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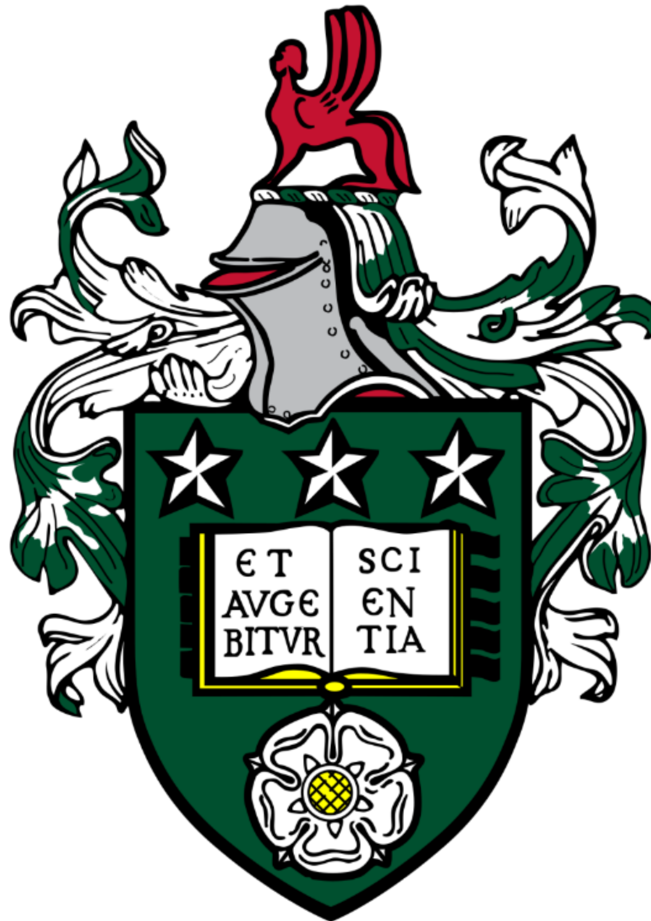
ENFORCED CAESAREANS: FOETAL RIGHTS AND LEGAL WRONGS – DOES THE REALITY MATCH THE RHETORIC?



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ABSTRACT

In 1997, the law surrounding competency and treatment refusal was clarified for pregnant women. It was held that a competent pregnant woman, is completely at liberty to refuse a caesarean section, even if this would risk her own life and that of her unborn child. This dissertation aims to ascertain whether the reality does match the rhetoric for women, who autonomously refuse a caesarean. This will be achieved through assessing the principle of autonomy pertaining to pregnant women and enforced caesareans, the exploration of the legal and moral status of the foetus and finally through the investigation of the conflict between respecting maternal autonomy over foetal interests. It will be argued that, despite the overwhelming regard for autonomy in society, it persists that the protection of foetal life still poses as a lacuna for female autonomy. Subsequently, it will be argued that this deprivation of maternal autonomy is unjustified, as there is no logical basis to afford the foetus a moral or legal status before birth. And so, it will be concluded that it is necessary for maternal autonomy to supersede the foetus' right to life as there is a pre-exiting willingness to override maternal autonomy and ere on the side of foetal life. Finally, the lack of clear authoritative precedent suggests that until a woman has successfully refused a caesarean, there will still be an overwhelming sense that the reality does not match the rhetoric for pregnant women who refuse medical intervention.

INTRODUCTION

The regulation of healthcare has always been an area of great legal contention. There are no more controversial decisions than those that concern life and death. Autonomy is a principle that is afforded great legal and moral respect in almost every democratic society. Therefore, restrictions placed upon this principle, are limited to very specific circumstances. In *Re MB (An Adult: Medical Treatment)* [1], it was clarified that competent pregnant women are completely at liberty to refuse a caesarean, that would save the life of their unborn child. This position was affirmed in the case of *St George's Healthcare NHS Trust v S*[2], where the Supreme Court held that the forced caesarean was unlawful, as the woman possessed the requisite competency to refuse the intervention. Albeit, this seemingly proposes that maternal autonomy will supersede that of the foetus, given societal regard for foetal life, it is suggested that women's autonomous choices will be still be overridden. That being so, it is ~~subsequently~~ important to explore whether the protection of foetal life still poses as a lacuna for female autonomy. This dissertation seeks to argue that it is imperative for the pregnant woman's autonomy to supersede the foetus' right to life. And following, the lack of clear authoritative precedent illustrating where a woman has successfully refused a caesarean, it is contended that, given the societal regard for foetal life and the discretion afforded to the courts and medical professionals, that the reality does not match the rhetoric. Accordingly, it will be concluded that there should be further safe guarding measures implemented to ensure that pregnant women are not subjected to this inequitable treatment. As to do otherwise would contravene the self-determination principles that govern every other aspect of life, in a liberal democratic society.

In order to answer this research question, a plethora of legal principles, academic literature and research will be analysed. Chapter one will consider whether pregnancy inherently undermines a woman's autonomy, and this will

[1] *Re MB (Medical Treatment*) [1997] 2 FCR 541.
[2] *St George's Healthcare NHS Trust v S Regina v Collins and Others, Ex Parte S* [1999] Fam 26.

be in relation to the legal principles surrounding autonomy and enforced caesarean case law. Secondly, the legal and moral status of the foetus will be analysed to determine whether the legal status of the foetus is morally justified and more importantly, whether this status would justify the restriction on maternal autonomy in enforced caesarean cases. Finally, after establishing that the correct position, is to afford the foetus a right to life at birth, it is necessary to explore the balancing act performed between respecting maternal autonomy and protecting foetal interests. This pertains to whether the theoretical preference of maternal autonomy is necessary and subsequently, what measures would need to be implemented in practice to facilitate this end.

CHAPTER ONE: AUTONOMY AND PREGNANT WOMEN

INTRODUCTION

In order to assess the question posed by this paper, it is firstly necessary to understand whether pregnancy inherently undermines a pregnant woman's autonomy. This is important, as autonomy is a well-respected principle within society and so to suggest that pregnancy itself may undermine the respect afforded to this principle is contentious. Therefore, this chapter will look at what autonomy is, the general legal principles surrounding autonomy and finally it will assess enforced caesareans case law with regards to these aforementioned principles. It will be argued that pregnancy does inherently undermine a woman's autonomy.

A) THEORETICAL UNDERSTANDINGS OF AUTONOMY

Firstly, it is important to understand the differing interpretations of autonomy and the value afforded to this principle. Autonomy is characterised as the right of an individual to "self-government".[3] Beauchamp and Childress define autonomy as the "personal rule of the self that is free from both controlling interference by others and from personal limitations that prevent meaningful choice… The autonomous individual freely acts in accordance with a self-chosen plan".[4] Additionally, John Harris posits that "it is autonomy that enables an individual to 'make her life her own'".[5] Therefore, it is clear that autonomy relates to an individual right to choose their own course of action.

The principle of respect for autonomy has deep philosophical roots and to provide context for this chapter these will be outlined. Kant argues that the

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[3] 'Autonomy, n.' (*OED Third Edition Online*, OUP 2011) <https://www.oed.com/view/Entry/13500?redirectedFrom=Autonomy#eid > accessed 15 April 2020.
[4] Tom Beauchamp, James Childress, Principles of Biomedical Ethics (Fourth Edition, Oxford University Press, 1994) 121.
[5] John Harris, 'Consent and End of Life Decisions' (2003) 29(1) *Journal of Medical Ethics* 10.

idea of an autonomous will, derives from a notion of the "idea of a will that is free 'in a negative sense'".[6] And so, for Kant to be autonomous was in reference to rationality, which was in the sense of embracing principles that followed varied conceptual tests, such as universality.[7] Mill, as a utilitarian, advocated for a different conception of autonomy. He developed the 'harm principle', which suggested that an individual's autonomous will should only be interfered or limited if that is necessary to prevent harm to others.[8] Subsequently, Mill's perception of autonomy is important as it highlights that, there has always been an appreciation that an individual's right to autonomy is contingent upon the consequences of their autonomous will. Nevertheless, it is still crucial to acknowledge the overwhelming respect for autonomy in society. Gillon justifies this substantial regard by providing an example of eating healthier.[9] He explains that he should eat healthier, but in fact he has made an autonomous choice to not do so. Subsequently, he contemplates whether it would "be a better or happier world, where there would be more eudaimonia, human flourishing or agape in a world where I and people like me were made to do what we acknowledge to be better for us?".[10] He concludes that, autonomous agents should not be compelled to do what is best for them, because respect for autonomy will 'result in a greater benefit' than interfering with people's choices.[11] Therefore, this suggests that there are opposing views as to whether individual's autonomy should be interfered with in society.

Moreover, having outlined the differing perspectives relating to autonomy, it is now necessary to consider the legal perspective on autonomy and the limits that the law places upon individual autonomy.

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[6] Robert Johnson, Adam Cureton, 'Kant's Moral Philosophy' (*The Stanford Encyclopedia of Philosophy,* 21 March 2019) < https://plato.stanford.edu/entries/kant-moral/#Aut> accessed 11 April 2020.
[7] Bruce Jennings, 'Autonomy' in Bonnie Steinbock (eds), *The Oxford Handbook of Bioethics* (Oxford University Press, 2007) 75.
[8] John Stuart Mill, *On Liberty and Utilitarianism* (Bantam Classics,1993) ch1,para 9.
[9] Raanan Gillon, 'Ethics Needs Principles- Four Can Encompass the Rest- and Respect or Autonomy Should be "First Among Equals" (2003) 29(5) Journal of Medical Ethics 307.
[10] Ibid, 310.
[11] Ibid.

B) THE LEGAL POSITION ON AUTONOMY

The principle of autonomy is enshrined in Article 8 of the European Convention on Human Rights[12], which covers the right to respect for private life and self-determination over one's own morality. This principle is also deep-rooted within English law, and in the context of medical law, there is a precedent of upholding an individual's right to self-determination, even if the course of action is different to that which the medical profession has recommended. This position was firstly confirmed in the case of *Airedale N.H.S Trust v Bland* [13], in which the legal stance on self-determination was clarified. Lord Keith explained that a competent adult is "completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die".[14] Therefore, this is illustrative of the substantial regarded afforded to autonomy, as it suggests that the consequences of a decision, should not preclude an autonomous choice. This principle was illuminated by Lord Goff, who outlined that "the principle of the sanctity of human life must yield to the principle of self-determination".[15] Thus, this suggests that, it is more important for someone to be able to freely choose how they live their life, than to protect life at all costs. This was furthered in *Re T (adult: refusal of medical treatment)*[16], where Lord Donaldson held that "the patient's right of choice exists whether the reasons for making the choice are rational, irrational, unknown or even non-existent".[17] Furthermore, this suggests that there is no requirement for the autonomous choice to reflect what society or the medical profession would deem as acceptable.

Despite, the courts clarifying that autonomous choices do not have to correspond with societal norms, in the context of medical law there are limits placed on an individual's right to choose. The legal position does initially appear to present autonomy as an absolute concept, however in reality this is

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[12] Convention for the Protection of the Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR, Art 8).
[13] *Airedale N.H.S Trust v Bland* [1993] A.C 789.
[14] ibid, 857.
[15] ibid, 864.
[16] *Re T (adult: refusal of medical treatment)* [1993] Fam. 95.
[17] ibid, 113.

not the case. In order to validly refuse medical intervention, an individual must have the requisite capacity. And as Coggon points out, capacity is not an absolute concept, therefore neither is the right to always be autonomous.[18] And so, in order to be able to make autonomous choices the test of capacity must be surpassed. The test for capacity is outlined in the Mental Capacity Act 2005, which codified the common law position.[19] Under section 3 of the Act an individual is

"unable to make a decision for himself is he is unable… (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use that information as part of the process of making the decision, or (d) to communicate his decision."[20]

This suggests that the law does reserve the power to restrict an individual's autonomy, especially in the context of medical treatment decision making. Following this acknowledgment of this reservation of power, it is important to look at the context in which certain individuals are frequently denied their autonomous rights.

C) ENFORCED CAESAREANS AND AUTONOMY

Between 1992 and 1997, there were several women in the UK, who were forced to undergo a caesarean. In order to assess whether pregnancy inherently qualifies a woman's right to choose, it is important to consider the circumstances in which these women have been denied this right. In *Re MB*[21], the relationship between women who refuse a caesarean and their autonomy was clarified. Butler-Sloss LJ explained that

"a competent woman who has the capacity to decide may, for religious reasons, or other reasons, for rational reasons or irrational reasons or for no

[18] John Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15(3) *Heath Care Analysis* 235.
[19] *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.
[20] Mental Capacity Act (2005) s3(1)(a)-(d).
[21] [1997] 2 FCR 541.

reason at all, choose not to have medical intervention, even though… the consequence may be death or serious handicap of the child she bears, or her own death."[22]

Therefore, following this, it is clear that the autonomy of a woman was not to be diminished simply due to the fact she was pregnant. Thus, the competency principles that govern every other adult equally apply to competent pregnant women. Michalowski[23] suggests that whilst this clarification was obvious, it was simultaneously necessary following the case of *Re S (Adult: Refusal of Medical Treatment).*[24] This concerned a 'born again Christian', who on religious grounds, refused to undergo a caesarean.[25] Sir Stephen Brown P in *Re S* did refrain from deeming the pregnant woman incompetent, but nonetheless he still allowed the declaration pursued by the hospital, and this was partly on the basis that the caesarean was in the vital interests of the mother. And so, from the reasoning provided in *Re S,* it is clear that failing to declare the woman incompetent, but still refusing to respect her autonomous wishes, did breach the principles of autonomy that were established in *Re MB.*

The decision in *Re MB* proved to be a significant, yet important departure from the previous position in *Rochdale Healthcare NHS Trust v C.*[26] In *Rochdale,* the pregnant woman was declared incompetent on the grounds that she was "in the throes of labour with all that is involved in terms of pain and emotional distress".[27] This was believed to affect her competency and thus ability to make an autonomous decision. And so, despite the consultant obstetrician believing that the pregnant woman did have the requisite competency to make the decision, it is clear the outcome of her decision, her death, was viewed by the court as irrational. Consequently, this suggests that within the area of enforced caesareans and autonomy, pregnant women's

[22] ibid, 561.
[23] Sabine Michalowski, 'Court- Authorised Caesarean Sections- The End of a Trend?' (1999) 62(1) *The Modern Law Review* 117.
[24] *Re S (Adult: Refusal of Medical Treatment*) [1993] Fam 123.
[25] ibid, 124.
[26] *Rochdale Healthcare NHS Trust v C* [1997] 1 FCR 274.
[27] ibid, 275.

wishes are only respected if her wishes coincided with what the professionals believed to be reasonable. However, this position was untenable, given the general regard for autonomy in medical decision making. And so, it could not be maintained that pregnant women represented an exception to this general rule. This is because it would suggest that labour itself, does inherently reduce the respect that is afforded to pregnant women's choices. Accordingly, that is why it was necessary, for the court in *Re MB* to clarify that the distress, typically associated with labour, did not preclude competency and thus an autonomous choice to refuse treatment.

On the same day as the decision in *Rochdale,* the case of *Norfolk and Norwich Healthcare NHS Trust v W*[28] was also decided. *Norfolk* illustrated another example of the courts using labour as a means to preclude competency and thus autonomous choices. Justice Johnson held that the mother was incompetent, as she was experiencing "acute emotional stress and physical pain in the ordinary course of labour"[29], despite not failing step one or two of the mental capacity test. Wei contends that *Rochdale* and *Norfolk* demonstrates the

"creation of a catch- 22 situation, whereby if a competent mother exercises her discretion to refuse medical intervention, the psychiatrist and judge would consider the mother incompetent by virtue of that very decision".[30]

This implies that pregnancy does inherently undermine a mother's right to choose. As, it is clear that her choice will only be respected if it corresponds with the recommended treatment. Widdett and Thompson support this by submitting that "women in labour (and perhaps earlier) may only have the capacity to withhold consent as long as they do not".[31] Subsequently, it is argued that this reoccurring theme, across the initial enforced caesarean

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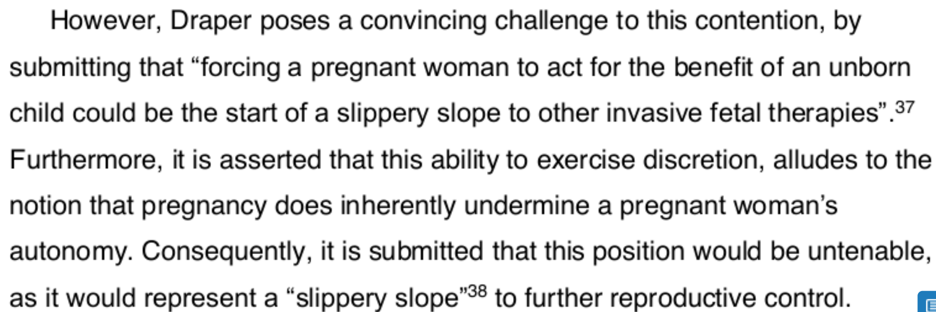
[28] *Norfolk and Norwich Healthcare NHS Trust v W* [1997] 1 FCR 269.
[29] ibid, 272.
[30] Mabel Wei, 'The Illusion of Choice – Have Enforced Caesarean Cases Introduced a New Class of Incompetent Adults' (2016) 4 *Legal Issues Journal* 85.
[31] Ceri Widdett & Michael Thomson, "Justifying Treatment and Other Stories" (1997)) 5(1) Feminist Legal Studies 77, 86.

cases, insinuates that there has always been a reluctance to deem the woman incompetent because she is in labour. And ultimately, the principles were manipulated in order to orchestrate the outcome that the medical professionals and the courts desired. Harris suggests that the "instability in our preferences is often cited as a justification for paternalism".[32] And so, Wei extends this and suggests that on this paternalistic basis "a mother's refusal to undergo a caesarean section operation need not be respected because it is so detrimental that it must carry with it an element of incompetence".[33] Consequently, these judicial paternalistic practices demonstrates that as the mother's preference to refuse treatment differs so substantially from the norm, the courts have, either intentionally or unintentionally, shown an overwhelming willingness to ere on the side of life and to deem the woman incompetent. Lemmens recognises that the courts have relied on the competency requirement to force caesareans upon the woman, as they have considered this to be in her best interests.[34] He does however, concede that "it seems all too clear that judges hide behind a determination of incompetency only to have a valid reason for ordering treatment against the woman's wishes".[35] And so, this suggests that competency is used as a means to disguise the true intentions of the courts, the safe delivery of the foetus. Maclean supports this and submits that the ability to exercise discretion, when determining competency has allowed the courts to acknowledge and act upon such assumptions, therefore sneaking paternalism through the "back-door".[36] Resultantly, it is argued that pregnant women are afforded autonomy as long as their choices coincide with societal expectations, and if they do not, then it has been shown that the courts will use their paternalistic discretion to orchestrate the ends, that society at large, would desire.

[32] John Harris, *The Value of Life: An Introduction to Medical Ethics* (London: Routledge & Kegan Paul, 1985) 198.
[33] Wei (n 31) 89.
[34] Christophe Lemmens, 'End of Life Decisions and Pregnant Women: Do Pregnant Women Have the Right to Refuse Life Preserving Medical Treatment? A Comparative Study' (2010) *European Journal of Health Law* 485, 489.
[35] ibid.
[36] Alasdair Maclean, 'Caesarean Sections, Competence and the Illusion of Autonomy' (1999) 4 *Web Journal of Current Legal Issues* <https://www.bailii.org/uk/other/journals/WebJCLI/1999/issue1/maclean1.html#contents> accessed 15 March 2020.



However, Draper poses a convincing challenge to this contention, by submitting that "forcing a pregnant woman to act for the benefit of an unborn child could be the start of a slippery slope to other invasive fetal therapies".[37] Furthermore, it is asserted that this ability to exercise discretion, alludes to the notion that pregnancy does inherently undermine a pregnant woman's autonomy. Consequently, it is submitted that this position would be untenable, as it would represent a "slippery slope"[38] to further reproductive control.

Moreover, that is why it was necessary for the courts in *Re MB* and *St George's Healthcare NHS Trust v S*[39] to depart from the previous position. *St George's* does differ from *Re MB,* as the court in *St George's* held that the woman was competent and therefore the forced caesarean was held to not be a lawful infringement upon her autonomy.[40] This was because, it was accepted that her detainment under Section 2 of the Mental Health Act[41] for an assessment of her depression[42] would not have "been considered, let alone justified"[43] if the woman had not been suffering from pre-eclampsia.[44] Therefore, her condition was not severe enough to warrant medical intervention, that questioned and undermined her competency. And so, it was eventually held, that it was unlawful to carry out the caesarean under these circumstances.[45] In *Bland,* it was clarified that "it is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult, who is conscious and of sound mind, without his consent".[46] Appropriately, as this was the case for the woman in *St George's* she was able to seek redress for the ends.[47] Therefore, a competent pregnant woman

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[37] Heather Draper, 'Women, Forced Caesareans and Antenatal Responsibilities' (1996) 22 *Journal of Medical* Ethics 328.
[38] Ibid.
[39] [1999] Fam 26.
[40] ibid, 40.
[41] Mental Health Act 1983, s 2(2).
[42] [1999] Fam 26.
[43] ibid, 56.
[44] Ibid.
[45] ibid, 57.
[46] [1993] AC 789, 857.
[47] [1999] Fam 62.

is at liberty to refuse a caesarean, and to force this surgery upon her would be an unjust infringement upon her autonomy.

CONCLUSION

It can be summarised that pregnant women's autonomy is inherently undermined, as the competency requirement has been used as a mechanism for medical professionals to exercise discretion and therefore override autonomous choices. This is because the courts and medical professionals are only willing to respect a pregnant woman's autonomous choices, so long as they coincide with the recommended treatment. Subsequently, this means that pregnant women, especially when in labour, are autonomous in theory until they choose to exercise their autonomy in practice. Moreover, without any clear, authoritative precedent on this matter, where a woman has successfully refused a caesarean, implies that the courts will still continue to exercise their paternalistic discretion. And so, it is illustrated that the reality of women being able to refuse a caesarean does not match the rhetoric as the courts have only ever shown a preference of erring on the side of life, in the interests of societal norms and accordingly to suggest that they would depart from this long-standing precedent would be rather optimistic and ambitious.

Following the establishment that pregnancy does inherently undermine a woman's autonomy, it is now appropriate to consider whether the foetus is afforded a legal status and if so, whether this legal status is morally justified.

CHAPTER TWO : IS THE LEGAL STATUS OF THE FOETUS MORALLY JUSTIFIED?

INTRODUCTION

In chapter one, it was established that the judiciary were overly willing to rely on the discretion that the competency requirement afforded, to override a pregnant woman's autonomy, when they refused a caesarean. Therefore, it is necessary to now decipher whether the infringement upon the mother's autonomy, in enforced caesarean cases, is justifiable following the assessment of the legal and moral status of the foetus. It is crucial to examine the distinction between the moral and legal status of the foetus, as the status accorded will inevitably influence the respect and weight afforded to the woman's autonomy. In order to determine whether the legal status that is afforded to the foetus is morally justified, it is important to ascertain when life begins. Or, rather, as John Harris contends, this question is better phrased as "when does life begin to matter morally?".[48] Subsequently, it is asserted that if the foetus is not accorded with a moral or legal status, until after birth, then any interreference upon the mother's autonomy may be indefensible.

Firstly, the key definitions surrounding this chapter will be outlined, to provide an understanding for the terms used within the chapter. Following this, the current legal position regarding the status of the foetus, through assessing the case law and statutes. This is significant as it will be useful to understand the legal stance prior to the evaluation of the moral position. Accordingly, the differing perspectives of when the moral status is afforded to the foetus will be addressed. This will include the arguments for the foetus' affordance of a moral status at the point of conception, during pregnancy and after birth. Subsequently, it will then be appropriate to explore whether the legal status of the foetus is morally justified or whether the legal position needs to change in light of the preferred moral stance. Finally, it will be

[48] John Harris, *The Value of Life: An Introduction to Medical Ethics* (London: Routledge & Kegan Paul, 1985) 8.

concluded that birth is the most practical, definitive point in which a foetus should be afforded a moral and legal status.

A) KEY DEFINITIONS

Before proceeding it is necessary to define the key terms. The first term being a 'legal person', in which Smith refers to as the "subject of rights and duties"[49], therefore this will be taken to mean an individual that the law recognises. Additionally, 'human' will be defined as "of, relating to, or characteristics of the species Homo sapiens".[50] The terms 'human', 'human being' and 'persons' are ones that academics regularly provide differing interpretations for. However, these scholars at the same time, put forward arguments where they use the terms interchangeably. For example, Glover bases his conclusions on the assumption that "human beings are automatically persons"[51], therefore suggesting that there are synonymous elements to these terms for Glover. In contrast to this, Warnock strongly rejects the term 'person' and instead favours the phrase 'full human beings' to signify status and value.[52] Additionally, to add further confusion, Frankfurt contends that "… it is conceptually possible that some members of the human species are not persons."[53] Despite this apparent confusion, the term 'persons' will be used to signify those with "moral importance".[54] And so, with this moral importance, there is a corresponding obligation "to treat them as ends in themselves and not merely instrumentally as means to ends",[55] as these are individuals whom we owe something morally. For the purposes of this dissertation, the terms 'human beings' and 'persons' will be used interchangeably, and both will denote an individual of moral significance.

[49] Bryant Smith, 'Legal Personality' (1928) 37 *Yale Law Journal* 283.
[50] 'Human, *adj.* and n' (*OED Online*, OUP 2009) <https://www.oed.com/view/Entry/89262?redirectedFrom=human#eid> accessed 06 April 2020.
[51] Jonathan Glover, *Causing Death and Saving Lives* (Penguin Kindle Edition 1990) 24.
[52] Mary Warnock, 'In Vitro Fertilisation: The Ethical issues (II)' (1983) 33(132) *The Philosophical Quarterly* 238, 241.
[53] Harry Frankfurt, 'Freedom of the Will and the Concept of a Person' (1971) 68(1) *Journal of Philosophy* 6.
[54] John Harris, 'Symposium on Consent and Confidentiality: Consent and End of Life Decisions' (2003) 29 *Journal of Medical Ethics* 10.
[55] ibid.

As the key terms have now been outlined, it is now appropriate to move on to the analysis of the legal status of the foetus.

B) LEGAL STATUS OF THE FOETUS

Under the current model, legal persons are afforded a considerable amount of value, which results in their entitlement to certain rights and privileges. This includes the fundamental right to life, which is outlined in article 2 of the Human Rights Act.[56] However, Lord Goff in the case of *Bland*[57] explains that "this principle, fundamental though it is, is not absolute".[58] An example of this right to life being lawfully breached, is where an individual uses self-defence to protect themselves, and this results in the taking of another man's life. Therefore, to end a legal person's life would be classified as murder, and so, this suggests that there is a legally recognised life with rights that can be infringed upon. Thus, suggesting that they have legal status. And so, this section will address whether the foetus constitutes as a legal person, whether foetus' are entitled to any legal protections and finally, whether the infringement upon the mother's autonomy, as a legal person, is justified due to the foetus' right to life.

i) Does the Common Law Afford the Foetus with a Legal Status?

The initial leading authorities, in England and Wales, which concerned the clarification of the foetus' legal status, are the cases of *Paton v British Pregnancy Advisory Service Trustees*[59] and *C v S*[60]. In *Paton,* Sir George Baker P clarified that under English law, the foetus is not entitled to a legal

[56] Human Rights Act 1998 Article 2(1). See also article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1953) (Cmd, 8969).
[57] [1993] AC 789.
[58] ibid, 864.
[59] *Paton v British Pregnancy Advisory Service Trustees* [1979] QB 276.
[60] *C v S* [1988] QB 135.

status, until it is delivered alive with an independent existence from the mother.[61] This was affirmed by the European Commission of Human Rights in *Paton v United Kingdom*[62]*,* where it was held that under article 2 the foetus was not entitled to an absolute right to life.[63] Therefore, this demonstrates the courts reluctance to assert that a foetus has a legal existence and thus, an ensuing right to life. Subsequently, this indicates that there are extensive ramifications for a woman's autonomy if the foetus obtains a right to life. Despite, this apparent simplicity in the law regarding the legal status of the foetus, Lord Donaldson in *Re T*[64] provided an important and arguably confusing extension of the law. He provided that where a competent adult refuses medical treatment "the only possible qualification is a case in which the choice may lead to the death of a viable foetus".[65] However, this position was clarified in *St George's*[66] using Butler-Sloss LJ's obiter in *Re MB,*[67] which explained that

"the foetus 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".[68]

This was furthered in *Re F (In Utero)*[69]*,* where it was held that "the court had no wardship jurisdiction over an unborn child"[70] as to do so would involve restricting the mother's behaviour.[71] This implies that when determining the legal status of the foetus, it is necessary to consider the inevitable impact that this would have upon maternal autonomy. As such, the

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[61] [1979] QB 279.
[62] *Paton v United Kingdom* [1980] 3 EHRR 408.
[63] ibid [19].
[64] [1993] Fam 95.
[65] ibid, 102.
[66] [1999] Fam 26.
[67] *Re M.B (An Adult: Medical Treatment)* [1997] 2 FCR 541.
[68] ibid, 561.
[69] *Re F (In Utero)* [1988] Fam 122.
[70] ibid.
[71] ibid, 130.

current legal position, is that the foetus has no legal status and thus is not afforded the right to life.

Alternatively, it can be argued that some judicial comments, illustrate a willingness to accept the foetus as having value, and this concurrently adds somewhat of a legal status to the unborn child. In *St George's*[72] the court explained "whatever else is may be a 36-week foetus is not nothing: if viable it is not lifeless and it is certainly human".[73] This tentative acknowledgement of foetal value demonstrates the legal reluctance to provide a unborn child with full legal status. In *Attorney-General's Reference (No.3 of 1994)*[74] the defendant had stabbed a woman in the abdomen, even though he knew she was pregnant.[75] It was held that "the intent to stab the mother (a live person) could not be transferred to the foetus (not a live person), an organism which could not be the victim of a crime of murder".[76] And so, as it was established that the principle of transferred malice did not apply to a foetus, it is clear that the courts are maintaining that there is no legal status of a foetus, which means they would not have the right to not be murdered. Scott contends this lack of legal recognition is due to the unborn child being inside the mother's body.[77] Therefore, suggesting that the physical dependence of the unborn child on the mother represents an unbalanced relationship. And, as this reliance is one-sided, because the mother does not depend on the foetus, it is illogical to afford a dependent foetus a legal status, that would simultaneously deprive the mother of her autonomy. Ultimately, as autonomy is a well-regarded principle for legal persons in society, it appears justifiable that foetuses are denied a formal legal status. Following this examination of the case law, the relevant statutory provisions will be assessed to determine whether they suggest that there is recognition of a foetal legal status.

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[72] [1999] Fam 26, 45.
[73] ibid, 952.
[74] *Attorney-General's Reference (No.3 of 1994)* [1998] A.C. 245.
[75] ibid, 245.
[76] ibid, 251.
[77] Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (Hart Publishing 2002) 166.

ii) *Is There Statutory Recognition of a Legal Status For the Foetus?*

Despite this aforementioned assertion about the common law legal status of the foetus, it is apparent in English law, that foetuses are considered to have some value. This appreciation of foetal value is illustrated in some statutes and judicial obiter. Under section 1(1) of the Infant Life (Preservation) Act 1929 there is a statutory crime of "child destruction".[78] This criminalises the deliberate killing of a viable foetus, which is taken to include any "child capable of being born alive".[79] Therefore, albeit this suggests that a foetus is afforded some value, however in reality, this value is contingent on the simultaneous harm to the mother, which is dealt with under separate criminal charges.[80] Moreover, the foetus' potential value and subsequent life interests, are clearly contingent upon maternal harm. This suggests that, the foetus is possibly being used to aggravate the criminal charges for those who harm pregnant women. Consequently, it is contended that this statute does not truly value the life of the foetus, if this value is based on the mother's value, as a recognised legal person. Additionally, the legal status afforded through this Act should not be overstated, as the Act was rarely used, even prior to the Abortion Act.[81] According to a Hansard report, citing the 'Criminal Statistics, England and Wales' records, it was shown that up until the end of 1959, only seven people were convicted using the Act.[82] Albeit, this data is fairly outdated it is important to note that this Act has largely been replaced by the Abortion Act and so, it is submitted that the 1929 Act cannot be said to illustrate a foetal legal status.

However, there is a greater issue with the 1929 Act and this is following the Private Member's Bill, labelled the Infant Life (Preservation) Bill, which aimed to amend section 1(2) of the Act to reduce the 28 weeks' presumption

[78] Infant Life Preservation Act 1929, s1(1).
[79] ibid.
[80] Stephen Smith and others, *Ethical Judgments: Re-Writing Medical Law* (Oxford: Hart Publishing, 2017) 234.
[81] Abortion Act 1967.
[82] HC Deb 22 February 1981, vol 37, cols 389W.

of viability to 24 weeks'.[83] Fortin contends that this report, detailing the deliberation over the proposed alterations, suggests that "grave moral problems are caused by the legal significance attached to the 'viability factor' by the 1929 Act".[84] Consequently, this implies that the foetus does have some legally recognised interests, as otherwise, this question of viability, would not have arisen. Accordingly, Fortin explains that "viability has a moral significance of its own and that if a foetus has developed to such a degree that it is capable of being born alive… it automatically deserves greater legal protection than the less developed foetus, which can be aborted".[85] Moreover, this is a rather convincing contention from Fortin, as it is wholly logical to assert that there is a moral element to a viability requirement. Therefore, this recognition of viability supports the notion of a foetal legal status and subsequently this results in the revival of foetal life having moral significance. And so, this implies that foetus' should possibly be afforded a formal legal status from an earlier point during development.

Additionally, it is important to acknowledge the recognition of foetal rights amongst statute governing other areas of law. In torts law, section 1 of the Congenital Disabilities (Civil Liability) Act 1976 details that "If a child is born disabled as the result of such an occurrence before its birth…and a person (other than the child's own mother) is under this section answerable to the child in respect of the occurrence".[86] This statute is significant, as it offers legal redress to a child if they are born with a disability, that was due to harm they suffered *in utero*. Despite, the case law outlining that a foetus is not a legal person, in actuality, a foetus is accorded a legal status, as once born alive, they are able to claim damages for harm they may have endured, prior to recognition as a legal person. Nevertheless, it is important to acknowledge that there are two crucial limitations to the legal status this Act affords. Firstly, the Act is unable to be used against the mother. The reasons for this maternal exclusion are highlighted in the 1974 Law Commission report[87], in which the

[83]HL Deb, 28 January 1987, vol 483, Cols 1415.
[84]Jane Fortin, 'Legal Protection for the Unborn Child' (1988) 51 *Modern Law Review* 54, 66.
[85] ibid, 67.
[86] Congenital Disabilities (Civil Liability) Act 1976, s1.
[87] Law Commission, *Report on Injuries to Unborn Children* (1974; Cmnd. 60).

1976 Act largely derived from. One of the justifications included that the "relationship between mother and disabled child is one of the most stressful that can exist. To add to it a legal liability… would…increase the tension already existing between them".[88] Thus, this suggests that providing financial remedies for the disabled child, to use against the mother, would undermine the whole gestation period. This is because pregnant women or those of reproductive age, may feel as if pregnancy is a way to restrict their autonomous choices. Furthermore, this implies that the maternal limitations of the statute are necessary due to the unique relationship that arises during pregnancy. Secondly, the Law Commission suggested that there should be a maternal exclusion, as to do otherwise, would be difficult to enforce. [89] For example, smoking, drinking and drug use have been heavily discouraged by medical professionals for women during pregnancy, as there are studies that have linked these with foetal health problems.[90] In particular, Simpson found that there is a correlation between foetal tobacco exposure and low birth weight and intrauterine growth restriction.[91] Moreover, it is contended that despite the clear link between foetal harm and maternal substance abuse, due to the lack of practicality, regarding enforcement, it is suggested that harm to the foetus is not sufficient enough to infringe maternal autonomy. Both of these reasons asserted by the Law Commission are important as they illustrate that the key justifications for not affording the foetus with a full legal status are based on the practical difficulties that would ensue if the foetus had legal redress against the actions of the mother. Therefore, it is argued that it is necessary for the mother to be excluded from the Act as a way of protecting her relationship with the foetus, whilst respecting her with autonomy during gestation. However, there is one exception to the general maternal exclusion

[88] ibid,22.
[89] ibid,22-23.
[90] Mick et al found that "there may be a link between attention-deficit hyperactivity disorder and prenatal exposure to cigarette smoking and alcohol abuse that is not an artefact of uncontrolled confounding". Eric Mick, Joseph Biederman, Stephen V. Faraone, Julie Sayer and Seth Kleinman, Case-Control Study of Attention-Deficit Hyperactivity Disorder and Maternal Smoking, Alcohol Use, and Drug Use During Pregnancy, (2002) 41(4) *Journal of the American Academy of Child & Adolescent Psychiatry* 378, 384.
[91] WJ Simpson, A Preliminary Report on Cigarette Smoking and the Incidence of Prematurity (1957) 73(4) *Am J Obstet Gynecol*, 807-15.

and this is where harm arises as a result of the mother's negligent driving.[92] Albeit, this appears to support a legal status of the foetus, in actuality this is purely a policy decision from Parliament, to ensure all passengers are able to access compensation, if required. Fortin, convincingly argues, that there should be no event in which a legal non-entity has a course of action against its mother for pre-natal negligence, as "the illogicality of such a provision can hardly be justified by the existence of ample insurance funds to meet any liability".[93] Therefore, it is illogical to maintain the maternal duty for a non-legal entity, in the context of driving a motor vehicle. And so, it is contended that the exception should be removed to prevent further confusion regarding the legal status of the foetus.

The second limitation of the Act, is the requirement for the child to be 'born alive'.[94] Section 4(2)[95] clarifies that a child can only be born alive when it as a separate existence from the mother. This section is important as it allows the prioritisation of maternal autonomy. Thus, it is suggested that this Act provides a halfway house between completely ignoring foetal life interests and affording them with the rights of a legal person, as it allows a course of action to crystallise upon birth. Furthermore, as these rights only crystallise upon birth this does not contribute to the idea of a foetal legal status. And so, it is asserted that the Congenital Disabilities Act does not illustrate a foetal legal status.

To summarise, there is no formal legal status afforded to the foetus, that would provide the foetus with an ensuing right to life. Despite, this lack of legal status it is submitted that the foetus is "not nothing".[96] And so, it is logical for the foetus to be legally recognised as having an existence. However, it is even more important that it is recognised that this existence has no legal bearing on the mother's autonomy. This is especially the case following the outcome of the first chapter, whereby it was concluded that in theory the

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[92] Congenital Disabilities (Civil Liability) Act 1976 s2.
[93] Fortin (85) 78.
[94] Congenital Disabilities (Civil Liability) Act 1976, s4(2)
[95] ibid.
[96] [1999] Fam 26, 952.

mother's autonomy should always prevail, however it was illustrated in the case law that, in practice, this was not the case. Thus, as it has been asserted that there is no legal status of the foetus, prior to birth, there should subsequently be no infringement upon maternal autonomy.

C) MORAL STATUS OF THE FOETUS

The moral status of the foetus has been much debated within literature. Academics differ on the moral weight that they afford to the foetus and frequently this depends on underlying religious views, the stage of pregnancy, the viability of the foetus or whether they consider the foetus to be a person. McGuinness suggests that the overwhelming attribution of individuality to the foetus, simultaneously deprives the pregnant woman of her own individuality.[97] Therefore, it is important to assess the differing interpretations regarding the moral status of the foetus as this could potentially justify restrictions on the pregnant woman's liberty in cases of maternal-foetal conflict.

Within this section, the key stages of foetal development will be considered. Including, whether the foetus should be afforded a moral status from conception, during pregnancy or after birth. It will be argued that the most convincing position is to afford the foetus with a moral status at birth.

i) Conception

The first position that will be considered, is the belief that the foetus is worthy of a moral status from the moment of conception and thus a right to life. It is recognised that this position has links to the 'sanctity of life' principle, and in western theology, it is acknowledged that this is deep-rooted in Judaeo-Christian teachings. The 'sanctity of life' doctrine posits that human life is created in the 'image of god'[98] and therefore holds an inherent dignity to

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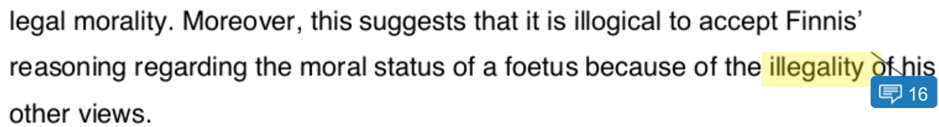
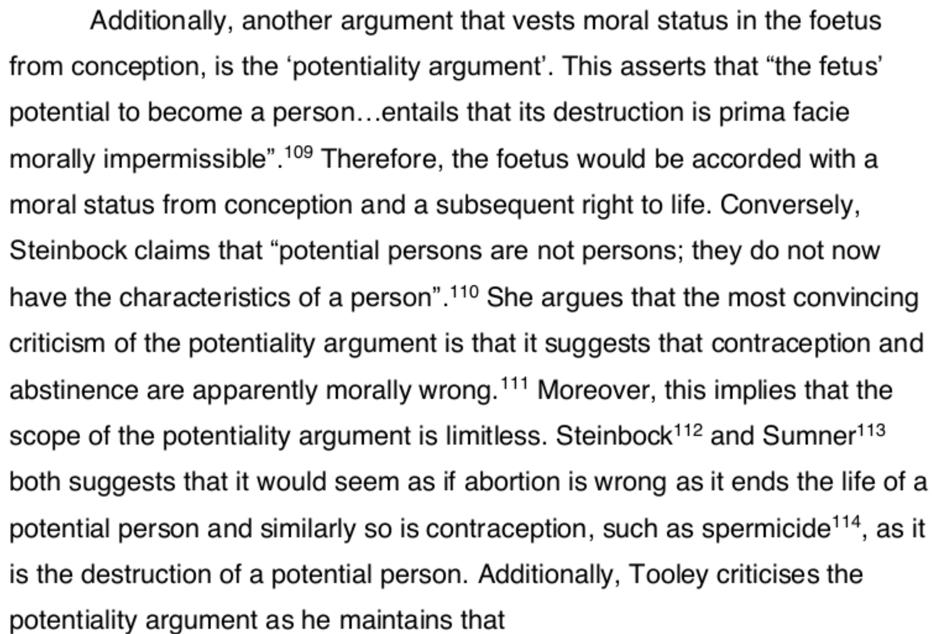
[97] Smith (n 81) 243.
[98] Genesis 1:26-27, Holy Bible: King James version.

be protected. Many have chosen to divorce the notion that a foetus should be afforded a moral status from conception, from its religious roots. This is due to the fact that there has been a long-term decline in religion in Britain.[99] Keown recognises this, and asserts that respect for life is not limited to religious beliefs, as it is well accepted amongst most societies that "one must never intentionally kill an innocent human being".[100] However, the question remains whether the foetus constitutes a human being and therefore it would be wrong to end their life. Finnis believes that all foetuses are moral persons from conception onwards.[101] He bases this argument on the premise that "capacity for self-consciousness… is present in the unborn human from a very early stage".[102] Subsequently, Finnis argues that foetuses should be the "subject of rights"[103] as the "human embryo is already 'in a condition to' have aims, experience disappointment, regret having been harmed in early life and so forth".[104] And so, for Finnis, foetuses have a moral status from conception due to their ability to be capacitous. Despite, Finnis' arguments appearing to be well reasoned, his out of date views on homosexuality undermines his approach regarding the moral status of a foetus. Finnis claimed that "homosexual acts are radically and peculiarly non-marital, and for that reason intrinsically unreasonable and unnatural".[105] The case of *Dudgeon v United Kingdom*[106] held that section 11 of the Criminal Law Amendment Act, which condemned homosexual acts,[107] was incompatible with the European Convention of Human Rights.[108] Thus, it is arguable that Finnis' views about homosexuality are fundamentally incompatible with the modern conception of

[99] Nancy Kelley, 'Key Findings: Britain's Shifting Identities and Attitudes' British Social Attitudes 36 (The National Centre for Social Research, 2019) <https://www.bsa.natcen.ac.uk/media/39287/0_bsa36_keyfindings.pdf> accessed 10 April 2020.
[100] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legislation* (Cambridge University Press, 2002) 40.
[101] John Finnis, 'The Rights and Wrongs of Abortion' in Marshall Cohen, Thomas Nagel and Thomas Scanlon, The Rights and Wrongs of Abortion (Princeton University Press, 1974) 112.
[102] John Finnis, 'Capacity, Harm and Experience in the Life of Persons as Equals' (2013) 39(5) *Journal of Medical Ethics* 281, 282.
[103] ibid.
[104] ibid.
[105] John Finnis, 'Law, Morality, and "Sexual Orientation"' in John Corvino, Same Sex: Debating the Ethics, Science, and Culture of Homosexuality (Lanham- New York-London, Rowman and Littlefield, 1997) 31, 36.
[106] *Dudgeon v United Kingdom* (1981) 3 E.H.R.R. 40.
[107] Criminal Law Amendment Act 1885, s11.
[108] *Dudgeon v United Kingdom* (1981) 3 E.H.R.R. 58.



legal morality. Moreover, this suggests that it is illogical to accept Finnis' reasoning regarding the moral status of a foetus because of the illegality of his other views.



Additionally, another argument that vests moral status in the foetus from conception, is the 'potentiality argument'. This asserts that "the fetus' potential to become a person…entails that its destruction is prima facie morally impermissible".[109] Therefore, the foetus would be accorded with a moral status from conception and a subsequent right to life. Conversely, Steinbock claims that "potential persons are not persons; they do not now have the characteristics of a person".[110] She argues that the most convincing criticism of the potentiality argument is that it suggests that contraception and abstinence are apparently morally wrong.[111] Moreover, this implies that the scope of the potentiality argument is limitless. Steinbock[112] and Sumner[113] both suggests that it would seem as if abortion is wrong as it ends the life of a potential person and similarly so is contraception, such as spermicide[114], as it is the destruction of a potential person. Additionally, Tooley criticises the potentiality argument as he maintains that

"the destruction of a human organism that is a potential person, but not a person, is prima facie no more seriously wrong than intentionally refraining from fertilizing a human egg cell, and destroying it instead. Since intentionally refraining from procreation is surely not seriously wrong, neither is the destruction of potential persons."[115]

Resultantly, it is argued that Tooley's logic for the rejection of the potentiality argument is more convincing than propositions posited in support

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[109] Bertha Alvarez Manninen, 'Revisiting the Argument From Fetal Potential' (2007) 2(7) *Philosophy, Ethics, and Humanities in Medicine* 1.
[110] Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses* (Second Edition, Oxford University Press, 2011) 59.
[111] ibid, 60.
[112] ibid.
[113] LW Sumner, *Abortion and Moral Theory* (Princeton University Press, 1981) 104.
[114] Steinbock (111) 60.
[115] Michael Tooley, *Abortion and Infanticide* (Oxford: Clarendon Press, 1983) 193.

of it. Thomson[116] and Wertheimer[117] support this, as they suggest that it is a 'slippery slope' to regard the foetus from as a person from conception.[118] This is because it lacks practical value. And arguably, it does not make sense to suggest that just because the foetus has potential to become a person at conception, does not mean they should be treated as a person from that point onwards. This is particularly important as the autonomous rights of a legally recognised woman, are brought into question. Therefore, this suggests that it would be erroneous to assert that a foetus has moral status from conception.

ii) During Pregnancy

Following on from this rejection of the conception argument, it is appropriate to address the arguments surrounding the attribution of a moral status during pregnancy. Viability, is the point in which a foetus could survive, independent of the mother. Under English law, the Abortion Act[119] outlines that a foetus is considered viable at 24 weeks of pregnancy. Section 1(a) of the Act allows an abortion prior to 24 weeks of pregnancy, unless there is a greater mental or physical risk to the mother then termination is permitted later on in gestation.[120] Glover disagrees with the viability argument[121] on the basis that viability is a "shifting boundary".[122] Therefore, he contends that the point which a foetus could survive if born earlier, is very subjective. Accordingly, he then argues that viability is not of relevance when determining the moral status of the foetus as the viability boundary is not certain.[123] Similarly, Wertheimer does not agree that a moral status is afforded during pregnancy.[124] Instead he recognises that in the case of a miscarriage, the

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[116] Judith Jarvis Thomson, 'A Defense of Abortion' in Marshall Cohen, Thomas Nagel and Thomas Scanlon, *The Rights and Wrongs of Abortion* (Princeton University Press, 1974) 3.
[117] Roger Wertheimer, 'Understanding the Abortion Argument' in Marshall Cohen, Thomas Nagel and Thomas Scanlon, *The Rights and Wrongs of Abortion* (Princeton University Press, 1974) 23.
[118] Thomson (n 117) Wertheimer (n 118).
[119] Abortion Act 1967.
[120] ibid, s1(a).
[121] It should be noted that when Glover was writing the point of viability was 28 weeks.
[122] Glover (n 52) 70.
[123] ibid.
[124] Roger Wertheimer, 'Understanding the Abortion Argument' (1971) 1(1) *Philosophy and Public Affairs* 67.

mother is the "object of grief" and hardly ever does anyone feel sadness for the embryo itself.[125] This indicates that the point in which moral status is attributed cannot be during pregnancy. The lack of consideration for the foetus during a miscarriage suggests that the foetus did not have a sufficient moral status to require their life interests being mourned.

iii) Birth or After Birth

Now there are some academics who would disagree with any of the above-mentioned contentions and instead argue that an individual does not acquire moral status until at after birth. Albeit, Dworkin does contend that life has an intrinsic value[126], he does posit that foetal life is not valuable in itself as instead he claims that value is acquired through life through the opportunity to work and redeem oneself.[127] Therefore, suggesting that the value typically associated with persons, is not an automatic right, but rather one that is attained through one's conduct. Likewise, Locke would contend that foetuses cannot be afforded with a moral status at any point before birth.[128] Locke sought to combine rationality and self-consciousness as the characteristics which make individuals persons. He outlined that a person is

"a thinking intelligent being, that has reason and reflection, and can consider itself, the same thinking thing, in different times and places; which it does only by that consciousness which is inseparable from thinking and seems to me essential to it; it being impossible for anyone to perceive without perceiving that he does perceive."[129]

Moreover, if the characteristics typically associated with persons not characteristics that a foetus could ever possibly possess, as they are not conscious, it is asserted that the foetus does not have a moral status prior to

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[125] ibid, 89.
[126] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia And Individual Freedom* (New York: Knopf, 1993) 68-9.
[127] ibid, 157
[128] John Locke, An Essay Concerning Human Understanding (Oxford University Press, London, Essay II, Ch 9, 1964).
[129] ibid, 115.

the ability to do this. Research conducted by Koulder et al found that there is not consciousness present in infants until they are at least 5 months old.[130] Therefore, under this research, if consciousness is not present until this point then foetuses certainly do not possess the requisite characteristics to obtain a moral status.

Similarly, Singer puts forward that "newborn babies cannot see themselves as beings that might or might not have a future, and so they cannot have a desire to continue living".[131] Consequently, he argues that "if a right to life must be based on the capacity to want to go on living, or on the ability to see oneself as a continuing mental subject, a newborn baby cannot have a right to life".[132] Thus, both foetuses and newborn babies do not possess the required capacity capability to be treated as persons, and so it is suggested that they arguably do not have moral status, even after birth. By way of contrast, Manninen insists that it is well recognised within society that newborn babies and infants do have a "welfare interest in continued existence, despite their lack of personhood".[133] Manninen claims that most would agree that if a newborn baby was terminally ill that it still does have a welfare interest in continued existence, and so should have the life-saving treatment, despite not having an interest in the operation being carried out.[134] It is argued that this is a very convincing argument posited by Manninen, as the rational can be extended to those that are mentally disabled and will never be capacitous enough to value their own existence. Therefore, as foetuses do not possess the capabilities to be conscious and nor do newborn babies, it is argued that in theory, they should not be afforded with a right to life. Nevertheless, it is submitted that this position, would lack practical value, as many would find it hard to treat newborn babies as not having a life interest. Singer, despite suggesting that a full legal right to life should only come into

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[130] Koulder S and others, 'A Neural Marker of Perceptual Consciousness in Infants' (2013) Science. 340(6130) 376-80.
[131] Peter Singer, *Practical Ethics* (Third Edition, Cambridge University Press, 2011) 152.
[132] ibid.
[133] Bertha Alvarez Manninen, "Revisiting the Argument From Fetal Potential' (2007) 2(7) *Philosophy, Ethics, and Humanities in Medicine* 8.
[134] ibid.

action a short time after birth, in which he proposes a month.[135] He does recognise the difficulties with maintaining this position, and subsequently does recommend that birth should remain the point in which moral status is accorded, for legal purposes.[136] And so, it is maintained that birth is the most appropriate point in which a foetus is afforded a moral status.

D) IS THE LEGAL STATUS MORALLY JUSTIFIABLE?

To summarise, there is no formal legal status afforded to the foetus that would provide the foetus with an ensuing right to life. Despite this, it is accepted that the foetus is "not nothing".[137] Accordingly, it is argued that it is logical for the foetus to be legally recognised as having an existence, however it is important to clarify that this existence should have no impact on maternal autonomy. Resultantly, it is concluded that the most satisfactory position cannot be conception as it is too entrenched in religion. Additionally, it cannot be during pregnancy, as the viability argument poses boundary issues and so is too subjective. Moreover, it is maintained that in theory the most satisfactory position is the affordance of a moral status after birth as this makes sense when considering the consciousness, capacity to value and have an interest in continued existence arguments. However, in reality to adopt this moral approach and thus alter the attribution of a legal status to a period after existence separate from the mother would lack enforcement as is suggested by Manninen's contentions. Furthermore, it is submitted that the most practical position where foetuses gain moral status is at birth. Therefore, it is necessary for the foetus to be acquire a legal status at birth and this is morally justified as to do otherwise would lack non-religious support, subjectivity and enforcement issues.

[135] Singer (n 132) 153.
[136] ibid.
[137] [1999] Fam 26, 45.

CONCLUSION

In conclusion, the current position of affording the foetus a legal status at birth, is morally justified, on a practical basis. This is important as it would render any infringement upon the mother's autonomy, to facilitate the foetus' safe delivery, as unconscionable. Ultimately, it is asserted that if a competent pregnant woman refuses a caesarean, the foetus' life interests should not be taken into consideration. Having established in chapter one, through analysing enforced caesarean case law, this is not necessarily the reality for dissenting pregnant women. And as this chapter has established that the foetus has no legal status until birth, it is now necessary to consider how maternal autonomy should be balanced against foetal interests. In order to determine whether there are circumstances where it would be permissible to infringe maternal autonomy.

CHAPTER THREE: SHOULD MATERNAL AUTONOMY BE BALANCED AGAINST THE INTERESTS OF A FOETUS?

INTRODUCTION

In chapter one, it was established that there is no authoritative precedent, illustrating where a competent pregnant woman had successfully refused a caesarean. It was ascertained that, this was due to the courts repeatedly preferring to ere on the side of life. That being said, in the second chapter it was subsequently established that this position is not justifiable following the assessment of the moral and legal status of the foetus. It was submitted that, the foetus, rightfully, has no formal legal status until birth and it was argued that this is position is morally justifiable. Therefore, it is understood that the courts interference with maternal autonomy is primarily due to the paternalistic desire to protect the foetus' life interests.

Following this development, it is now necessary to assess the maternal-foetal conflict to explore whether there are legitimate reasons for the courts showing this preference for foetal protection. This maternal-foetal conflict is a concept well recognised within the literature surrounding enforced caesareans. This conflict is evoked when a pregnant woman refuses medical intervention, which includes a caesarean section. Due to the woman's unique and unparalleled relationship with her foetus, means that a 'third party' is inadvertently affected.[138] Subsequently, it is this additional consequence that results in the controversy, however, it is important to not overstate this conflict. Scott contends that this is

"an unfortunate term, since pregnant women are generally renowned for putting the interests of the fetus they are carrying before their own, for

[138] Maclean (n 37).

worrying enormously about the potential impact of their choices and actions on the fetus and for doing all they can to enhance its wellbeing".[139]

Nonetheless, it is suggested that this conflict is particularly animated when a pregnant woman autonomously refuses a caesarean. Therefore, this section will assess the conflict in relation to enforced caesareans.

This chapter will firstly cover, whether foetus' should be treated as an individual patients, to determine whether this would justify the consideration of foetal interests. It will then be discussed whether medical professionals are afforded too much discretion in the maternal-foetal conflict. Subsequently, it will explore whether there should be a duty to not harm the foetus in the later stages of gestation and whether the continuation with pregnancy vitiates maternal autonomy. It will be argued following the assessment of these areas it is necessary for maternal autonomy to supersede foetal life interests.

A) SHOULD FOETUSES BE TREATED AS INDIVIDUAL PATIENTS?

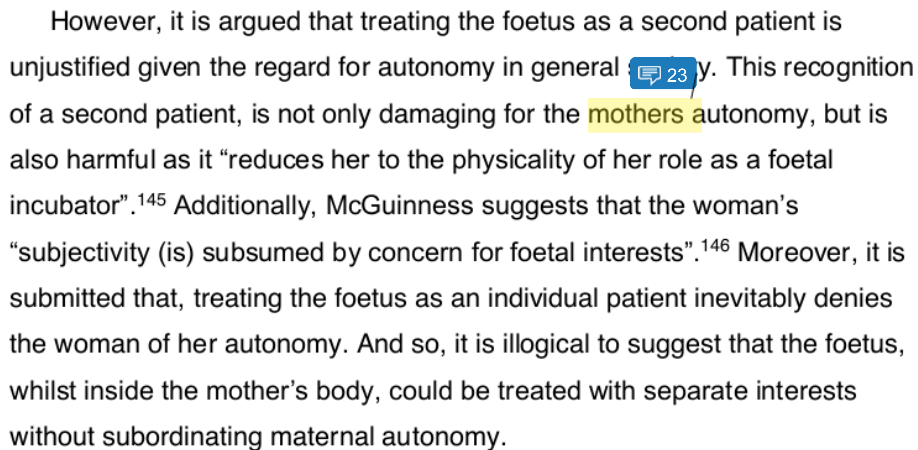
i) Antenatal Technology

One of the reasons the maternal-foetal conflict has spiked particular controversy is due to the advancements in antenatal technology. Nelson and Milliken contend that "advances in the knowledge of fetal physiology and the development of new technology have enabled physicians to see the fetus in detail with ultrasound, to assess its condition with amniocentesis and fetal heart rate monitoring, and to operate on it in-utero".[140] Therefore, these developments have increased the visibility of the foetus and simultaneously, this has increased societal awareness and regard for foetal life. Halliday agrees with this contention as she suggests that, technology has orchestrated

[139] Scott (n 78) xxv.
[140] Lawrence Nelson, Nancy Milliken, 'Compelled Medical Treatment of Pregnant Women. Life, Liberty, and Law in Conflict' (1988) 259(7) *The Journal of the American Medical Association* 1060.

a substantial shift in the relationship between the pregnant woman and the medical professionals treating her.[141] She explains that this shift is due to "reducing the reliance of professionals upon knowledge imparted by the woman, and indeed largely reversing the flow of information between the two".[142] Therefore, if medical professionals no longer rely on the mother to determine her health and the stage of foetal development, this will inevitably result in the professionals assuming that they know what is best for the mother and the foetus.

Resultantly, this links to the aforementioned notion of the medical professionals and the courts using competency as a means to override the pregnant woman's autonomy, in order to produce their desired ends, namely, the safe delivery of the foetus. This concept, is further supported by Halliday, who recognises that this increase in technology has not resulted in the empowerment of pregnant women and their choices, but rather has been used to identify a second patient.[143] Kilby contends that the introduction of ultrasounds has "allowed the visualisation of our second patient, the fetus".[144]



However, it is argued that treating the foetus as a second patient is unjustified given the regard for autonomy in general [illegible]y. This recognition of a second patient, is not only damaging for the mothers autonomy, but is also harmful as it "reduces her to the physicality of her role as a foetal incubator".[145] Additionally, McGuinness suggests that the woman's "subjectivity (is) subsumed by concern for foetal interests".[146] Moreover, it is submitted that, treating the foetus as an individual patient inevitably denies the woman of her autonomy. And so, it is illogical to suggest that the foetus, whilst inside the mother's body, could be treated with separate interests without subordinating maternal autonomy.

[141] Samantha Halliday, *Autonomy and Pregnancy: A comparative Analysis of Compelled Obstetric Intervention* (Abingdon, Oxon, Routledge, 2006) 1.
[142] ibid.
[143] ibid, 2.
[144] Mark Kilby, 'Prenatal Diagnosis: The Way Ahead' (1998) 59(10) *Hospital Medicine* 752.
[145] Smith and others (n 81) 244.
[146] ibid.

B) MEDICAL PROFESSIONALS' DISCRETION

i) Non "Neutral Observers"[147]

Moreover, this conflict is expounded as the development of antenatal technology creates another issue aside from visibility. It is posited that, the medical professionals, who treat the pregnant woman, are not "neutral observers".[148] Hobbs submits that many midwives do contend that pregnant women, who refuse recommended treatment and subsequently risk the life and health of their foetus, cannot be rational and therefore they perceive forced interventions as justifiable and respectable.[149]

Moreover, it is proposed that due to the people responsible for the pregnant woman's care, the woman's autonomy will inevitably be undermined. Thus, it is illogical to place the decision of affording pregnant women in the hands of the individuals least likely to respect it. This is supported by Savulescu and Momeyer, who submit that the substantial emphasis that medical ethics places on respecting patient autonomy, encourages medical professionals to be tolerant of patients making harmful choices based on their own values.[150] Additionally, this implies that they suggest that values held by patients, that are contradictory to those of clinicians, are not rational, and resultantly, decisions founded on those irrational values are not autonomous. This indicates that for a pregnant woman to dissent from the recommended treatment, places her in a vulnerable position. This is because the very act of refusing a caesarean, results in the questioning of maternal competency and thus denial of autonomy. Cahill argues that a patient refusing recommended medical treatment does not signify incompetence or mental illness.[151] Therefore, this reinforces the notion that there is an undue desire to declare

[147] Halliday (n 142) 1.
[148] ibid.
[149] L Hobbs, 'The Great Divide' (1998) 94(41) *Nurs Times* 72-73.
[150] Julian Savulescu, Richard Momeyer, 'Should Informed Consent Be Based on Rational Beliefs?' (1997) *23*(5) *Journal of Medical Ethics* 282.
[151] Heather Cahill, 'Non-Consensual Caesarean Section- Some Arguments For Respecting Women's Autonomy' (Thesis, University of Keele 1999).

pregnant women incompetent, who disagree with the medical professional's recommendations.

Widdett and Thompson further this by arguing that in some circumstances,[152] pregnancy is viewed as causative of mental illness and psychiatric disorders.[153] Subsequently, these labels are relied upon by clinicians to deprive women of their autonomy, through questioning their competency.[154] Moreover, this highlights how difficult pregnancy is for some women, not only is their body experiencing many physical and psychological changes, but their ability to remain competent and thus autonomous, is also frequently questioned. In the case of *Parkinson v St James and Seacroft University Hospital NHS Trust*[155], Hale LJ, as she was known then, explains that "from the moment a woman conceives, profound physical changes take place in her body and continue to take place not only for the duration of the pregnancy but for some time after".[156] Therefore, it is contended that women are vulnerable as a result of the changes that they endure through the course of pregnancy. And so, the regard for autonomy in other aspects of society suggests that it is unsustainable to maintain that women should not have this additional pressure during pregnancy, of justifying their choices. This is supported by Nelson and Milliken, who posit that by questioning the pregnant woman's refusal and subsequently involving the judiciary

"inevitably invades a woman's privacy… and thrusts the woman into the adversarial system, where she must defend her choices on a highly personal matter at a time where she is psychologically and physically ill-disposed to do so".[157]

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[152] See the case law assessed in the Autonomy chapter.
[153] Ceri Widdett & Michael Thomson, "Justifying Treatment and Other Stories" (1997)) 5(1) *Feminist Legal Studies* 77- 89.
[154] ibid.
[155] *Parkinson v St James and Seacroft University Hospital NHS Trust* [2001] 3 WLR 376.
[156] ibid, 285.
[157] Nelson and Milliken (n 141) 1061.

Furthermore, it is argued that because the medical professionals, entrusted with caring for the pregnant women, are not "neutral observers"[158] results in the deprivation of maternal autonomy. This issue is worsened as women, especially during labour, are particularly vulnerable. This vulnerability forces them to rely on individuals, who are possibly acting to bring about their own desired ends, rather than respecting and upholding the autonomous wishes of the woman.

ii) Independent Advocates

However, there has been an effort to protect and guide patients, as social services can provide an Independent Advocate, who will help individuals understand the care process, stand up for their rights and aid the patient in making decisions.[159] Albeit, this appears to be a useful resource, the efficacy of the Independent Advocates is doubted.

In a Parliamentary Select Committee paper, it was identified that the funding available is not protected by ring-fencing and therefore is not tracked to ensure that it is used for the intended purpose.[160] Furthermore, Newbigging et al[161] identified another issue with Independent Advocates, more specifically Independent Mental Health Advocates. They found that there is a problem of unequal uptake for some 'qualifying patients'.[162] Therefore, this suggests that access to these resources is limited and resultantly so is the efficacy, as some are not able to understand let alone rely on this resource. Moreover, it is contended that there should be further safeguards put in place to ensure that patients, specifically pregnant women are not being treated under these

[158] Halliday (n 142) 1.
[159] 'Someone to Speak Up For You (Advocate)' (*NHS*, 2018) < https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/someone-to-speak-up-for-you-advocate/> accessed 16 April 2020.
[160] Health Committee, 'Supplementary Written Evidence From the Mental Health Alliance (MHA 01)' (*House of Commons Select Committees*, March 2013) <https://publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584we02.htm> accessed 15 April 2020.
[161] Karen Newbigging and others, 'The Right to Be Heard, Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England' (University of Central Lancashire, 2012).
[162] ibid, 91.

biased pretences. Thus, to ensure that pregnant women's autonomy is upheld there should be greater access to Independent Advocates or an equivalent resource. At the same time, it is also suggested that there should be greater accountability placed upon medical professionals to ensure that women have been made aware of this support.

Ultimately, as it has been outlined that there is a lack of respect of pregnant women's autonomy, despite the courts clarifying that competent women are to remain in charge of their own medical treatment. It is argued that it would be irrational to contend that the mother's autonomy should be subordinated in the interests of a viable foetus. Therefore, it is suggested that if the maternal-foetal conflict was to favour the protection of foetal life interests, over maternal autonomy, would result in an unsustainable and inequitable view of pregnant women in society. Thus, it is submitted that it is necessary for pregnant women to remain superior to the foetus as to otherwise would further deprive women of autonomy in medical treatment decision making.

C) SHOULD THERE BE A DUTY TO NOT HARM THE FOETUS?

Draper suggests that there are many things that could harm the foetus, therefore this implies that it should not automatically be the mother's duty to protect the foetus from all forms of harm.[163] However, it is contemplated that "if women are forced to have a caesarean section for the sake of the foetus, then it is not unreasonable that they should also be forced to stop smoking whilst pregnant."[164] Thus, under this reasoning, women's actions should also be controlled during pregnancy as a means to prevent foetal harm. Draper does discredit this notion, as she contends that if there is an obligation imposed upon women to refrain from smoking whilst pregnant, then there is an equivalent obligation imposed upon the parents to refrain from smoking

[163] Draper (n 38) 331.
[164] ibid.

after the child is born.[165] Subsequently, following this logical development Draper argues that an

"enforced caesarean is not unfair because women are obliged to consent but rather because it is simply inconsistent with other similar obligations which are generally not imposed and enforced upon parents and others in relation to children".[166]

This is a very convincing point submitted from Draper, as it poses a cogent challenge to the notion that women's autonomous choices should be restricted during pregnancy, in the interests of preventing foetal harm. Subsequently, the high regard afforded to autonomy, under English law, does suggest that that the regulation of the behaviour of a woman during pregnancy does not fall within the remit of what the law should dictate. This is supported by Do and Mapulanga-Hulston as they claim that it is obviously necessary for pregnant women to think about how they should conduct themselves during pregnancy, however they do propose that this is not a place where the judiciary should prescribe how they should act.[167] Furthermore, if it was accepted that the judiciary could control the way women conduct themselves during pregnancy then this would imply that it would be appropriate for the judiciary to also enforce restrictive controls over women of "reproductive age".[168] However, this position is rejected on the basis that it would be unconscionable and impractical to contend that it would be appropriate for the judiciary to place restrictive controls of those of reproductive age, in the interests of preventing harm to the foetus. This is because, these measures would be inappropriately pre-emptive and would devalue women in society, as this would suggest that women should be judged and controlled based upon their reproductive capabilities. Moreover,

[165] ibid.
[166] ibid.
[167] Christina Do and Jackie Mapulanga-Hulston, 'The Ethical and Legal Conundrum: Should a Mother Owe a Duty of Care to Her Unborn Child?' (2013) *Journal of Applied Law and Policy* 1, 11.
[168] Martha Field, 'Controlling the Woman to Protect the Foetus' (1989) 17(2) *Law, Medicine and Health* Care 114, 118.

this position is unconscionable given the regard for autonomy in the rest of society.

D) DOES THE CHOICE TO CONTINUE WITH PREGNANCY VITIATE THE WOMAN'S RIGHT TO CHOOSE?

Even though the arguments against imposing a duty upon the mother are very convincing, it is suggested that the choice to continue with pregnancy, may justifiably vitiate the woman's right to choose. This is because the choice to continue pregnancy may create a positive obligation to prevent foetal harm.[169] It has been established, within the first chapter, that control has been exerted over women and their autonomous choices during labour. And so, this alludes to the idea that this control should be extended over the woman during gestation, to prevent foetal harm.

Draper contemplates that the mother's choice to continue with the pregnancy results in an "additional responsibility to the fetus to agree to a caesarean section since a mechanical delivery is a well-known possible outcome of confinement".[170] Deshpande and Oxford support this idea of the continuation of pregnancy resulting in an obligation, regarding the wellbeing of the foetus.[171] Therefore, this implies that it is possibly unfair for the mother to exercise autonomy to sustain life, up until the point of labour, and then reject intervention that would facilitate the safe delivery of the foetus. Moreover, it is contended that as the woman has had many opportunities to either prevent or terminate her pregnancy, through the use of contraception, [172] emergency contraception[173] or undergoing an abortion.[174] And so, it would be wrong to

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[169] Steinbock (n 111) 158.
[170] Draper (n 38) 328.
[171] Neha Deshpande, Corrina Oxford, 'Management of Pregnant Patients Who Refuse Medically Indicated Cesarean Delivery' (2012) 5(3-4) *Rev Obstet Gynecol* 144, 147.
[172] 'How can I Avoid Pregnancy? Your Contraception Guide' (*NHS*, 2017) <https://www.nhs.uk/conditions/contraception/how-can-i-avoid-pregnancy/> accessed 15 April 2020.
[173] 'Emergency Contraception (Morning After Pill, IUD) Your Contraception Guide' (*NHS*, 2018) <https://www.nhs.uk/conditions/contraception/emergency-contraception/> accessed 15 April 2020.
[174] 'What Happens, Abortion' (*NHS*, 2016) < https://www.nhs.uk/conditions/abortion/what-happens/> accessed 15 April 2020.

suggest that enforcing a caesarean would be a significant, unjustifiable, infringement upon maternal autonomy.

Kluge provides a compelling exception to this position, as he posits that to justify this infringement upon the mother's autonomy, society must have a duty to provide the appropriate measures to prevent and also terminate pregnancy.[175] However, it is argued that the availability of resources does not legitimise such an invasion, upon the woman's body. Thomson suggests, that the continuation of pregnancy does not inevitably enforce a duty upon the mother, to sustain the foetus' life.[176] She does this by providing an example of an "unconscious violinist"[177], who is now plugged into an individual's body to keep the violinist alive.[178] Thomson supposes that "all persons have a right to life and all violinists are persons"[179] and therefore this right to life "outweighs your right to decide what happens in and to your body".[180] Subsequently, Thomson contends that this position would be regarded as barbaric, and so argues that "if a human being has any just, prior claim to anything at all, he has a just, prior claim to his own body".[181] Therefore, Thomson would assert that women should be free to make choices their own body, irrespective of the foetus' right to life.

Thomson extends this and makes a distinction between actions that are "minimally decent" and those of a "good Samaritan".[182] She suggests that to sustain the life of a foetus would be the act of a good Samaritan and that the law does not always compel individuals to be minimally decent, let alone good Samaritans.[183] Thus, it is contended that

[175] Eike-Henner Kluge, 'When Caesarean Section Operations Imposed by a Court Are Justified' (1988) 14(4) *Journal of Medical Ethics* 206, 210.
[176] Judith Jarvis Thomson, 'A Defense of Abortion' (1971) 1(1) *Philosophy & Public Affairs* 47.
[177] ibid, 48.
[178] ibid, 49.
[179] Ibid.
[180] ibid, 49.
[181] Ibid, 54.
[182] ibid, 62.
[183] ibid, 64.

"no person is morally required to make large sacrifices to sustain the life of another who has no right to demand them, and this is even where the sacrifices do not include life itself; we are not morally required to be good Samaritans or anyway very good Samaritans to one another".[184]

Furthermore, this logical development posited by Thomson, does pose a cogent challenge to the notion that the continuation of pregnancy vitiates the woman's autonomy. Moreover, this suggests there is no duty for the mother to continue with pregnancy, in the interests of a foetus, as that would constitute an unjustifiable infringement upon her autonomy. This is because restricting maternal autonomy for this purpose would lack correspondence with other obligations enforced upon individuals in society.

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Ultimately, it would be unfair to suggest that pregnant women have a duty to submit their body to the foetus, as this would inexcusably extend what they should be obliged to too far. Thus, it is submitted that if a woman autonomously chooses to continue with pregnancy, sustaining the life of the foetus, but then autonomously refuses a caesarean, then this is her right to do so. This is because maternal autonomy, must supersede foetal interests as making one autonomous choice to continue pregnancy does not undermine the ability to make an autonomous choice in the future to end pregnancy or refuse a caesarean.

CONCLUSION

To summarise, it has been established that foetuses should not be treated as individual patients, despite the advancements in technology encouraging this. And so, it is illogical to suggest that the foetus, whilst inside the mother, could have separate interests worth considering. This is because medical professionals are already afforded too much discretion, and resultantly treat the woman in accordance to their own values regarding the foetus. Therefore, it would be unreasonable to identify the foetus, as a second

[184] ibid.

patient as this would further undermine the woman's autonomy and the respect that clinicians afford to it. Additionally, it is was also argued that there should be no maternal obligation to protect the foetus from all forms of harm, as there is no corresponding obligation placed upon parents once the foetus is born. Similarly, it was found that if obligations were imposed upon women during pregnancy, this would imply that these controls could be imposed of those of reproductive age. And as this does not correlate with the autonomy principles within society, it was suggested that the judiciary should not regulate this behaviour. It was also established that the choice to continue pregnancy should not vitiate future autonomous choices, as this would lack compatibility with other obligations placed on individuals. Ultimately, given the overall regard afforded to the principle of autonomy, it is necessary for the foetus' interests to be subordinate to the mother's autonomy.

Finally, as it was established in the earlier chapters that the reality does not match the rhetoric as maternal autonomy is frequently overridden through the liberal use of the competency test. And subsequently it was submitted that the foetus has no justifiable legal or moral status prior to birth to legitimise the infringement upon maternal autonomy. It is concluded that, it is overwhelmingly necessary for maternal autonomy to supersede foetal interests. And so, for the reality to match the rhetoric, there needs to be further guidance and further enforcement of measures to facilitate this genuine respect for maternal autonomy.

CONCLUSION

In conclusion, it has been made explicit by the exploration of the legal and ethical principles governing maternal autonomy and foetal interests, that the reality does not match the rhetoric. Through individually assessing autonomy, the status of the foetus and the balancing of maternal and foetal interests, it is concluded that that there is no justifiable legal, moral or ethical basis to preclude a woman's autonomous choice to refuse a caesarean, in the interests of protecting foetal life. Despite this contention, it was ascertained that there still persists a lacuna where there is a legal and medical reluctance to uphold maternal autonomy, when the woman refuses a caesarean. Subsequently, it is asserted that it is absolutely necessary for maternal autonomy to supersede foetal interests, given the pre-existing willingness of the medical professionals and the courts to ere on the side of foetal life. And so, to ensure that maternal autonomy is respected in accordance to the general societal regarded for self-determination, it is necessary to increase the availability of information surrounding autonomy and treatment refusal to ensure the efficacy of measures in place to facilitate this end.

Initially, chapter one investigated whether pregnancy inherently undermines a woman's autonomy, through looking at the general legal principles and the enforced caesarean section case law, in relation to autonomy. It was concluded that pregnant women's autonomous choices are inherently undermined, through the discretion afforded to the medical professional with the competency requirement. And so, without any clear authoritative precedent on the matter, where a woman has successfully refused a caesarean, implies that the courts will continue to exercise their paternalistic discretion to ere on the side of life. Subsequently, it was submitted that to suggest that they would depart from this position would be rather optimistic and ambitious.

Following this, to understand the willingness to deem pregnant women as lacking competency, chapter two examined whether the legal status afforded to the foetus was morally justified. It was concluded that birth was the

most suitable point to afford the foetus with a legal status, given the societal regard for autonomy. Consequently, it was established that it would be preferable to afford the foetus a moral status at a later point after birth, when the child would possess the requisite capacity capabilities to be classed as a 'person'. However, given this underlying valuing of foetal life, it was acknowledged that this would lack practical enforcement and so it was maintained that birth should remain the decided edge where an individual gains a moral and legal status.

Lastly, chapter three focused on whether maternal autonomy should be balanced against the interests of a foetus, in order to decipher whether there are any circumstances where it would be permissible to infringe maternal autonomy. Through analysing the contentions of the previous two chapters, it was concluded that maternal autonomy must supersede foetal interests. Accordingly, it was asserted that despite the convincing reasons for valuing foetal life and protecting the foetus from harm, it was maintained that given the pre-existing willingness to protect foetal life, it is necessary to sustain that a foetus' right to life is subordinate to the mother's autonomy. As to do otherwise, would give rise to greater deprivation of maternal autonomy and would pave the way for forcible treatments upon pregnant women, in the interests of the foetus. Furthermore, due to the self-determination principles that dictate every other aspect of life in a liberal democratic society, it is crucial for pregnant women to remain in control over their own bodies, regardless of societal views about the foetus.

The lack of recent case law demonstrating the courts and medical profession respecting the autonomous wishes of competent pregnant woman, who refuses intervention, has led to the relevancy of this dissertation but has also caused simultaneous limitations. The main focus of this dissertation was to ascertain whether the reality does match the rhetoric for pregnant women. And so, a limitation of this paper is that the conclusions are premised on educated conjectures of the existing theoretical model. And so, whether the inferences drawn in this paper do indeed accurately depict the current state of

affairs for dissenting pregnant women, will depend upon the outcome of the next caesarean refusal.

Finally, it is asserted that there needs to be further research conducted into the efficacy and advertisement of independent advocates for pregnant women. Furthermore, there should be further investigation into the respect afforded to pregnant women, who refuse recommended medical treatment and also whether medical professionals, through the competency requirement, are afforded too much discretion. Additionally, it would be appropriate to carry out further research to decipher whether other 'vulnerable' groups are subjected to the overuse of the competency requirement to override their autonomy.

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LAW3320 Long Dissertation

GRADEMARK REPORT

FINAL GRADE

74/100

GENERAL COMMENTS

Instructor

First marker,

This thesis demonstrates an excellent understanding of the law in this area.

has evaluated the sources and considered counterarguments to arrive at her own conclusions. There were one or two weak spots in the argument (e.g. the rebuttal of Finnis, which 'played the man not the ball' and there could have been a few more counterarguments in the autonomy section) but, overall, the level of analysis was strong throughout.

The work is logically structured. the introduction sets out the problem and signposts the dissertation. It is clear what the 'job' of each section is and the conclusion ties together the argument.

The range of sources and discussion of the ethical literature was impressive. has evidently researched the topic from a number of different angles.

The work is clearly communicated, neatly presented and properly referenced. However, there was an overuse of commas and transitional words for the start of sentences - the latter was distracting at times.

Second marker,
This is a well-researched and clearly-argued dissertation, which showed good understanding of the laws surrounding enforced caesareans. The doctrinal analysis was particularly strong. But the conceptual work could have been better. Autonomy is an important

principle, but it is often limited in health law as in other areas - and I wonder if it might have been worth comparing and contrasting enforced caesareans with some of these.

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Comment 1

Good - gives context to the problem.

Strikethrough.

PAGE 6

Comment 3

Good signposting

PAGE 7

PAGE 8

Comment 4

Which view is the best?

PAGE 9

PAGE 10

Comment 5

Good discussion. Counterargument: some might say that if you lack capacity you do not have autonomy to restrict in the first place.

PAGE 11

PAGE 12

PAGE 13

Comment 6

Very good argument/use of literature.

PAGE 14

Comment 7

Link discussion back - counterarguments?

PAGE 15

PAGE 16

Comment 8

Good distinction

PAGE 17

Comment 9

Good signposting

Comment 10

Good - very clear

PAGE 18

PAGE 19

PAGE 20

PAGE 21

Comment 11

Good

PAGE 22

PAGE 23

Strikethrough.

Comment 13

cause

Comment 14

Good discussion

Comment 15

Ad hominem? This does not necessarily mean that his views on the moral status of the foetus are wrong.

Comment 16

His views are not illegal.

Comment 17

Good point.

Comment 18

Good point but could give an example. Viability has changed over time. And location.

Comment 19

Right word? If terminal then life could not be saved.

Comment 20

Counterargument - some conditions where it is not in the child's interest to be saved? But I suppose

they would also apply to adults.

PAGE 31

Comment 21

Good.

PAGE 32

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Comment 22

Good signposting

PAGE 35

Comment 23

missing apostrophe

PAGE 36

Comment 24

Interesting argument

PAGE 37

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PAGE 39

PAGE 40

Comment 25

Good point

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PAGE 43

Comment 26

Good use of Thomson's argument

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Comment 27

Good conclusion that ties together the argument and answers the overall question.

PAGE 48

Comment 28

Impressive range of primary and secondary sources used.

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RUBRIC: UG ASSESSMENT CRITERIA

CONTENT	Very Good
EXCELLENT	Exceptional understanding of complex material. Identification of less obvious issues not widely discussed in the literature
VERY GOOD	Complete answer which displays an in-depth understanding of the key issues; discussion always related to the question
GOOD	Full answer (only minor omissions) which displays a good understanding of the key issues; discussion predominantly related to the question
SATISFACTORY	Solid answer but some omissions and may be lacking in detail; understanding of the key issues is variable and may be shallow at times; discussion typically related to the question but may be some digressions
LIMITED	Partial answer with a number of omissions; displays a reasonable understanding of the material but may be superficial at times; discussion frequently strays away from the focus of the question.
BELOW PASS STANDARD	Unsatisfactory answer due to failure to identify and/or understand the key issues, and/or limited relevance to the question

ANALYSIS	Good
EXCELLENT	Exceptional level of analysis Demonstrates excellent evaluative skills when using sources
VERY GOOD	Highly analytic answer which draws upon - and evaluates a range of sources - to reach own conclusions
GOOD	Analytic approach adopted throughout the answer making appropriate use of evidence to support the analytic points made
SATISFACTORY	Some level of analysis but answer is likely to be overly descriptive at times; analysis may be confined to the final section of the essay and points made may not be explored in-depth or substantiated
LIMITED	Primarily descriptive with only limited analysis, which is likely to be superficial and without reference to any sources
BELOW PASS STANDARD	Overly descriptive answer with little, if any, analysis

STRUCTURE	Very Good
EXCELLENT	Imaginative and innovative argument Almost faultless structure
VERY GOOD	Engaging introduction which lays out a structure for the answer and demonstrates a full understanding of the issues raised by the questions; robust conclusion which consolidates the argument advanced in the main body of the essay; discussion flows

	effectively as argument is developed throughout
GOOD	Introduction lays out a structure for the answer and identifies key issues; conclusion consolidates the argument built up in the main body of the essay but both may benefit from further development; answer is generally well organised with clear progression
SATISFACTORY	Introduction may be pedestrian, simply outlining what will be discussed; brief conclusion which does not consolidate the argument presented in the body of the essay; evidence of planning but answer would benefit from some reorganisation of material to improve the flow of the argument
LIMITED	Introduction may be pedestrian, simply outlining what will be discussed; conclusion may be asserted rather than following on logically from the argument advanced in the essay; answer would benefit from reorganisation of material
BELOW PASS STANDARD	Introduction, if present, offers little more than a list of issues to discuss; conclusion, if present, does not answer the question; disorganised answer.

RESEARCH	Very Good
EXCELLENT	Considerable evidence of independent scholarship High level of synthesis
VERY GOOD	Draws upon a wide range of both primary and secondary sources (including those not listed in module materials) and uses them effectively to support points made; very good synthesis of sources to convey understanding of relevant literature
GOOD	Draws upon a range of both primary and secondary sources (relying predominantly on those listed in module materials) and uses them to support points made; good synthesis of sources to convey understanding of relevant literature
SATISFACTORY	Draws upon primary and secondary sources (relying predominantly on the latter) and uses them to support points made; discussion tends to focus on individual sources
LIMITED	Draws on a limited range of sources, predominantly secondary sources; not all points made are supported by reference to the sources used; discussion focuses on individual sources
BELOW PASS STANDARD	Minimal use of sources; points made are generally not accompanied by reference to sources

PRESENTATION	Good
EXCELLENT	Close to reaching the expectation for an academic publication Exceptional attention to detail
VERY GOOD	Fluent and precise writing style with only minimal errors; academically appropriate language; full, consistent and accurate referencing
GOOD	Fluent academic writing style with only minor errors; occasional minor referencing errors
SATISFACTORY	Clear writing style on the whole but some errors and areas of confusion; no serious

	referencing errors
LIMITED	Writing style sometimes lacks clarity and precision and may not be academically appropriate; referencing may also be problematic (e.g. inconsistent approach) but not indicative of plagiarism
BELOW PASS STANDARD	Difficult to read due to frequent errors and/or problematic (possibly non-academic) writing style; problematic referencing which may raise concerns about academic integrity