

AAPT, Pregnancy Loss and Planning Ahead

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The commentaries in response to our paper are indicative of the varied perspectives that can be taken towards AAPT and more specifically its relationship with pregnancy (loss).

Kennedy rightly argues that empirical research is essential for understanding the experiences of pregnancy loss and AAPT [1] and our own advocacy of empirical research is evident in previous work [2] [3] [4]. Kennedy also acknowledges the current impossibility of researching AAPT experiences since it has not yet been applied in clinical settings. It is precisely for this reason that we draw upon the reported experiences of NICU parents since they present the closest analogy which can be drawn with the technology.ⁱ What we reject in Kennedy's response, however, is the claim that the experiences of NICU parents have been 'exploited' by us [1]. Studies documenting the experiences of NICU parents were drawn upon to indicate that our considerations are more than mere speculation. As stated, the experiences of NICU parents, particularly the pregnant individual who experiences pregnancy loss, is the closest indication we have of how AAPT and what it entails *may* be experienced. To claim that this data is being exploited by us is to undermine the very purpose that such research is undertaken- to indicate how future care may be improved. It would be much more harmful to not use this information. Whilst we believe that experiences of NICU may not directly map onto experiences of AAPT, it is nevertheless a useful exercise to consider synergies between the two, particularly in light of Cavolo's claim that AAPT 'will be part of NICU' [5].ⁱⁱ Kennedy's claim that our practical recommendations which follow from this are 'pointless' suggests that we cannot and should not plan care pathways for AAPT at all because the required empirical data is not yet available. Without some form of forethought and preparation, which will inevitably require some speculation, users of AAPT, particularly those participating in clinical trials, are at risk of receiving inadequate care.

We conveyed in our original paper that our suggestions as to how AAPT *may* be experienced is not a statement of how it *will* or *should* be experienced. We therefore agree with Bidoli that pregnancy loss may be welcomed by some and provide relief in certain circumstances [6]. We were clear to outline that information provision in regard to pregnancy loss should be value-neutral and additional information and psychological support should not be compulsory, rather only engaged with if this is

ⁱ This is also the drive behind future empirical research that we are undertaking. See <https://wp.lancs.ac.uk/futureofhumanreproduction/sg-chloe-romanis/> for more information.

ⁱⁱ Acknowledging NICU being the closest synergy in terms of understanding parental experience does not, however, require conceding that NICU and AAPT are the same. We are of the view that there are important metaphysical distinctions between NICU care pathways and AAPT care pathways [13][14].

what the pregnant person desires. Fetal-centric narratives can cause harm in opposing directions- to coerce individuals into relinquishing their pregnancies *and* other individuals into maintaining them. It is a real possibility that the implementation of AAPT may re-enforce the ‘naturalistic fallacy’ [6] and attention equally needs to be paid to ensuring coercive pressure is not placed on individuals to maintain pregnancies, particularly dangerous ones, when it is not in their interests [7]. We are mindful that the lack of studies reporting positive feelings associated with pregnancy loss may be indicative of the societal pressure to embrace pregnancy that Bidoli refers to. As expressed in our original paper, we are encouraging of an environment where diverse experiences of pregnancy and loss can be shared without judgement.

Whilst our paper was directed towards AAPT and its potential impact on the experiences of pregnant people, a further aim was to refocus the pregnancy and childbirth experience on the pregnant person, countering the dominate fetal-centred narratives we discuss. Cavolo suggests that our paper weighs too heavily in favour of the experiences of pregnant persons putting us at risk of contributing to the narrative of maternal-fetal conflict [5]. Our aim was not to dismiss the impact of the technology on the health and outcomes for the fetus, particularly when positive outcomes are desired by the pregnant person. Rather, we sought to minimise the focus given to *wholly* fetal-centric narratives that do not give due regard to the desires of the pregnant individual. This is not to emphasise maternal-fetal conflict, rather it is to highlight the existing problems that contemporary obstetric care (with maternal-fetal conflict thinking baked in) has caused – our approach advocates for more holistic pregnancy and procreative care. The excellent commentary of Carpenter and others further illuminates the distinction we highlighted between pregnancy loss and procreative loss, focusing on procreative loss without pregnancy loss, and the importance of reframing pregnancy from this perspective [8]. In centralising the pregnant person, perspectives of pregnancy and childbirth are broadened, and room is made to cater care towards the individual undertaking pregnancy rather than a narrow focus on the outcome of the process. Cavolo further accuses us of ‘exaggerating the risks and downplaying the benefits of AAPT’ [5] despite the introduction of our work clearly setting out that we welcome the technology in light of its potential to improve morbidity and mortality of those born prematurely. What we raise in our paper is the *potential* risks that AAPT may present in terms of exacerbating reported negative experiences related to NICU and call for design of the technology to take this potential into account. Just as De Bie and others suggest AAPT may be less traumatic for parents [9], we are presenting the counter possibility that it *could* result in increased trauma if care pathways are not attentive to the risks we highlight.

We stressed in our paper that the factors we presented in relation to loss- sensitive care pathways were not exhaustive. The important response of Schott and others is an example of the types of discussions we hoped to elicit [10]. They rightly highlight the racial disparities associated with preterm birth in

the US and such disparities have also been reported in the UK [11]. One of us has highlighted elsewhere that those already harmed by social inequality and discrimination, and therefore more likely to experience premature birth, may likely shoulder the burdens of clinical trials of AAPT [12]. We welcome Schott and others' suggestion that care pathways should account for these social inequalities, particularly with regards to the treatment of Black birthing people in reproductive healthcare [10]. How this may be achieved requires further consideration than space allows for here, but the loss-sensitive care pathways we referred to in our paper should, at a minimum, include consideration of the social support that the pregnant person has in place at the time they decide whether or not to engage with AAPT.

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