The American Journal of Bioethics

ISSN: 1526-5161 (Print) 1536-0075 (Online) Journal homepage: http://www.tandfonline.com/loi/uajb20

# For Whom the Burden Tolls: Gender and the Unequal Management of Fetal Risks and Parental Expectations

Leslie Ann McNolty & Jeremy R. Garrett

**To cite this article:** Leslie Ann McNolty & Jeremy R. Garrett (2016) For Whom the Burden Tolls: Gender and the Unequal Management of Fetal Risks and Parental Expectations, The American Journal of Bioethics, 16:2, 17-19, DOI: 10.1080/15265161.2015.1120811

**To link to this article:** https://doi.org/10.1080/15265161.2015.1120811

Published online: 01 Feb 2016.

The authors note that three states have abrogated this common law rule by statute (usually called "Bad Samaritan" laws because they punish a knowing failure to aid another in need), when in fact it is four. Wisconsin makes it a misdemeanor to fail to assist victims of crime (Wisconsin Statutes 2015), but the very small number of states that don't follow the common law rule is striking.

Also, while commenting on legal distinctions among types of bodily intrusion that can be required by law, the authors state that the law does not permit forced removal of a bullet from criminal suspects in order to obtain it as evidence against them when there is precedent for doing so after due process has been afforded them (Nelson 1994). Pregnant women who are forced by court orders to undergo cesarean delivery for the sake of their prenatal humans almost never receive such due process.

Finally, I believe pregnant women intending to deliver do have an ethical obligation to accept reasonable medical treatment and to behave in other ways that benefit and do not harm their prenatal humans (Nelson and Millliken 1988) and that the unborn have significant moral status apart from what the individual women who gestate them think they have (Nelson 2016). However, I am opposed to using the coercive power of the state to enforce such an obligation. We can and should inform pregnant women about the evidence-based risks their behavior poses to their unborn and urge them to do the right thing, but the on-the-ground decisions to sort out all the risks and benefits to all affected parties should rest with the women who must live with those decisions. ■

## REFERENCES

*Casey v. Planned Parenthood*. 1992. 505 U.S. 833.

Guttmacher Institute. 2015. Substance abuse during pregnancy. Available at: http://www.guttmacher.org/sections/by-type.php?type=spib.

*International Union v. Johnson Controls*. 1991. 499 U.S. 187.

Minkoff, H., and M. F. Marshall. 2016. Fetal risks, relative risks, and relatives' risks. *American Journal of Bioethics* 16(2): 3–11.

National Advocates for Pregnant Women. 2010. Prenatal exposure to illegal drugs and alcohol: Media hype and enduring myths are not supported by science. Available at: http://www.guttmacher.org/sections/by-type.php?type=spib.

Nelson, L. 1994. The mother and fetus union: What god has put together, let no law put asunder? In *The beginning of human life*, ed. F. Beller and R. Weir, 301–17. Dordrecht, The Netherlands: Kluwer Academic Publishers.

Nelson, L. 2009. Of persons and prenatal humans: Why the constitution is not silent on abortion. *Lewis & Clark Law Review* 13:155–207.

Nelson, L. 2016. A crisis for women's rights? Surveying feticide statutes for content, coverage, and constitutionality. *University of Denver Criminal Law Review*, in press.

Nelson, L., and N. Milliken. 1988. Compelled medical treatment of pregnant women: Life, liberty, and law in conflict. *Journal of the American Medical Association* 259:1060–66.

*Roe v. Wade*. 1973. 410 U.S. 113.

*Wisconsin Statutes*. 2015. §940. 34.



# For Whom the Burden Tolls: Gender and the Unequal Management of Fetal Risks and Parental Expectations

**Leslie Ann McNolty,** Center for Practical Bioethics
**Jeremy R. Garrett,** Children's Mercy Bioethics Center and University of Missouri–Kansas City

At first glance, maternal–fetal medicine seems fraught with ethical hazards for clinicians and policymakers. It seems that doctors, judges, and legislators face an overwhelming task as they try to identify and distinguish their obligations to the pregnant woman and those to her developing fetus. Minkoff and Marshall (2016) argue that such ethical dilemmas for clinicians and/or public officials are largely illusory. Instead, they suggest a simple rule—decision-making in such situations rightly belongs to pregnant women and not their doctors (or judges and legislators). It is only "the pregnant woman whose personal, fetal, and family interests hang in the balance ... and it is the

Address correspondence to Leslie Ann McNolty, Center for Practical Bioethics, 1111 Main Street, Kansas City, MO 64105-2116, USA. E-mail: lmcnolty@practicalbioethics.org

decisionally capable pregnant woman, not third parties with false claims to objective decision making, who is best situated to speak on these matters" (9).

In arriving at this conclusion, Minkoff and Marshall offer a cogent rebuttal to a number of problematic applications of the concepts of risk and rescue in the context of fetal and pediatric decision making, a rebuttal likely to be welcomed by those, like us, who are concerned with the exercise of legal, institutional, and professional control over women's bodies in such contexts. However, the authors miss an important opportunity to expand and deepen a gender-based critique of the status quo in their attempt to explain why the same physicians are willing to "coerce 'recalcitrant' pregnant women for the sake of their fetuses" but unwilling to "sanction unconsented surgery on mothers for the sake of born children" (8). Where the authors appeal exclusively to conflicting moral domains within an unwieldy five-part moral psychology, we propose to explain these asymmetrical intuitions in a simpler and arguably more perspicacious way—namely, as the predictable outcome of gendered cultural expectations of women and men both as parents and as moral agents. These cultural differences are instructive in contexts where the burdens of risk assignment and management fall to both parents jointly (the neonate case) versus the mother only (the fetus case). It is worth considering the two explanations in more detail.

Minkoff and Marshall argue that discrepancies in risk assessment for different maternal decisions with similar absolute risks to the fetus (i.e., home birth vs. trial of labor after cesarean section) are explained by motivated reasoning—"a cognitive bias in which an individual looks for different levels of evidence depending on whether a statement agrees with or contradicts his or her preconceived notion" (5). In cases where motivated reasoning produces sharply different intuitions about clinician/state justification for overriding the personal and bodily autonomy of women to benefit fetuses versus born children, the authors attribute the divergence to a conflict between the moral domains of harm and reciprocity, which value autonomy, and the moral domain of purity, which values innocence and sanctity. They argue that because the fetus is even more "dependent on ascribed 'virtuous' parental behavior than a born child," (8) we are more inclined to override the demands of autonomy to ensure the parental behavior that benefits the fetus.

Yet there seems to be a much simpler and readily evident explanation for these discrepancies based in gendered parental expectations. It is not accurate to say that the fetus is more dependent on virtuous parental behavior than the born child; rather it is more dependent upon virtuous maternal behavior. The social expectations of mothers and fathers are different in important and relevant ways here. While women are solely responsible for the physical well-being of their fetuses due to natural biology, gendered cultural expectations of mothers influence how we weigh a woman's bodily integrity and personal identity against the interests of her fetus. The cultural narrative of motherhood is one of sacrifice; mothers are expected to sacrifice their personal interests in favor of their children's interests. On the other hand, fathers traditionally have been expected to sacrifice much less for their children. While there has been a great deal of lip service to a sea change in the cultural expectations of fathers in recent decades, very little actually has changed. In everything from television shows and commercials to magazine articles and parenting handbooks, fathers are expected to be part-time helpers to fully responsible mothers. Statistical measures of the division of household and parental responsibilities consistently show that women continue to do the lion's share of reproductive and domestic labor at the expense of their professional and personal interests (Wall and Arnold 2007). Culturally, not all "relatives" are equal when it comes to risk and rescue; it really does matter "for whom the burden tolls." Mothers are expected to risk more to rescue their children than fathers are, and interventions to control or punish women to enforce this expectation are more readily accepted.

These distinct cultural expectations of mothers and fathers explain the difference between intuitions in the justification for violating bodily integrity for the benefit of one's offspring. Since typically only mothers make physical sacrifices for fetuses and mothers are expected to sacrifice for their children, they are expected to expose themselves to greater risks and to sacrifice more to protect their unborn children. Yet both mothers and fathers can make physical sacrifices on behalf of born children. Because fathers are not expected to sacrifice to the same extent that mothers are, we are less inclined to require significant sacrifices from men on behalf of born children. Referring back to Minkoff and Marshall's example, we are more inclined to think forcing a pregnant woman to submit to an unconsented cesarean is justified than forcibly extracting a mother's bone marrow because only a woman will ever be subjected to an unconsented cesarean, while a man might be equally at risk of having his bone marrow forcibly extracted. The reason more doctors think violations of autonomy are justified in the fetal case versus the neonatal case is because biology dictates that only women are subject to such violations in the fetal case.

Examining the different gendered expectations of women and men as moral agents can also inform and strengthen the authors' account of the different moral domains. As feminist thinkers from Wollstonecraft to Gilligan have long pointed out, gender and virtue are deeply intertwined. The virtues that issue from each of the moral domains described by Minkoff and Marshall are not equally assigned to each gender. Virtues like autonomy, authority, and justice are assigned to men. Loyalty and purity are assigned to women. Men and women are expected to operate in and from different moral domains. Arguments against home birth and unconsented cesareans reflect not just "the belief that some pregnant women cannot be trusted to subsume the ethics of autonomy to the

ethics of sanctity" but also the belief that the ethics of sanctity is the appropriate ethics for women, while the ethics of autonomy is paradigmatic for men.

As noted earlier, we applaud and support Minkoff and Marshall's cogent rebuttal of the gender imbalanced assumptions regarding risk, rescue, and parental sacrifice often found in the context of maternal–fetal medicine and pediatrics. Understanding and appreciating the fuller scope and wider impact of these assumptions only deepens and strengthens the authors' critique of various unjust practices toward women as child-bearers and mothers. Ideally, such a critique can contribute to the reform of such practices so that the unequal physical burden of pregnancy necessitated by biology does not also entail unjust violations of women's bodily integrity and personal autonomy. ■

## REFERENCES

Minkoff, H., and M. F. Marshall. 2016. Fetal risks, relative risks, and relatives' risks. *American Journal of Bioethics* 16(2): 3–11.

Wall, G., and S. Arnold. 2007. How involved is involved fathering? An exploration of the contemporary culture of fatherhood. *Gender and Society* 21(4): 510–12.



# Regulating Risk and the Boundaries of State Conduct: A Relational Perspective on Home Birth in Australia

**Jindalae K. Skerman,** University of Sydney
**Ainsley J. Newson,** University of Sydney

The concept of motivated reasoning and conflicting moral domains behind the state's conduct toward pregnant women, as described by Minkoff and Marshall (2016), can also be observed in the apparent attitudes toward home birth in Australia. In this commentary, we briefly outline the status of home birth in Australia and provide some examples of motivated reasoning in the Australian context. Despite this, some commentators have refrained from risk-based judgments to instead emphasize the importance of communication with, and making "reasonable accommodation" for, pregnant women, even in high-risk situations. We consider that a relational approach might work better than Minkoff and Marshall's conclusion that pregnant women are best situated to decide on risk. Indeed, their article hints at a relational approach at several points, but this is not explicitly taken up. We also claim that a relational approach provides a way to give rise to a principled compromise of conflicts in this contested space.

## HOME BIRTH IN AUSTRALIA

While less than 1% of women in Australia plan a home birth (Commonwealth of Australia 2009), access is becoming increasingly difficult. Where home birth is available, women can access it via two pathways. The first is through a publicly funded program, although entry is often restricted to those living in a particular (often urban) catchment. It is also only usually available to women assessed as "low risk." Second, women can engage the services of a private, independent midwife. However, pending changes to midwife registration processes will mandate professional indemnity insurance. This may make it more difficult for independent midwives to practice home birth, as there are currently no Australian insurers willing to provide cover that includes home birth.

## MOTIVATED REASONING IN AUSTRALIA

The type of motivated reasoning outlined by Minkoff and Marshall has also been observed in the Australian context. For example, the language of risk has been used to support claims that the state should not facilitate home birth as an option for pregnant women (Pesce 2010). Unlike the United States, Australia has not yet seen a court-ordered cesarean section, but scenarios with similar features have occurred. In 2005, the Royal Brisbane and Women's Hospital reported a woman to the Department of Child Safety when she refused a repeat cesarean. She later attended another hospital where she gave birth vaginally (Australian Associated Press 2005).

Address correspondence to Ainsley J. Newson, Centre for Values, Ethics and the Law in Medicine, Level 1, Medical Foundation Building, University of Sydney, 92-94 Parramatta Road, Sydney, NSW 2006, Australia. E-mail: ainsley.newson@sydney.edu.au