such harm in a bodily pregnancy would require the pregnant woman

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85 See note 4 above.
86 Although not towards a legal person. See note 33 above.
87 While this might not come under any existing offence, we might be justified in creating an offence or even amending s 23 OAPA to include an external foetus as a potential victim (although this would be in conflict with the title of the Act which refers to offences against the *person)*. This would then cover intentional *and reckless* harm by administration of a noxious substance to the external foetus. For example, if a woman administered a potentially harmful substance to her external foetus in the hope that it would make her baby taller, provided she was aware of the risk of harm to her future child, she would have committed an offence under the modified version of s 23 OAPA.

to avoid alcohol or at least restrict her consumption to a minimal amount for the whole nine months of pregnancy. Alcohol is an addictive substance and it would seem likely that those who drink heavily would be influenced by some level of addiction. This raises questions regarding the appropriateness of criminal liability in circumstances of addiction.[88]

Returning to Cave and Stanton's example of the woman who takes heroin during pregnancy causing the death of her child after it is born alive; in this scenario the pregnant woman could be guilty of manslaughter following the reasoning in *Attorney-General's Ref (No 3 of 1994)* as the death would be of a child who had been born alive. It would be irrelevant that the perpetrator was the pregnant woman; she would be considered as much to blame for the unintended death of the child as the man who stabbed his pregnant partner. This leaves no room for consideration of the argument that an individual who fails to resist a highly addictive substance such as heroin and administers it to herself bears a very different level of moral blame for the unintended consequences of her actions than a third party who attacks a pregnant woman.[89] The same argument applies to alcohol consumption.

Unfortunately, in *CP v CICA*, it was not contested that CP's mother had administered alcohol to the foetus[90] and so an opportunity was missed for the court to highlight that what it was being asked to consider a crime of violence was the failure to resist administering to herself a highly addictive substance for nine months or more. Had it done so, the argument could then have been made that this was not sufficiently blameworthy behaviour to be subject to criminal penalties. This is clearly illustrated in *CP v CICA* itself as CP's biological mother had shown what might be considered superhuman levels of self-control and determination in giving up illicit drugs and reducing her alcohol intake considerably for the sake of her future child, but still CP suffered from FASD.[91]

Although a full discussion of this issue is beyond the scope of this paper, the point remains that addiction plays a role in harmful maternal prenatal conduct in a way it does not for third parties. There is a debate regarding the impact of addiction on criminal liability[92] and the criminal law on prenatal conduct can only take account of and inform this debate, if it adopts a relational approach to prenatal conduct.

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88 For a discussion on this topic see AM Honoré, *Responsibility and Fault*, (Oxford: Bloomsbury, 2002) Chapter 6, 121-142 and J Tolmie, 'Alcoholism and Criminal Liability' (2001) 64 Modern Law Review 688.

89 Indeed, Emma Cave argues that seeking retribution from pregnant addicts for prenatal harm resulting from their addictions would be inappropriate as they have little choice or control over that behaviour. Cave 'Mother of All Crimes', 86-8.

90 *CP v CICA* [14] (Lord Treacy).

91 *CICA v First-tier Tribunal and CP (CIC)* [2013] UKUT 0638 (AAC) [3].

92 See Tolmie, 'Alcoholism and Criminal Liability'.

The wider need for a relational approach is illustrated by Wilkinson et al's argument that:

In the non-lethal gestational harm case, where a pregnant woman ingests a toxin that she is aware will harm her future child, she should be held accountable for that wrong.[93]

As Wilkinson et al appear to acknowledge, the blameworthiness of the pregnant woman might be influenced by addiction.[94] However, I would argue that referring to heavy drinking during pregnancy as simply 'a pregnant woman ingesting a toxin' is not sufficiently accurate to enable a proper consideration of blameworthiness to take place. This description does not reflect the fact that the unique relationship of pregnancy means that what would be criminalised is the failure to maintain a sufficient 'maternal environment' for nine months or more. If we acknowledge that adults have an interest in consuming substances which might be considered toxins such as alcohol or medicines, what we would be criminalising is the failure of pregnant women to subordinate their own interests to those of their future children. It is this oversimplification of the nature of the conduct that leads to the assumption that ingesting a toxin that she is aware will harm her future child will be a wrong. The fact that she might have other interests served by administering that toxin *to her own body* is lost in this description. For example, if she ingests a toxin as part of chemotherapy treatment.

As the criminal law is concerned with harm caused in a blameworthy manner it would be appropriate for it to adopt a relational approach to prenatal harm as this would enable it to capture the moral nature of the unintentionally harmful prenatal conduct. Once this has been achieved, the argument that pregnant women whose conduct unintentionally causes harm to their future children should face criminal penalties because they have caused harm to those future children in an equally morally blameworthy manner as the man who stabs his pregnant partner, can be shown to be inaccurate. This has the potential to finally close the door to maternal criminal liability for unintentionally harmful prenatal conduct.

5. Conclusion

The rulings in *Attorney-General's Ref (No 3 of 1994)* and *CP v CICA* leave open the possibility of women being held criminally liable for their conduct during pregnancy which unintentionally causes harm to their future

93 Wilkinson et al, 428.

94 Although, their argument appears to be that some factors that might lead to addiction (rather than the addiction itself) could warrant a more lenient approach, Wilkinson et al, 431.

children, at least where that harm occurs after the child has been born alive. The potential for this door to be pushed wide open is increased because the criminal law leaves no room for the argument to be made that a pregnant woman whose conduct unintentionally harms her future child is not worthy of the same level of moral blame for the unintended consequences of her actions as a third party who attacks a pregnant woman. While the criminal law views pregnant women in this way, arguments in favour of criminalising women for their behaviour during pregnancy based on misguided notions of 'bad mothering' cannot be fully addressed. It would be appropriate to adopt a relational approach to harmful prenatal conduct as this would enable the criminal law to take account of the different reasons and interests pregnant women might have for acting towards their own bodies compared to third parties acting towards another individual and the implications of this for the blameworthiness of their conduct. This approach is also desirable because it could lend valuable support to those who call for the door to maternal criminal liability to be firmly closed by addressing the arguments in favour of such liability based on misguided notions of what constitutes the 'good pregnant woman'. The question which follows on from this discussion is *how* should a relational approach to prenatal conduct be reflected in the criminal law? Although a detailed consideration of this question is beyond the scope of this paper, it seems that we will have to wait for a decision of the Supreme Court limiting the ruling in *Attorney-General's Ref (No 3 of 1994)* to cases involving third parties and distinguishing this from considerations of maternal conduct, if and when such an opportunity arises. This is necessary both to protect the interests of pregnant women and to enable the criminal law to accurately consider when harm has been caused in a blameworthy manner. Until then, in the absence of legislative reform, there is a risk that the particular moral condemnation directed at pregnant women could translate into criminal maternal liability for prenatal harm with the extreme intrusion into women's lives this would represent.

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IS THE UNEQUAL TREATMENT OF MATERNAL AND PATERNAL LIABILITY UNDER THE CONGENITAL DISABILITIES (CIVIL LIABILITY) ACT 1976 JUSTIFIED?

CATHERINE E. BOWDEN *

Centre for Social Ethics and Policy, University of Manchester, Manchester, M13 9PL, UK

ABSTRACT

Under the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) a child born disabled as a result of an occurrence prior to its birth can bring a claim against the individual responsible for that occurrence. Significantly, mothers are exempt from liability (except in relation to negligent driving) but fathers are not. Since the CDCLA came into force in 1976, there have been significant shifts in the landscape in which it operates: a more gender-neutral model of parenting; transmission of an infection to a sexual partner can be a criminal offence; and growing evidence regarding the impact of prenatal events. In addition, there is a trend for presenting prenatal harm as a problem of individual behaviour. This article presents a timely consideration of the potential for parental liability under the CDCLA and asks whether restricting the exemption of parental liability to mothers but not fathers can be justified. It is argued that the reasons for unequal parental liability in relation to gestational harm are not sufficient to justify restricting the broad exemption to mothers but not fathers and a change in the law is required to bring the CDCLA up to date with advances in the criminal law, society, and medical science.

KEYWORDS: Congenital Disabilities (Civil Liability) Act 1976, maternal liability, parental liability, paternal liability, wrongful life

* Catherine.Bowden@Manchester.ac.uk

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I. INTRODUCTION

Under the Congenital Disabilities (Civil Liability) Act 1976 (CDCLA) a child born disabled as a result of an occurrence prior to its birth can bring a claim against the individual responsible for that occurrence. Significantly, mothers are exempt from liability under the CDCLA (except in relation to negligent driving) but fathers are not.[1] Since the CDCLA came into force in 1976, there have been significant shifts in the landscape in which it operates: the move towards an acceptance of a more gender-neutral model of parenting; non-disclosure of a sexually transmitted infection to a sexual partner can now be the basis of a criminal offence; and there is growing evidence regarding the impact of prenatal events on future children. In addition, there is a growing trend for presenting prenatal harm as a problem of individual behaviour.[2] This article presents a timely consideration of the potential for parental liability under the CDCLA and asks whether restricting the exemption of parental liability to mothers but not fathers can be justified in light of these shifts.

The arguments in favour of the unequal treatment of maternal and paternal liability differ depending on the timing of the event. Therefore, it is necessary to distinguish between three categories of events which could lead to liability under the CDCLA; those that occur prior to conception (pre-conception harm), those that occur at the time of conception (conception harm) and those that occur during pregnancy or birth (gestational harm). I will consider each of these in turn to establish precisely how the liability of mothers and fathers is unequal under the CDCLA before considering whether such an inequality is justified. This will lead me to conclude that while there are reasons for treating paternal and maternal liability differently in relation to gestational harm these are not sufficient to justify restricting the broad exemption to mothers but not fathers. Therefore, a change in the law is required to bring the CDCLA up to date with advances in the criminal law, society, and medical science.

II. LIABILITY UNDER THE CDCLA

The CDCLA was brought into law following the thalidomide tragedy[3] to provide compensation for a child born alive suffering disabilities as a result of either, an occurrence prior to conception which affected either parent's ability to have a healthy child, an occurrence affecting the mother during pregnancy, or one affecting the mother or child during its birth.[4] Any such liability under the CDCLA is dependent on a breach of legal duty owed to the parent although there is no requirement that the affected parent is harmed themselves.[5] In this way, although the claim is brought by the child, it reflects liability for harm done to the parent's ability to have a healthy child. For example, if a doctor fails to warn a pregnant woman of a risk associated with a caesarean

1 In the context of this article, I use 'father' to refer to the genetic father or sperm donor and 'mother' and 'pregnant woman' to refer to the genetic mother and gestator. I acknowledge that not all sperm donors or pregnant people will identify with these terms.

2 Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Hart Publishing 2001) 151–59; Catherine Bowden, 'Are We Justified in Introducing Carbon Monoxide Testing to Encourage Smoking Cessation in Pregnant Women?' [2019] 27(2) Health Care Anal 128.

3 See Harvey Teff and Colin R Munro, *Thalidomide: The Legal Aftermath* (Saxon House 1976).

4 CDCLA, s 1.

5 CDCLA, s 1(3).

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section and that risk materialises causing the child to be born disabled, whether that child can bring a claim against the doctor will depend on whether the risk was one which the doctor had a duty to warn the woman of.[6] If there was no duty to warn the woman of that risk the child will have no claim. Crucially, the CDCLA provides an exemption for harm due to the actions of the child's mother, other than for injuries caused by negligent driving.[7] Therefore, a child cannot sue its mother for harm suffered as a result of her conduct before or during pregnancy, or her choices regarding delivery.[8] There is no equivalent exemption for paternal conduct.

Before I can consider whether the unequal treatment of maternal and paternal liability under the CDCLA is justified, I must first establish that the treatment *is unequal* by demonstrating that paternal liability is a possibility where maternal liability is not.

A. Is Paternal Liability Possible where Maternal Liability is Not?

Under the CDCLA, section 1(1), the child's mother is excluded from liability under the Act but there is no parallel provision excluding fathers from liability. Although fathers are not included in the exemption under CDCLA, section 1(1) this might not amount to unequal treatment if paternal liability is not possible for another reason. Indeed, in 1997 Margaret Brazier argued that the exclusion of maternal but not paternal liability under the CDCLA was justified in part because the construction of the CDCLA meant that liability for either parent was extremely unlikely even without the exclusion.[9] This is supported by the lack of claims against fathers since the CDCLA has been in force. However, since then there have been significant developments in medical science and in the law on the duty to warn sexual partners of sexually transmissible infections which mean that paternal liability might not be as unlikely as it once was. If this is the case, paternal liability would be possible under the Act where maternal liability is not. In order to establish the potential for paternal liability under the CDCLA I will consider parental liability for gestational, pre-conception, and conception harm separately.

B. Gestational Harm

The construction of the CDCLA means that liability of either parent for gestational harm is only possible in very limited circumstances even without the maternal exclusion in section 1(1).[10] As explained above, the CDCLA does not create a duty of care,

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6 The question of whether the risk falls within the scope of the doctor's duty to warn will be decided by applying the principle in *Montgomery v Lanarkshire* [2015] UKSC 11 discussed below.

7 CDCLA, s 2. As a policy decision the maternal exemption does not apply to liability in relation to negligent driving as such liability would be covered by motor insurance which is a legal requirement for all drivers. Law Commission, *Injuries to Unborn Children* (Law Com No 60, 1974) para 60.

8 The CDCLA does take some account of the potential for maternal responsibility in that in a case where a child is suing a third party such as the mother's doctor in relation to an injury suffered prenatally, under CDCLA, s 1(7) the child's damages may be reduced if the mother contributed to the disability. As Brazier and Cave note, this provision envisages cases where a pregnant mother contributes to the child's disability by smoking, drinking, or failing to take precautions, against medical advice. M Brazier and E Cave, *Medicine, Patients and the Law* (6th edn, Manchester University Press 2016) 344.

9 Margaret Brazier, 'Parental Responsibilities: Foetal Welfare and Children's Health' in C Bridge (ed), *Family Law Towards the Millennium: Essays for P M Bromley* (Butterworth-Heinemann Ltd 1997).

10 Except for liability in relation to negligent driving by the mother which does not depend on a duty of care to the affected parent.

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it merely extends any existing duty of care owed to the affected parent to also provide a cause of action for the child born disabled as a result of the defendant's actions. Therefore, any liability of a mother to her child would be dependent on her already owing a duty of care to the child's father which, if breached, could affect his ability to have a healthy child (the mother could not owe a duty of care to herself) and vice versa.

Without the exclusion in CDCLA, section 1(1) maternal liability for gestational harm might be possible under the Act. For example, if the pregnant woman was the father's employer she would owe him a duty of care as his employer, and she could breach this duty by having an unsafe work environment (perhaps stress or exposure to a toxin). Even if this does not harm the father, if it harms her future child that child could potentially claim against the mother for disability if the maternal exemption was not in place. It is questionable whether this would count as having affected the father's ability to have 'a normal, healthy child'[11] as the harm is occurring through the pregnant woman's body and so it may be the mother rather than the father who is considered to be the affected parent. However, it could be argued that the pregnant woman's breach of duty towards him has prevented him having the normal, healthy child he otherwise would. Even if technically possible, such liability seems highly unlikely particularly as the child would be able to claim against the company employing his father rather than the mother as an individual. If maternal liability for gestational harm is at most a remote possibility even without the exclusion in section 1(1), the exclusion has little impact on liability in relation to gestational harm.

What about paternal liability for gestational harm? As the CDCLA does not create a new duty of care, paternal liability is dependent on the father owing an existing duty of care to the pregnant woman or otherwise being liable to her in tort.[12] Perhaps, the clearest example of this is where a father commits an intentional tort such as a battery against his pregnant partner. In this case, the father would be liable to the mother in tort and so would be liable to the child under the CDCLA for any disabilities it was subsequently born suffering from as a result of the battery.

Is paternal liability for *negligent* gestational events possible under the CDCLA? For example, if a man regularly smokes in the home he shares with his pregnant partner, knowing that there is a risk to the health of his partner and the future child, could this be a breach of a duty care in negligence? The existence of a duty of care would most likely depend on the three-part test set out by the House of Lords in the case of *Caparo v Dickman*: (i) damage must be reasonably foreseeable as a result of the defendant's conduct; (ii) the parties must be in a relationship of proximity or neighbourhood; and (iii) it must be considered fair, just, and reasonable to impose liability.[13] The first two requirements are likely to be satisfied as first, it is foreseeable that the woman could suffer harm from the effects of passive smoking as this is a known

11 CDCLA, s 2(a).

12 Brazier (n 9) 275.

13 [1990] UKHL 2 [1990] 2 AC 605; This was confirmed as the relevant test for novel scenarios in which there is no established duty of care in negligence in the case of *Robinson v Chief Constable of West Yorkshire Police* [2018] UKSC 4.

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risk,[14] and secondly, there is likely to be sufficient legal proximity as there is a close relationship between the father and his pregnant partner which could be argued to be a relationship of some responsibility. However, even if these requirements are met, there are strong arguments against imposing liability on the basis that it would not be fair, just, and reasonable.[15] Interfering with an individual's conduct in the privacy of their own home requires a high degree of justification, and it is difficult to see what would be gained from litigation in these circumstances.[16] In addition, the partner has some degree of choice over whether smoking is permitted in the home and/or whether she remains in the same room as her partner when he smokes or not. Further, even if a duty of care were held to exist, liability under the CDCLA would still be unlikely as the mother (the affected parent) would be likely to have been aware of the risk and viewed as having chosen to accept that risk in all but exceptional circumstances.[17]

Therefore, in relation to gestational events, it seems that the only significant potential for paternal liability is where the father's conduct represents an intentional tort such as a battery against the pregnant woman. As any liability pregnant women could have faced for gestational harm is excluded under the CDCLA, we can conclude that there is unequal treatment of mothers and fathers in relation to gestational harm under the CDCLA.

C. Pre-Conception Harm

There is a growing body of medical science demonstrating the impact of the pre-conception behaviour of both men and women on the health of their future offspring.[18] Fathers are not exempt from liability under the CDCLA for pre-conception conduct such as smoking or drug taking which damages their own gametes leading to their future children being born disabled. However, such liability is unlikely as this would require the man to owe a duty of care to his sexual partner, or even his future sexual partner, to tailor his conduct in order to safeguard her ability to have healthy

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14 The NHS website states that 'Secondhand smoke is dangerous, especially for children. The best way to protect loved ones is to quit smoking. At the very least, make sure you have a smokefree home and car. . .Pregnant women exposed to passive smoke are more prone to premature birth and their baby is more at risk of low birthweight and cot death.' NHS, 'Passive Smoking' <https://www.nhs.uk/live-well/quit-smoking/passive-smoking-protect-your-family-and-friends/> accessed 20 May 2021.

15 Many of these arguments apply to paternal liability in general and are discussed below.

16 Imposing liability on an individual for smoking in their own home could also raise human rights issues. The smoker might argue that such liability interferes with his right to respect for home and private life under art 8 of the European Convention on Human Rights as given effect by the Human Rights Act 1998. However, this would have to be balanced against the claimant's art 8 rights to not be exposed to smoke. For a consideration of the case law on this point, see John Coggon, 'Public Health, Responsibility and English Law: Are There Such Things as No Smoke without IRE or Needless Clean Needles' [2009] 17 Med L Rev 127; Neil Allen, 'A Human Right to Smoke?' [2008] 158 New Law J 886; Yvette van der Eijk and Gerard Porter, 'Human Rights and Ethical Considerations for a Tobacco-Free Generation' [2015] 24(3) Tob Control 238.

17 CDCLA, s 1(4).

18 For example, Kathleen Abu-Saad and Drora Fraser, 'Maternal Nutrition and Birth Outcomes' [2010] 32(1) Epidemiol Rev 5; Jonathan Day and others, 'Influence of Paternal Preconception Exposures on Their Offspring: Through Epigenetics to Phenotype' [2016] 5(1) Am J Stem Cells 11; D Savitz, P Schwingl and M Keels, 'Influence of Paternal Age, Smoking, and Alcohol Consumption on Congenital Anomalies' [1991] 44(4) Teratology 429.

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children. It is highly improbable that the law would ever consider it fair, just, and reasonable to impose such a duty given the extreme interference with individual liberty this would represent.[19] For example, such a duty might hold a man liable for taking a job as a research scientist in nuclear energy (with the risk of exposure to radiation and damage to his sperm[20]) decades before he had either contemplated fathering a child or met the woman with whom he would have a child. The improbability of such a duty of care existing in relation to pre-conception harm at the gamete stage means that the lack of paternal immunity under the CDCLA does not represent unequal treatment in any meaningful way in relation to pre-conception harm.

D. Conception Harm (Failure-to-Warn)

A more problematic way in which unequal treatment arises under the CDCLA is in relation to cases involving a duty to warn a sexual partner of risks such as sexually transmitted infections such as Human Immunodeficiency Virus (HIV) prior to them having unprotected sexual intercourse. If there were such a duty and the risk was not disclosed, any resulting child that is born HIV positive could have a potential claim against him under the CDCLA.[21]

At the time that the CDCLA came into force liability based on such a duty was unlikely on two grounds. First, it had not been considered a criminal offence for an individual to infect a sexual partner with HIV having failed to inform that partner of his HIV positive status and so it was unclear whether a duty existed to disclose HIV status to a sexual partner in the civil law of negligence. This has since changed with the criminal case of *R v Dica*.[22] Secondly, it was possible that claims by a child under the CDCLA would be excluded as wrongful life claims following the ruling in *McKay v Essex*.[23] However, both of these grounds have shifted, making paternal liability under the CDCLA more likely.

1. Is there a duty to disclose HIV status to a sexual partner?

In the criminal case of *R v Dica*,[24] Dica was convicted of two counts of inflicting grievous bodily harm contrary to Offences Against the Person Act 1861 (OAPA), section 20 after he infected his lovers with HIV. The Court of Appeal held that the transmission of an infection can amount to the infliction of harm for the purposes of OAPA, sections 18 and 20 and that consent to sexual intercourse should not be regarded as consent to the risk of consequent disease.[25] The lack of consent to the risk of contracting HIV did not vitiate the consent to the sexual intercourse so that the charge is one of rape. However, this did not preclude a conviction for inflicting serious bodily

19 Brazier (n 9) 275–76.

20 Although there are evidential issues in proving causation in such cases—see for example, *Reay v British Nuclear Fuels Plc* [1993] 10 WLUK 71.

21 Brazier (n 9) and Catherine Stanton, 'Genetic Transmission of Disease: A Legal Harm?' 24 [2016] Health Care Anal 228, 240–41.

22 [2004] EWCA Crim 1103, [2004] QB 1257.

23 [1982] 1 QB 1166, [1982] 2 All ER 771; Brazier (n 9) 276.

24 *R v Dica* (n 22).

25 ibid [59].

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harm as an assault is no longer required for this offence; it simply requires that serious harm is inflicted on the victim without her consent.[26]

The reasoning in *R v Dica*[27] falls short of making it a criminal offence to fail to disclose one's HIV status to a sexual partner as it is the transmission of the infection that founds a conviction under OAPA, section 20, not the failure to disclose the risk; a conviction is only possible if the infection has in fact been passed on following the failure to disclose the risk. However, the judgment in *R v Dica*[28] can be used to make a strong argument that a duty of care to disclose material risks to sexual partners should be recognised in the civil law of negligence.

As explained above, a duty of care in negligence can be established in a novel scenario by applying the requirements set out in *Caparo v Dickman*.[29] The requirements of foreseeability of harm and legal proximity between the claimant and the defendant are likely to be satisfied as it is known that HIV can be transmitted via unprotected sexual intercourse and there is a close connection between the claimant and defendant who have assumed some responsibility towards each other by becoming sexual partners.[30] It seems likely that such a duty would be considered fair, just, and reasonable as following *R v Dica*,[31] a breach of such duty could lead to criminal liability if the infection is passed on.

It could be argued that the current lack of civil claims indicates that a civil duty of care between sexual partners is unlikely to ever be more than hypothetical. However, there are several reasons to believe that such a duty is a real possibility. First, as I argue below, the landscape in which the law operates has shifted due to developments in societal norms, the criminal law, and medical science, meaning that the current lack of cases is not guaranteed to continue. Secondly, civil liability between sexual partners is a reality in other jurisdictions such as the USA[32] and Canada.[33] Thirdly, some law firms in the UK are already indicating in their promotional material that civil claims

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26 This reasoning has been followed in cases such as *R v Golding* [2014] EWCA Crim 889 and *R v Konzani* [2005] EWCA Crim 706. Cases such as *Assange v Sweden* [2011] EWHC 2849 (Admin), *R(F) v DPP* [2013] EWHC 945 (Admin), [2014] QB 581 and *McNally* [2013] EWCA Crim 1051 re-opened the question of whether non-disclosure could invalidate consent for the purposes of sexual offences; however, it seems likely that non-disclosure of HIV would not invalidate consent as it does not alter the nature of the act as discussed in Law Commission, *Reform of Offences Against the Person* (Law Com No 361, 2015) 157–59.

27 *R v Dica* (n 22).

28 ibid.

29 [1990] UKHL 2.

30 As argued by Stanton in relation to a duty to warn sexual partners of genetic risks, Stanton (n 21).

31 *R v Dica* (n 22).

32 Lane Powell PC, 'Liability for Transmission of HIV and Other Sexually Transmitted Diseases in Washington' (*Lexology*, 5 May 2011) <https://www.lexology.com/library/detail.aspx?g=617851df-13a5-4e31-9d81-2773c133f75e> accessed 28 March 2022; Adam Liptak, 'People Who Pass on AIDS Virus may be Sued' (*New York Times*, 4 July 2006) <https://www.nytimes.com/2006/07/04/health/people-who-pass-on-aids-virus-may-be-sued.html> accessed 28 March 2022; Neil Shouse, 'Can I Sue Someone for Giving Me Herpes?' (*Shouse Injury Law Group*, 8 July 2021) <https://www.shouselaw.com/ca/blog/personal-injury/can-i-sue-someone-for-giving-me-herpes/> accessed 28 March 2022.

33 Anna Matas, 'Liability and the Sexually Transmitted Disease' *The Lawyers Weekly* (7 February 2014) <https://lernerspersonalinjury.ca/wp-content/uploads/Liability-and-the-sexually-transmitted-disease.pdf> accessed 28 March 2022.

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against partners for transmission of HIV could be possible.[34] Fourthly, an absence of reported claims does not necessarily mean that no claims have been made; it is possible that claims have settled out of court. Therefore, a civil law duty to warn sexual partners of material risks seems a real possibility.[35]

The parameters of the duty to warn in a medical context might provide a useful model for determining what would count as a 'material risk' to be disclosed between sexual partners. The case of *Montgomery v Lanarkshire*[36] established that in a medical context a risk is material if:

> ...in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.[37]

It seems reasonable to suggest that an individual should have a duty to inform a sexual partner of risks which a reasonable person in the partner's position would attach significance to, or that the individual is or should be reasonably aware that the particular partner would be likely to attach significance to. Basing the duty on this model would take account the seriousness of an HIV infection, the likelihood of transmission, and any particular concerns of the particular partner. This would not necessarily support a blanket duty to inform a sexual partner of a HIV-positive status: for example, if the individual was taking medication and was frequently tested showing a minimal viral load and condoms were being used. However, given the potential seriousness of an HIV infection, it would support a duty of care to inform a sexual partner of HIV-positive status if the risk was more than minimal or that partner had expressed a concern regarding contracting HIV.[38]

If there were a duty of care in negligence to disclose risks of serious infections to sexual partners, liability under the CDCLA could exist even where the infection is not passed on to the sexual partner. This is because it is possible for the infection to be passed from the father to the child without the mother being infected.[39] If the defendant ('D') failed to disclose his HIV status to the victim (V) but the infection was not in fact transmitted, it is likely that D owed V a duty of care to disclose and D breached

34 Cohen Cramer Solicitors, 'Catching a Sexually Transmitted Disease' <https://www.cohencramerpi.co.uk/cica-claims/claims-for-victims-of-rape-and-sexual-assault/claim-for-sexually-transmitted-disease/> accessed 28 March 2022; Katie Allard, 'HIV – Still a Death Sentence?' (*Kingsley Napley*, 20 November 2015) <https://www.kingsleynapley.co.uk/insights/blogs/medical-negligence-and-personal-injury-blog/hiv-still-a-death-sentence> accessed 28 March 2022.

35 Margaret Brazier cites the case of *Shepherd v Davies* (1 November 1989, unreported) in support of a duty of care between sexual partners but I have not been able to find details of this case. Brazier (n 9) 276.

36 [2015] UKSC 11.

37 ibid [87].

38 For a discussion of how the varying levels of risk and definitions of sexual partners might affect a duty to disclose risks to sexual partners (pre *R v Dica*) see Rebecca Bennett, Heather Draper and Lucy Frith, 'Ignorance Is Bliss? HIV and Moral Duties and Legal Duties to Forewarn' [2000] 26(1) J Med Ethics 9.

39 S Murugan and R Anburajan, 'Father to Child Transmission of Human Immunodeficiency Virus Disease while Sero-Discordant Status of the Mother Is Maintained' [2013] 34(1) Indian J Sex Transm Dis AIDS 60.

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that duty. There would be no causation of any recoverable loss to V. Therefore, V's claim in negligence would fail. However, that would be no barrier to a subsequent child born disabled as a result of that failure to disclose bringing a claim against D under the CDCLA. Therefore, following *R v Dica*,[40] it seems likely that a duty to disclose HIV status to a sexual partner would be recognised in negligence.

2. *Would Such Claims be Prohibited as Claims for Wrongful Life?*

The second reason that at the time the CDCLA was passed it was unlikely that a child could bring a claim based on a duty to disclose risks of sexually transmitted infection such as HIV, is the potential for such a claim to be prohibited as a claim for wrongful life. Medical science at the time was such that in these circumstances the only way for that child to not have been born suffering from HIV was for her conception not to have taken place and her not to have been born at all. In the view of the Court of Appeal in *McKay v Essex AHA*,[41] such claims lie outside the scope of the CDCLA as the aim of the CDCLA is to compensate children born with disabilities which would not otherwise have been present.[42] However, following the recent case of *Toombes v Mitchell*,[43] it is no longer clear that such claims would be prohibited and even if they were prohibited, the treatment options now available mean that non-existence is no longer the only way of avoiding the harm.

3. *Toombes v Mitchell*[44]

The question of how the prohibition on claims for wrongful life impacts on claims under CDCLA, section 1(2)(a) was considered in the recent case of *Toombes v Mitchell*.[45] The claimant in this case had been born with a neural tube defect causing spinal cord tethering resulting in limited mobility and double incontinence. She alleged that her disability was caused by her mother's failure to take folic acid supplements prior to her conception as a result of her general practitioner's failure to advise her of the benefits of such supplements. It was the claimant's contention that but-for the Defendant GP's failure to advise her mother of the benefits of folic acid, her mother would have delayed attempting to conceive until she had increased her folic acid levels and therefore the claimant would not have been born. Any child that would have been subsequently conceived would have been a genetically different person to the claimant. The issue for the Court was whether such a claim for wrongful conception and birth represents a lawful cause of action under the CDCLA. The Court drew a distinction between claims involving an occurrence during pregnancy under CDCLA, section 1(2)(b) and claims under section 1(2)(a) which deals with preconception occurrences. CDCLA, section 1(2)(b) carries the rider 'so that the child is

40 *R v Dica* (n 22).
41 *McKay v Essex* (n 23).
42 See J Fortin, 'Is the "Wrongful Life" Action Really Dead?' [1987] 9 J Soc Welfare L 306.
43 [2020] EWHC 3506 (QB).
44 ibid.
45 ibid.

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born with disabilities which would not otherwise have been present' which the Explanatory Note to the draft Bill explains as follows:

> the clause gives the child no right of action for 'wrongful life' [. . .] Subsection (2)(b) is so worded as to import the assumption that, but for the occurrence giving rise to a disabled birth, the child would have been born normal and healthy (not that it would not have been born at all).[46]

However, section 1(2)(a) relating to preconception occurrences does not contain this rider and so does not prohibit claims by children who, but for the wrongful act, would never have been conceived. In relation to preconception occurrences Lambert J stated that:

> . . .all that a claimant must prove to come within the Act is a wrongful act or omission leading to an occurrence (as defined) which results in a child who is born with disabilities. Unlike in a post-conception case, there is no need for the claimant to prove that, but for the wrongful act, he or she would still have been born. It is sufficient that the claimant was, in fact, born with a disability resulting from the occurrence.[47]

On this basis Lambert J held that sexual intercourse without the protective benefit of folic acid supplementation was a relevant occurrence for the purpose of section 1(2)(a) and therefore, a claim such as this, based on the assertion that the conception itself had harmed the claimant, was valid.[48] This is supported by the Law Commission's opinion that a child's claim based on her father's failure to inform her mother that he was infected with a sexually transmissible disease prior to sexual intercourse would *not* amount to a claim for wrongful life. In the Law Commission's opinion:

> Where the disabilities with which a child is born are actually caused by the sexual intercourse which results in his conception we do not think that any action he may have for such disabilities is properly called a 'wrongful life' action. It is not for being born that he seeks a remedy but for compensation for the disability resulting from the sexual intercourse. If that sexual intercourse and consequent disability can be shown to have resulted from the fault of another, then we do not think that the child should be without a remedy.[49]

Therefore, claims based on the mother's assertion that had she been informed of the father's HIV status she would not have had unprotected sexual intercourse with him, would appear not to be prohibited as claims for wrongful life.

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46 CDCLA (n 7) [6].
47 *Toombes v Mitchell* (n 43) [53].
48 ibid [46]–[48].
49 CDCLA (n 7) [88].

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A different view was taken by Lord Justice Henderson in the Court of Appeal in *Criminal Injuries Compensation Authority v First-tier Tribunal and Y (CICA v F-tT and Y)*[50] for the purposes of a claim under the Criminal Injuries Compensation Scheme. Henderson LJ was of the opinion that for an injury to have taken place the individual must have previously existed (albeit as an embryo or foetus) in an uninjured state. In his opinion, a claim in relation to conception harm was a claim for wrongful existence and as such was not one for which compensation could be assessed as held in *McKay v Essex*.[51]

If claims based on the mother's assertion that had she been informed of the father's HIV status she would not have had unprotected sexual intercourse with him at all were not barred as claims for wrongful life; it is also possible that claims based on the mother's assertion that had she been informed of the father's HIV status she would have not had unprotected sexual intercourse with him *at that time*, but would have on another occasion to which the same risk would attach, could also succeed. Causation could be established on a similar basis to that in *Chester v Afshar*.[52] The risk of the resulting child being infected would be unaffected by the failure to warn (as in *Chester*) and that risk would be less than 50% at any time.[53] Therefore, but-for the failure to warn, on the balance of probabilities the harm would not have occurred and the principle in *Chester* could be applied to establish legal causation.[54] Factual causation does not fail because the claimant *could* still have suffered the same harm on another occasion, but only if the claimant *would* have suffered the harm, on the balance of possibilities.[55] However, subsequent cases have confined the principle in *Chester* to its particular circumstances,[56] and so it is not clear if the argument in *Chester* could be relied upon to establish causation beyond a failure to warn of a risk of treatment scenario.

Lambert J justified limiting the classification of prohibited wrongful life claims to those involving post-conception occurrences and not pre-conception occurrences on

50 [2017] EWCA Civ 139.

51 ibid [31].

52 [2004] UKHL 41.

53 Prior to interventions, the risk in Europe of vertical transmission (parent to child) of HIV was approximately 20% and with interventions this is reduced to about 1%. L Sherr and N Barry (2004) 'Fatherhood and HIV-Positive Heterosexual Men' 5 [2004] HIV Med 258, 260.

54 As explained by the Court of Appeal in *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA Civ 1307 [56–58], factual causation had been established in *Chester* on a traditional 'but-for' basis. The claimant faced a 2% chance of the harm occurring on the day she had the procedure. If she had the procedure on another day she would have faced the same 2% risk. Therefore, if she had been warned of the risk and so had the procedure on another day, the chance that she would have still suffered the harm is only 2%. This means that on the balance of probabilities, but-for the failure-to-warn, her harm would not have occurred. Thus, factual causation was established. The question in *Chester* was one of legal causation, ie whether the fact that if warned of the risk the claimant would still have had the procedure but on a different day, made the loss too remote to be recoverable at law. In *Chester*, it was held that in order to uphold the claimant's right to autonomy and dignity, legal causation was established. *Chester* (n 52) [24], Lord Steyn.

55 T Clark and D Nolan, 'A Critique of *Chester v Afshar*' 34(4) [2014] Oxf J Leg Stud 664.

56 *Duce* (n 54); *Beary v Pall Mall Investments* [2005] PNLR 35; *Meiklejohn v St George's Healthcare NHS Trust* [2014] EWCA Civ 120; *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356; *Shaw v Kovac* [2017] 1 WLR 4773.

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the basis that post-conception occurrences engage social and moral policy issues in a unique way:

> A negligent failure to prevent the birth of an already conceived child engages a range of social and moral policy issues, not least the imposition upon the medical profession of a duty to advise abortion in possibly dubious circumstances. However, claims based upon a wrongful act before conception which leads to the intercourse and conception raise no such difficulties.[57]

Thus, a distinction is drawn between claims in which the child says it would have been better if her mother had aborted her pregnancy, and claims in which the child says that it would have been better if her mother had not conceived her. Given that in both of these scenarios the alternative for the child is non-existence and the mother could bring a claim for wrongful birth in either scenario, it is not clear why this distinction should be relevant from the child's perspective.

The interpretation of CDCLA, section 1(2)(a) in this case appears to be reflecting the role of the CDCLA in protecting the reproductive health of the parent. What was central to the decision in *Toombes*[58] was the fact that but-for the defendant's negligence, the claimant's mother could have had *a* healthy child; it did not matter whether the claimant could have been a healthy child. However, as we will see, it is not clear whether it is sufficient that the mother could have had a healthy child with another partner or whether it is necessary that that couple could have conceived a healthy child together.

Lambert J illustrates this point with the example of a couple who conceive a child following negligent advice regarding their genetic status and that child is born suffering from an inherited genetic condition. It is Lambert J's assertion that such a child would have no claim under the CDCLA as there would be '. . .no circumstances affecting the intercourse in which a healthy child could have been conceived and no causal connection between the occurrence and the disability.'[59] This differs from the scenario in *Toombes*, as in that case the claimant's mother would have been more likely to conceive a healthy child with the same partner at a later date after having increased her folic acid levels, whereas the couple in Lambert J's example could not improve their chances of conceiving a healthy child together at any time even if they had been accurately informed of their genetic status, and it is this that it is alleged would bar the child's claim. However, in the case of sexually transmitted infections such as HIV, if the mother states that had she been informed of the risk of HIV infection she would not have had unprotected intercourse with the father there are no circumstances in which a healthy child could have been conceived between that couple (as is the case for the couple in Lambert J's example).[60] The mother could have conceived a

57 *Toombes v Mitchell* n 43 [52].

58 ibid.

59 ibid [55].

60 Unless the mother states that she would not have had unprotected intercourse with the father but they would have attempted to conceive with the assistance of fertility treatment including sperm washing, which can reduce the chances of transmission of HIV infection. V Savasi and others, 'Safety of Sperm Washing and ART Outcome in 741 HIV-1-Serodiscordant Couples' [2007] 22(3) Hum Reprod 772.

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healthy child but would not have done so with that partner. It is not clear from the discussion in *Toombes*[61] whether that is sufficient for a claim under CDCLA, section 1(2)(a) or whether it is necessary that the couple could have conceived a healthy child together at another time.

Lambert J's example could be distinct from a case involving a sexually transmitted infection such as HIV if that example was limited to the scenario in which any child of either parent would inherit the genetic condition as opposed to only children that they conceived together. If the couple receiving genetic counselling were both wrongly informed that they did not carry a gene for an inheritable condition when in fact any child that either parent conceived would inherit that condition, then the negligent advice has not affected the parent's ability to have a healthy child and so would not satisfy CDCLA, section 1(2)(a). However, in the case of a father's failure to warn of his HIV status, the mother could have had a healthy child with another partner and so her ability to have a healthy child has been affected by the father's breach of his duty to warn. In this case, what matters for pre-conception occurrences is whether but-for the breach of duty the mother could have had a healthy child even if this would have been with another partner.

It appears that the interpretation of CDCLA, section 1(2)(a) and its interaction with the bar on claims for wrongful life is not yet fully resolved but it is clear that the CDCLA was intended to cover claims by children born disabled after having been conceived in circumstances where the father does not disclose that he has a sexually transmitted infection to his sexual partner.[62] In relation to HIV, such a claim may no longer need to be on the basis that the claimant should not have been conceived but could instead be brought on the basis of a missed opportunity for treatment.

4. Missed Opportunity for Treatment

Due to developments in medical science, treatment options to prevent the infection passing to the future child are now available if the HIV-positive status of the father is known.[63] Therefore, a child's claim based on her father's failure to inform her mother of his HIV-positive status prior to sexual intercourse would no longer need to be a claim for wrongful conception and birth. Instead, it could be for the claimant's disability which could have been avoided but-for the father's breach of his duty to inform his sexual partner that he was infected with a sexually transmissible disease. This would also remove the need for the claimant to show that her mother would not have consented to sexual intercourse had she been informed of the risk.

The child's claim could be based on the assertion that if the father had informed the mother of his HIV status, his mother would have still consented to having unprotected sexual intercourse with him but she would have then sought treatment to prevent the infection from passing to the future child. Treatments such as antiretroviral therapy (ART), appropriate management of delivery, and avoidance of breastfeeding

61 *Toombes v Mitchell* (n 43).

62 Law Commission, Explanatory Notes to the Draft Bill (n 7), 47 para 5.

63 Claire L Townsend and others, 'Low Rates of Mother-To-Child Transmission of HIV Following Effective Pregnancy Interventions in the United Kingdom and Ireland, 2000–2006' [2008] 22 AIDS 973.

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have been shown to reduce transmission rates from mother to child to 1–2%.[64] Some studies indicate even lower transmission rates from women on ART for at least the last 14 days of pregnancy, with each additional week of treatment corresponding to a 10% reduction in the risk of transmission.[65] This means that if the mother had been warned of the father's HIV status, and she would have sought treatment, it is more likely than not that the child's harm would have been prevented. Therefore, it seems likely that a child would have a valid claim under the CDCLA on the basis of a failure by the father to warn the mother of the risk of a sexually transmitted infection such as HIV, if three things were established: (i) that the mother would still have consented to the sexual intercourse; (ii) she would have then sought treatment to prevent the infection passing to the child; and (iii) that treatment would have had a greater than 50% chance of preventing the infection passing to the child.[66]

It could be argued that a child's claim under the CDCLA against her father based on his failure to warn his sexual partner of his HIV status would fail on the basis that the mother was aware that having unprotected sexual intercourse carries a risk of HIV infection for her and any resulting future child and she chose to accept that risk.[67] However, this argument is unlikely to succeed as even if the mother was aware of a general risk, without being informed of her partner's HIV status she cannot be said to have been aware of the actual risk she was taking.[68]

Given the likelihood of a duty of care to warn sexual partners of significant infection risks following the case of *R v Dica*[69] and the availability of highly effective treatments to prevent vertical transmission of HIV and the possibility that treatment might not be sought without knowledge of the HIV status of the parents, paternal liability for conception harm is a real possibility. However, maternal liability for conception harm is excluded under CDCLA, section 1(1). Therefore, paternal and maternal liability is unequal under the CDCLA.

III. IS THE UNEQUAL TREATMENT OF MOTHERS AND FATHERS JUSTIFIED?

Maternal liability under the CDCLA was originally excluded due to fears that the mother would not have the funds to meet any award without causing hardship to the rest of the family, the parental bond between mother and disabled child would be

64 European Collaborative Study, 'HIV-Infected Pregnant Women and Vertical Transmission in Europe since 1986' [2001] 15 AIDS 761; European Collaborative Study, 'Mother-to-Child Transmission of HIV Infection in the Era of Highly Active Antiretroviral Therapy' [2005] 40 Clin Infect Dis 458; ER Cooper and others, 'Combination Antiretroviral Strategies for the Treatment of Pregnant HIV-1-Infected Women and Prevention of Perinatal HIV-1 Transmission' [2002] 29 J Acquir Immune Defic Syndr 484; Centers for Disease Control and Prevention, 'Achievements in Public Health. Reduction in Perinatal Transmission of HIV Infection–United States, 1985–2005' [2006] 55 MMWR Morb Mortal Wkly Rep 592.

65 Townsend and others (n 63).

66 It is possible that a claim could be successful even if there was a less than 50% chance of the treatment preventing the infection passing to the child following the departure from usual causation principles in *Chester v Afshar* (n 52), although this would have to take into account subsequent case law such as *Duce v Worcestershire Acute Hospitals NHS Trust* (n 54), which has sought to limit the scope of this departure.

67 CDCLA, s 1(4).

68 *R v Dica* (n 22) [59].

69 ibid.

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disturbed, and a legal action, or the threat of one, could be used as a weapon by fathers against mothers in custody disputes.[70] At that time the Law Commission did not believe that these dangers warranted an exclusion of paternal liability.[71] As Collier and Sheldon have argued, it was the mother's familial role that was thought to require protection as it was assumed that mothers would be the primary carers for their children and fathers the breadwinners.[72] Since then, there has been a significant shift towards a more gender-neutral model of parenting adopted in law and policy, moving away from the father as breadwinner model and acknowledging fatherhood as including a role of care.[73] There has also been a shift in the experience of fatherhood since the 1970s. The time that British fathers spend in primary care has increased by 15–20 min each decade since the 1970s and paternal care in 2015 was equal to the amount of maternal care in the 1960s.[74] However, the gap between the time investment of mothers and fathers in caring for children has increased.[75] While childcare remains highly gendered, with the majority of the responsibility still falling to women,[76] a shift has taken place in the decades since the CDCLA came into force, at least in the perception of what the roles of mothers and fathers should be. According to the British Social Attitudes survey, in 1987, 48% of people supported a gendered separation of roles, with the woman as the primary carer and the father as the breadwinner, but this has declined to just 13% in 2012.[77] However, this has not translated into a more equal distribution of familial roles between mothers and fathers in practice, and one possible explanation for this is a 'structural lag' whereby societal institutions such as parental leave, childcare, and employment, have not yet caught up with the changes in women's roles, significantly in paid employment.[78] Instead of lagging behind these societal changes, there is an opportunity here for the CDCLA to contribute to the reconceptualising of reproduction and childrearing as a shared enterprise. Somewhat paradoxically, by extending the exclusion of liability under the CDCLA to fathers, the law could support the move towards fathers bearing more of the responsibility in reproduction and childrearing; instead of reinforcing the view that reproduction and childrearing is and should be 'women's business', the law would be acknowledging the importance of the father–child bond and the acceptance of male single-parent families. Therefore, it appears that the Law Commission's reasons for excluding maternal liability could now also be seen as justifying an exclusion of paternal liability in order to support the move towards a more gender-neutral model of parenting.

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70 Law Commission (n 7) [54]–[64].

71 ibid [92].

72 R Collier and S Sheldon, *Fragmenting Fatherhood: A Socio-Legal Study* (Bloomsbury Publishing 2008) 56.

73 ibid 101–37.

74 E Altintas (2016) 'Are British Parents Investing Less Time in Their Children? Centre for Social Investigation Briefing Note 27' (Oxford Nuffield College) <http://csi.nuff.ox.ac.uk/wp-content/uploads/2016/09/CSI-27-Are-British-Parents-investing-less-time.pdf> accessed 19 November 2021.

75 ibid.

76 In 2012, men reported spending an average of 10 h a week looking after family members, while women reported spending an average of 23 h a week. A Park and others (eds) 'British Social Attitudes: The 30th Report' (London, NatCen Social Research 2013) 126 <https://www.bsa.natcen.ac.uk/media/38457/bsa30_gender_roles_final.pdf> accessed 19 November 2021.

77 ibid 119.

78 ibid 134.

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An underlying reason for the Act's exemption of maternal but not paternal liability is the concern that maternal liability has the potential to conflict with abortion law[79]; how can a woman be liable for causing harm to her foetus but not for destroying it? As Brazier points out, this is a perceived rather than an actual conflict as it is possible that a woman could owe a duty of care to a future child that she intends to bring to birth, but be permitted to abort a foetus she does not intend to bring to birth.[80] The subject of her duty of care is the child that will exist in the future rather than the foetus that currently exists. No such conflict would be perceived in relation to paternal liability as a man has no power to request an abortion. However, the desire to avoid a perceived rather than real conflict does not seem to justify the unequal treatment of mothers and fathers under the CDCLA.

Paternal immunity was considered by the Law Commission but ultimately rejected for several reasons. First, a father's conduct was not thought to be able to affect the future child to the same extent as the mother's and so paternal liability would not lead to the same extreme surveillance of men's lives as it would women's.[81] While this is likely to be true in terms of gestational events, there is growing scientific evidence that a man's behaviour can lead to pre-gestational harm to a future child in the same way as a woman's. Everything from how much he smokes and how much alcohol he consumes, to how much stress he experiences and what he eats, can all have an impact on the health of his future child.[82] Similarly, although a pregnant woman has a unique physical connection to the future child, a father's behaviour during the pregnancy can still have a significant impact on the health of that future child, for example, smoking in the home, domestic violence, or creating a stressful environment for the pregnant woman.[83] Therefore, paternal liability, particularly in relation to pre-gestational harm, could lead to extreme surveillance of men's lives. However, it is notable that, despite the Law Commission's efforts to protect women from extreme surveillance, women's behaviour is subject to increasing surveillance in the name of protecting future children, in a way that men's behaviour is not.[84] Evidence that a man's conduct can affect the health of his future child has been substantial for decades and as yet the surveillance of pre-gestational conduct remains focused on women as the potential cause of prenatal harm. The view that women rather than men are almost exclusively the cause of prenatal harm to men is not simply a matter of biology but instead relies heavily on ideas of gender.[85] This is clearly evident in the parliamentary debates leading to the

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79 Brazier (n 9) 269.

80 ibid 270.

81 Law Commission (n 7) [92].

82 Jonathan Day and others (n 18); Savitz, Schwingl and Keels (n 18).

83 For example, BM Donovan and others, 'Intimate Partner Violence during Pregnancy and the Risk for Adverse Infant Outcomes: A Systematic Review and Meta-Analysis' [2016] 123 BJOG 1289; Lijuan Zhao and others, 'Parental Smoking and the Risk of Congenital Heart Defects in Offspring: An Updated Meta-Analysis of Observational Studies' [2020] 27 Eur J Prev Cardiol 1284.

84 For example, the recent policies to screen all pregnant women for carbon monoxide and alcohol consumption. Bowden (n 2); Ellie Lee and others, 'Beyond "the Choice to Drink" in a UK Guideline on FASD: The Precautionary Principle, Pregnancy Surveillance, and the Managed Woman' [2021] 24 Health, Risk & Society 17.

85 Sally Sheldon, 'Reconceiving Masculinity: Imagining Men's Reproductive Bodies in Law' [1999] 2 J Law Soc 129, 132.

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CDCLA in which the dangers posed by male bodies were conceptualised as occupational, and those posed by female bodies were associated with individual 'choices' such as drugs and alcohol.[86] Cynthia Daniels connects this to four ideals of reproductive masculinity: the assumption that men are secondary in biological reproduction, the assumption that the male reproductive system is less vulnerable than the female reproductive system to the harms of the outside world, the assumption of male virility, and the presumption that men are more distant (than women) to the children they father.[87] As Daniels argues, these ideals are not only harmful to women because they are more likely to be blamed for prenatal harm than men, but they are also harmful for men because little attention is paid to developing safe workplace regulations to protect men's reproductive health.[88] Rather than reinforcing this harmful ideal of masculinity and relying on it to protect men from surveillance, the CDCLA could acknowledge the potential for men's behaviour to impact on future children and so avoid contributing to the conflict view of pregnancy by posing pregnant women as a unique threat to future children.

The Law Commission argued that because the potential allegations of paternal harm were more limited than those of maternal harm it was far less likely that legal action under the CDCLA would be used as a weapon in matrimonial disputes against fathers than against mothers.[89] Given our enhanced understanding of the impact of paternal behaviour on the health of future children and the desire to move towards a more gender-neutral model of parenting discussed above, it seems that if the potential use in custody disputes is sufficient to justify the exclusion of maternal liability it could also justify an exclusion of paternal liability.

Another reason given by the Law Commission for not extending the exclusion of liability to fathers was that the father of the child might not be the husband of the mother and so any legislation excluding fathers from liability could lead to 'very bizarre litigation'.[90] Any problems defining who counts as the child's father could be overcome by limiting father to genetic father in relation to pre-conception harm and those individuals (regardless of gender) who go on to have parental responsibility for gestational harm. Applying an exclusion on the basis of these definitions would avoid the scrutiny of men's lives linked to harmful lifestyle factors and avoid the harm to the parental bond in relation to those who go on to have parental responsibility for the child. In any event, this is a problem the law deals with in many circumstances and is no more problematic for fathers than mothers given the potential for surrogacy arrangements, gamete donors, trans parents, and other non-traditional definitions of parent. Therefore, any difficulties in defining father do not justify the unequal treatment of mothers and fathers under the CDCLA.

86 ibid 141–42.

87 Cynthia Daniels, *Exposing Men: The Science and Politics of Male Reproduction* (Oxford University Press 2008); See also Sheldon (n 85).

88 Daniels (n 86) ch 5.

89 Law Commission (n 7) [92].

90 ibid. It is assumed that what the Law Commission was referring to was the possibility that a child may not be able to bring a claim against her biological father with whom she may not have a loving bond but she could bring a claim against her social father with whom she does.

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In the Law Commission's opinion, the conclusive justification for not extending the exemption to fathers was the desire to permit a child born disabled as a result of an assault by her father on her mother to bring a claim against her father in respect of those disabilities:

> We are also of the opinion that [. . .] a child born disabled as a result of an assault by a man on the mother should have a cause of action against that man, even though it was the assault itself which caused the conception.[91]

Although this would include assaults at the pregnancy stage (see below), the Law Commission's main concern appears to have been the scenario, whereby a child is born disabled having been conceived in circumstances in which her father did not disclose to his sexual partner that he was suffering from a sexually transmissible disease. It is clear from the Law Commission's consideration of the example of a man who does not inform his sexual partner that he is infected with syphilis that this is what is meant by the Law Commission's reference to 'an assault which causes the conception'.[92] Although this would no longer be termed an assault,[93] it could still constitute a civil wrong in the form of a breach of a duty to warn as explained above.

If a man is under a duty of care to warn his sexual partner of the risk of transmission of an infection such as HIV and he breaches this duty, it seems entirely in keeping with the purpose of the CDCLA for him to be liable to any subsequent child born disabled whose disabilities would have been avoided if the father had fulfilled his duty of care to the mother. After all, this is merely extending his liability to the affected parent to include liability to the child born disabled as a result of his breach.[94] However, if this is the case, it is not clear why it would be inappropriate for mothers to face similar liability under the CDCLA for a failure to warn their sexual partners of their disease status. The possibility of a woman committing a civil wrong against her sexual partner by not informing him that she is infected with a sexually transmissible disease was not considered by the Law Commission. A woman (presumably) owes the same duty to inform her sexual partner of her HIV positive status. If she breaches that duty and a child is born with HIV, the father could argue that had he been informed of her status, even if he would still have had unprotected sexual intercourse with her, he would have made medical staff aware and sought treatment for the child at least immediately following birth (treatment during pregnancy may not have been something he could have arranged on the balance of probabilities as the woman would have been unlikely to consent given that she did not seek treatment herself).[95] Alternatively, if, as suggested by the judgment in *Toombes*,[96] a claim can be brought under CDCLA,

91 Law Commission (n 7) [92].

92 ibid [88], [92], [93].

93 *R v Dica* (n 22) [47].

94 Brazier (n 9).

95 Treatment of the child after birth can be highly effective in reducing signs of the virus resulting in less damage to the immune system. Pilar Garcia-Broncano and others, 'Early Antiretroviral Therapy in Neonates with HIV-1 Infection Restricts Viral Reservoir Size and Induces a Distinct Innate Immune Profile' [2019] 11(520) Sci Transl Med eaax7350.

96 Matas (n 33).

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section 1(2)(a) on the basis that the affected parent would have had a child with another partner if he had been informed of her status, the child could argue that the father would not have consented to sexual intercourse and so she would not have been conceived. If this is the case, exempting mothers from liability arising out of a failure to warn her sexual partner of the risk of transmission of a sexually transmitted infection but retaining such liability for fathers does not appear to be justified. Either it is appropriate for a parent to be liable to a child born disabled as a result of that failure to warn, or it is not.

A. Gestational Harm

Although, as explained above, a woman can commit an equivalent wrong in relation to pre-gestational harm, there is no equivalent maternal conduct during pregnancy to the man that commits a battery against a pregnant woman; any intentional violence by the pregnant woman that caused harm to the future child would be directed at her own body. This might appear to justify the unequal liability of mothers and fathers. However, this is one specific type of conduct and does not necessarily justify retaining liability for all forms of paternal conduct. Further, retaining paternal liability for gestational harm might not be necessary as other forms of redress might be available to a child whose congenital disabilities are caused by violence against the mother during pregnancy. In particular, in these circumstances, it may be possible for a child to be compensated by the Criminal Injuries Compensation Authority.

B. Is CICA Compensation Available in Relation to Harm In Utero?

The Criminal Injuries Compensation Scheme (the Scheme) provides compensation to those who have sustained a criminal injury which is directly attributable to their being a direct victim of a crime of violence.[97] Although a foetus lacks legal personhood, it does have some protection under the criminal law[98] and so a child who suffered harm at the foetal stage may be able to be considered a victim of a crime of violence. Indeed, under the earlier versions of the Scheme children born with Foetal Alcohol Spectrum Disorder were compensated as victims of their mothers' drinking during pregnancy.[99] In addition, Annex B to the 2012 Scheme states that:

> 4. (1) A crime of violence will not be considered to have been committed for the purposes of this Scheme if, in particular, an injury:
> [. . .]
> (e) was sustained in utero as a result of harmful substances willingly ingested by the mother during pregnancy, with intent to cause, or being reckless as to, injury to the foetus.[100]

97 Criminal Injuries Compensation Scheme 2012, para 4.

98 For example, under OAPA, ss 58 and 59; Infant Life Preservation Act 1929, s 1.

99 *CP (A Child) v First-tier Tribunal (Criminal Injuries Compensation)* (CA) [2014] EWCA Civ 1554 [3] (Treacy LJ).

100 Criminal Injuries Compensation Scheme 2012, Annex B <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/808343/criminal-injuries-compensation-scheme-2012.pdf> accessed 5 August 2021.

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Significantly, this implies that other forms of harm sustained in utero such as from an attack on the pregnant woman can be compensated.[101]

The Court of Appeal considered the possibility of a child being compensated for a crime against her mother that occurred prior to her birth in the case of *CICA v F-tT and Y*.[102] In this case, Y had been born suffering from a serious genetic disorder after being conceived by incestuous rape. Initially, the claim for compensation was refused and this refusal was upheld by the First-tier tribunal on the grounds that Y was not a victim of a crime of violence and he had never had an uninjured state as it was the crime that had led to his conception. An application for judicial review was heard by the Upper Tribunal which granted compensation, finding that Y had suffered injuries which were directly attributable to a crime of violence within the meaning of paragraph 8 of the 2008 scheme which was applicable at the time.[103] CICA appealed the decision of the Upper Tribunal to the Court of Appeal which upheld the appeal, refusing Y compensation because Y had not been conceived at the time of the crime as it was the crime itself that led to Y's conception and so he could not be considered a victim of a crime of violence and there was no 'uninjured state' with which to compare the child's current state for the purposes of assessing compensation.[104] In the case of an attack on the pregnant woman, this problem would not arise as the child would have been conceived prior to the attack and so there is an 'uninjured state' with which to compare the child's current state. Therefore, it seems likely that a child born disabled as a result of her father committing a battery against her mother during pregnancy could be compensated under the Scheme.

An award under the Scheme is likely to be less than the damages available in a civil claim with claims under the Scheme capped at £500,000 and the vast majority of claims being substantially less than that.[105] However, the levels of compensation could be increased if the level of redress available to the child was the concern rather than the source of that redress.

Because of this potential for redress under the Scheme and the option to limit paternal liability under the CDCLA to intentional torts against the mother during pregnancy, the desire to provide redress to the child born disabled as a result of her father committing a battery against her mother during pregnancy does not justify retaining all paternal liability under the CDCLA while mothers are exempt except in relation to negligent driving.

101 There does not appear to be any data available as to whether any awards have been made on this basis; however, there is some anecdotal evidence that it has not. For example, Nick McCarthy, 'Stabbed Mum's Unborn Baby Is Refused Criminal Injuries Compensation' *Birmingham Mail* (24 November 2016) <https://www.birminghammail.co.uk/news/midlands-news/stabbed-mums-unborn-baby-refused-12225378> accessed 5 August 2021.

102 *CICA v F-tT and Y* (n 50).

103 *Y v First-tier Tribunal and Criminal Injuries Compensation Authority* [2016] UKUT 0202 (AAC) 2, JR/2930/2014.

104 *CICA v F-tT and Y* (n 50) [26].

105 Criminal Injuries Compensation Scheme [31]; Criminal Injuries Compensation Calculator <https://criminal-injuries-compensation.co.uk/how-much-compensation-will-i-receive/> accessed 5 August 2021.

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IV. CONCLUSION

Liability of either parent under the CDCLA might be unlikely due to the dependence on a duty of care owed to the affected parent but such liability is possible particularly in relation to failure to disclose risks to sexual partners. Mothers are protected from such liability by virtue of the exemption in section 1(1) CDCLA but fathers are not. This inequality in treatment is not justified by the outdated view of how parental roles should be split between the genders, the danger of liability under the CDCLA being used in matrimonial disputes, the practical difficulties in defining fathers, nor the desire for redress for a child born disabled as a result of an attack by her father on her mother during pregnancy.

While there is a case for permitting a child to claim against its father for intentional harm such as an attack on the mother during pregnancy, this could be argued to be unnecessary as the child could instead be compensated by CICA for this harm. Given that a child harmed in this way would not be without redress, retaining paternal (but not maternal) liability to cover such scenarios does not justify the resulting unequal liability for pre-gestational harm such as the failure to warn of risks between sexual partners. At most, it would justify making an exception to a paternal exemption to cover intentional torts against the pregnant woman.

The solution largely depends on whether it is desirable for a child born disabled as a result of her parent's failure to warn their sexual partner of their HIV status to be able to bring a claim against that parent under the CDCLA. If it is desirable, this liability should apply equally to mothers and fathers. If it is not, there is a strong case for extending the maternal exemption to fathers as well. Changes in society since the CDCLA came into force mean that the problems associated with a child bringing a claim against her parent identified by the Law Commission in relation to maternal liability, such as taking funds away from those caring for the child, disturbing the parental bond, and the potential for use in matrimonial disputes, now apply equally to paternal liability. Therefore, it is likely that such liability would do more harm than good. This is not to say that the individual who does not disclose their HIV status to a sexual partner should not face any form of liability, only that liability to the child is not appropriate. Either parent could still face criminal and civil liability to each other in respect of their non-disclosure.

An alternative solution would be to remove the maternal exemption; however, the significant symbolic value of the exemption of maternal liability in reinforcing the principle that there is no legal obligation for women to prioritise the welfare of their future children would then be lost.[106] It is possible that extending the exemption to include fathers would have a similar value to men. While there are historical and current social reasons for making a clear statement that women are not to be considered primarily as vessels for future children, this does not require the law to place men under an obligation to prioritise the welfare of their future children in a way that women are not. Indeed, the case against maternal liability would be strengthened by an equal statement applying to men as this would remove any objection to the maternal exemption based on unjustified unequal treatment. Therefore, it would appear that the most appropriate solution is for the exemption to be extended to fathers with an exception for intentional torts committed against the mother during pregnancy.

106 Brazier (n 9) 266.

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