Pregnancy: Transformations in Philosophy and Legal Practice
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Introduction

In this paper we explore the transformation of pregnancy in philosophy and in legal practice in the United Kingdom through a number of areas: the gendered aspects of pregnancy (section 1) and how this has transformed historically (section 2); the understanding of pregnancy itself as a transformative experience (section 3), which we critique via feminist legal theory (section 4); the transformation of the pregnant body from the private to the public (section 5); the transformation of the pregnant person's autonomy, agency, and control (section 6) via considerations of their capacity (section 7), their foetus (section 8), and their mental health (section 9); and finally the transformation of (the concept of) pregnancy through the advancements and interventions of medicine and technology (in section 10). In bringing together these various strands, we aim to develop a multi-disciplinary understanding of the transformation that pregnancy *is*, that pregnancy *makes*, and that pregnancy has *had* historically, in philosophy and law in the United Kingdom.

1. Pregnancy and Gender

Pregnancy is overwhelmingly women's work. But not all who are pregnant identify as women or mothers. As such, in this paper we use the terms 'pregnant person' or 'gestator' as more inclusive terms in order to avoid gendered and social connotations, and to not overlook trans men and non-binary people who experience pregnancy.[1] Nevertheless, many cultural issues regarding pregnancy are heavily gendered, and much of the language used reflects that.[2] Relatedly, O'Donovan and Marshall have argued for a conceptual distinction between the person who gives birth and 'mother'. They proposed the term 'birthgiver'.[3] In our analysis here, we draw on this work to explore how a conceptual distinction between the pregnant person and mother can transform understandings in both philosophy and law about the meaning of pregnancy.

The starting assumption legally is that the best person to bring up a child is, in judicial words, 'the natural parent' provided that the child's moral and physical health are not endangered.[4] This is a gendered issue: voluntary relinquishment is seen as 'unwomanly',[5] an act of self-betrayal, a woman divided against herself who ought to behave differently, namely, more 'authentically' in keeping with their identity, which is now inextricably linked to being pregnant.[6] The rare and only very recent developments now legally recognising men as capable of being pregnant and giving birth demonstrate the gendered nature of pregnancy, for, in law, the pregnant person and the mother are conflated. This was confirmed in the legal

[1] See Finn and Isaac 2021 and Kingma and Woollard (forthcoming) where it is explained more fully. See also MacDonald 2016 for an account of transgender pregnancy.
[2] For example, we refer to the maternal-foetal conflict even though the relevant party may not identify as 'maternal', and this may be so even if identifying as female. And we use the term 'foetus' to denote both foetuses and embryos at any stage of pregnancy in order to stay neutral on whether it meets certain metaphysical and scientific conditions to be regarded as a baby. This too follows the terminology used by Finn and Isaac 2021 and Kingma and Woollard (forthcoming).
[3] Building on Ruddick 1989, see O'Donovan and Marshall 2006.
[4] Re KD A Minor Access Principles 1988 2 FLR 139 per Lord Templeman at para 141.
[5] O'Donovan 2002.
[6] Marshall 2008.

decision of TT[7] which restates that the birthgiver is legal 'mother' and must be registered as such, regardless of their legal gender. This demonstrates an ideology of motherhood, an ideology that we will critique against the backdrop of the historical transformation of the agency, autonomy, and control that the gestator has during their pregnancy and beyond.

2. Historical Perspectives

Pregnancy is legally regulated and protected with medical policies, philosophies, ethics, and social and cultural attitudes, which have long and intertwining roots. As such, philosophy, law, and medicine worked as mutually reinforcing narratives, which is evidenced historically.[8] In the seventeenth century, 'preformation' was a scientific theory, which stated that male gametes contained the whole of a future person (originally described as 'animalcules'). The reproductive role of the female was understood to be entirely that of an incubator, an environment in which a future child would grow separate from (though inside) the gestator.[9] This idea in some way traces back to the philosophy of Aristotle[10] and is still to this current century reflected in the philosophical literature.[11] Back in the seventeenth century, primogeniture (the passing of wealth and property from father to first born son) was not merely a legal construct, but one that was seen to have 'scientific' grounding. The female's role in reproduction was exclusively that of providing a gestating environment, not a partner in the provision of DNA (which, of course, had yet to be discovered) or legal identity.[12] When considered alongside the marriage contract, which obliged a wife to provide (for) her husband's children,[13] we see that pregnancy in the 1600s is difficult to understand as the act of an autonomous female. Any child born in wedlock would be the lawful progeny of its father only, as 'confirmed' by science, and any child born out of wedlock was the lawful progeny of no-one.

Fox's recent work on eighteenth century experiences of pregnancy and childbirth uncovers further 'scientific reasoning' behind patriarchal influences.[14] For example, theories included the notion that the female should be happy, cheerful, and moderate in order to conceive, and that too much sexual activity would destroy the chances of maintaining a foetus in the womb. A full pregnancy and birth of a healthy child therefore demonstrated good moral behaviour. Alternatively, an unhealthy child would be seen as evidence of bad female behaviour. We see here the foundations of contemporary assumptions that 'good mothers' are 'model women', authentically living in accordance with their destiny and inherent identity. Women who did not conform to this ideal were considered 'monstrous',[15]

[7] R (TT) v Registrar General for England and Wales v AIRE Centre [2019] 3 WLR 1195; R (McConnell and YY) v Registrar General for England and Wales [2020] EWCA Civ 559.

[8] See Smart 1989.

[9] As Baron 2019 notes, our historical evidence or data is limited: "The historical record, of course, reflects the views of those who were politically and structurally dominant; we know comparatively little about women's views of pregnancy during Antiquity and the Middle Ages" (493).

[10] For Aristotle, the foetus "behaves like seeds sown in the ground… [its] growth … supplied through the umbilicus in the same way that the plant's growth is supplied through its roots" (Connell 2016: 129) – though Connell has recently changed view on this.

[11] Kingma 2019 argues that the recent version of this idea "is contingent on particular historically situated social developments and often on gendered and classed power-structures" (614).

[12] See also Katz-Rothman 1994 who states: "The perception of the fetus as a person separate from the mother draws its roots from patriarchal ideology, and can be documented at least as far back as the early use of the microscope to see the homunculus" (105).

[13] See Romanis et al 2021: 821. See also v R R. 1 AC 599, H.L 1991.

[14] Fox 2022.

[15] "From classical times, theologians and physicians declared barren women to be monstrous" (Romanis et al 2021: 821).

and as Kingma and Woollard argue, we still encounter a "heavily gendered cultural ideal of motherhood", which we can trace back through this long history of control over the female body.[16]

In the nineteenth century, a strong legislative momentum in all areas of law developed. The enactment of the Offences Against the Person Act 1861 was a landmark in the legislative agenda for many reasons. In particular, it made abortion a criminal offence and this law remains on the statute books today. Such legislative enthusiasm continued into the twentieth century. Acts of Parliament became more specifically targeted at pregnant women and new mothers. Notably, the Infant Life (Preservation) Act 1929 and the Infanticide Act 1938 emphasise the protection of the foetus and neonate, and, in 1967, the Abortion Act created defences to the termination of pregnancy. Current legislation[17] covers an ever-broadening range of reproductive issues such as technological and medical advances, and, as a result, the last 50 years or so have transformed who can be pregnant, how they can behave, and what choices they have during and after pregnancy.

3. Pregnancy as a Transformative Experience

In the paper 'What You Can't Expect When You're Expecting', L.A. Paul[18] argued that you cannot rationally choose to become a parent on the basis of what you think being a parent might be like for you because becoming a parent for the first time is what Paul describes as a 'transformative experience'. Whilst Paul's paper predominantly refers to the experience of 'becoming a parent' quite broadly, there are of course lots of different parts of the process that this could encapsulate. Woollard[19] focuses on the experience of being pregnant, arguing that pregnancy is a transformative experience in the way that Paul describes. In this paper, we too will focus on pregnancy, and will analyse what Paul and Woollard mean in taking pregnancy to be a transformative experience, critiquing what might be concluded as a resulting lack of autonomy in decision making about pregnancy.

'Transformative experience' is a philosophical term of art, defined by Paul as an experience that is both epistemically transformative and personally transformative (which again are terms of art). An epistemically transformative experience is one that Paul describes as one that "teaches you something you could not have learned without having that kind of experience".[20] Then, as a result of having the experience, "[your] knowledge of what [it] is like, and thus [your] point of view, changes".[21] So, an epistemic transformation transforms your knowledge. A transformative experience, however, also transforms you personally. A personally transformative experience is one that, according to Paul, "may change your personal phenomenology in deep and far-reaching ways"[22] such that you yourself are transformed. The experience "radically changes what it is like to be you, perhaps by replacing your core preferences with very different ones".[23] Ullmann-Margalit had argued prior to Paul that "in these instances a person's inner core of beliefs and desires does not simply gradually evolve but undergoes, instead, an abrupt transformation".[24] Experiences that

[16] Kingma and Woollard (forthcoming). See also Hays 1998; Bueskens 2018; Kukla 2005; Mullin 2005.
[17] See, for example, Adoption and Children Act 2002; Congenital Diseases (Civil Liability) Act 1976; Human Fertilisation and Embryology Act 1990; Human Fertilisation and Embryology Act 2008; Human Reproductive Cloning Act 2001; Human Tissue Act 2004; Surrogacy Act 1985.
[18] Paul 2015.
[19] Woollard 2021.
[20] Paul 2015: 476.
[21] Paul 2014: 16.
[22] Paul 2015: 156.
[23] Paul 2015: 156.
[24] Ullmann-Margalit 2006: 159.

encapsulate such transformation pose a problem regarding how we ordinarily may choose to undergo an experience, as they present "choices that straddle two discontinuous personalities with two different rationality bases".[25] As such, one cannot rationally choose to have a transformative experience on the basis of what one thinks it might be like.

Having children and being pregnant (as Paul and Woollard argue, respectively) are examples of these transformative experiences, since they meet the conditions of being epistemically and personally transformative.[26] In terms of the epistemic transformation of what you know, they say that the experience "is not projectable",[27] as the experience is unknown and cannot be known prior to having the experience itself. And once it is known through the experience, it will radically change your point of view among other aspects of you personally, such that you also undergo personal transformation.[28]

As a result of being both epistemically and personally transformative, the argument goes that one cannot rationally choose to become pregnant or have children via considering what the experiences would be like, for one cannot know what the experience is like, nor what one's future self is like. This arguably puts some pressure on those who want to maintain the decision-making capacities of those who become pregnant, and it is this that we will be responding to. If one cannot rationally choose to become pregnant or have a child based on what it is like, then can one rationally choose what happens to oneself once one is pregnant or has a child? We do not argue against the theories of transformative experience, but rather consider a broader understanding of what it means for pregnancy to be considered transformative. It may not be just becoming pregnant that is transformative, but what becomes of the pregnant person too in their social context. We will describe the transformation pregnancy has (in practice) on a person's autonomy, agency, and control over their body, recognising that whilst this is contingent and descriptive of how things happen to be, they need not and ought not be the case. The epistemic power and personal choice to become pregnant, stay pregnant, or end a pregnancy, must be restored to the pregnant person themselves.

4. Legal Feminist Critique

The starting point in law, at least in liberal democracies governed by the rule of law, is that we have rights over our own body. Put negatively, this body is not to be touched without our consent. Legally, unwanted touching is, at least, assault and can be rape. Put positively, the law assumes we are in control of our body and so have a right to stop others touching us. This biological body has legal rights and obligations, and they generally attach to the legal person bounded by that body. In the liberal legal tradition (though hotly debated in philosophy), it is this body in which the mind resides, and it is in the mind where rational decisions take place. In legal thought, law privileges this person, the one in their so-called 'right mind', deemed capable of making choices in life, and planning for their future in ways that are deemed reasonable and rational, or otherwise, with attendant responsibilities.[29]

This is an individualised human, a person who is detached, unencumbered from circumstances, family, abstracted from place and time, independent and self-sufficient. This is the normative framing of the person of law and in much Western philosophy. In Locke's vision of rights, ownership over our bodies starts from the subjective experience of one's own

[25] Ullmann-Margalit 2006: 167.
[26] Though Paul 2015 concedes that "[T]he claim that having a child is epistemically transformative does not entail that it is also personally transformative: for most people, it is. For some people, it isn't" (fn.21 p.161).
[27] Paul 2015: 155.
[28] Paul 2015: 156-7.
[29] Rousseau 1974.

body and what we choose to do with it.[30] The importance of bodily autonomy is also present in other historical philosophers' works. Kant explains that no human should be used as a means or object of another,[31] while Mill's paramountcy of individual choice and consent makes clear that unless we harm others, it is not the law's business to interfere in our life choices.[32] This traditional liberal representation of the human person is the starting point for the legal principles of bodily autonomy, privacy, and individual choice enshrined in legal systems. This includes the importance of non-invasion and non-intrusion into our private lives, including our bodies, without our consent.

Communitarians[33] and cultural (or ethic of care) feminist legal theorists[34] critique this version of the person represented in law. Communitarians describe this abstracted human as 'atomised' and 'unencumbered' from our bodies, our situations, and society.[35] Many feminists highlight the gendered nature of this person and explain that it causes problems for those bodies which do not fit into the norm of the detached, independent, decontextualised person of the law, and that includes pregnant (and women's) bodies. They argue that it is empirically impossible and untrue to say persons are detached, independent, unencumbered. Further, even if this presents a normative view of the person, not meant to be sociologically or empirically realistic, it is not attractive as a standard to be achieved and should be changed.

Writing in the 1980s, West analyses the view of the human represented in legal theory. She maps out liberal legalism's view of the human and states that this correlates to the radical feminist view of the human. They both, says West, assume that individuals are essentially separate from one another. For radical feminism, harm to women is caused by unwanted intrusion, particularly by a foetus (which radical legal feminist MacKinnon describes as "more like a parasite than a part"[36]), and by unwanted sexual contact.

In common with liberal legal theory, human subjects are presented as craving a sense of non-interference from others. What is valued is an autonomous individual, one who is free because they are independently separate from others, can be left alone to choose and enjoy their own lifestyles, and to exercise voluntary choices through the satisfaction of subjective desires and preferences. This is what West names the 'separation thesis', the 'official story' of legal theory. In contrast, the 'unofficial story' of legal theory is presented by cultural feminists and critical legal scholars: what is craved instead is connection, care, sharing, interdependence, and attachment, both materially and existentially.

Even if maximisation of self-welfare as the motivations for actions is true of men, cultural feminism argues this is not true for women. West sets out four recurring ways this is not accurate for women who are connected, materially and existentially, to others: through the biologically based activities of pregnancy, menstruation, breast feeding, and heterosexual intercourse. On this account, because of the sense of connection felt by women, women's lives are not autonomous in the way which may be true for men. The legal system and legal language therefore fails women. The law fails to represent women's sense of connection, fear of separation, fear of lack of intimacy, and women's sharing and caring experiences. The law fails to view harms in the same way that women view harms. This is a view that therefore does not want to uphold the autonomous individual as an aspiration. Being pregnant does not

[30] Locke 1988.
[31] Kant 1988.
[32] Mill 1991.
[33] Taylor 1992; Sandel 1998.
[34] West 1988.
[35] Taylor 1992; Sandel 1998. See also analysis by Frazer and Lacey 1993.
[36] MacKinnon 1991: 1314.

fit with this version of the person. If this autonomous individual is the norm, those pregnant will never meet the norm and always be disadvantaged.

It must be possible to have control over one's own body and things that happen within it or to it, without needing to hold onto atomistic versions of autonomy. Other feminist legal theorists are keen to stress the importance of relationships and interdependence in *developing* the capacity for agency. Autonomy does not have to mean isolation: it is formed and exists because of relationships that provide support and guidance.[37] As such, pregnancy is not (or *should not be*) in conflict with the pregnant person's autonomy. Decisions to become and remain pregnant must (or *ought to*) be viewed as matters of choice and agency, contra what one might conclude from the transformativity of the experience. Yet, in practice, once pregnant we *do* see a shift, philosophically and legally, with respect to the autonomy the pregnant person can exercise over their body, and it is this transformation that we will now explore.

5. Transformation from Private to Public

A primary theme in feminist literature is analysis of the different spheres of the public and private.[38] Women are said to be generally assigned to the latter, the bodily and domestic sphere of the home and family, which requires women as wives and mothers in the family.[39] This is echoed historically since at least the times of Socrates, who compared himself to a midwife helping others to birth their ideas: "[M]y art of midwifery is just like theirs in most respects. The difference is that I attend to men and not women, and that I watch over the labour of their souls, not of their bodies".[40] Here we see a sharp distinction between the public sphere of philosophy (occupied by men and the mind) and the private sphere of the family (occupied by women and the body), and the contradictory placement of pregnancy across the divide. Once known to be pregnant, there appear to be two transformations that are in tension with each other. Firstly, behaviour is expected to conform to stereotypes of the good (pregnant) woman with visions of homely private bliss away from the marketplace,[41] yet, secondly, the state has much more control over a pregnant person's life (with other members of the public, like the midwife, 'attending' to them and much more legal regulation of their bodies).

This division is political, illustrating the perceived shortcomings of political systems, particularly liberalism, which is claimed to create and rely upon it, detrimentally affecting women's lack of choices in ways of living our lives. An ideology of motherhood plays an important role in viewing women as somehow separate, meaning deviant or different, and 'other' in comparison to 'normal' citizens (where the man is 'neutral' and, in Beauvoir's terms, the woman is the 'second sex'[42]): this is especially evident when pregnant and becoming a mother, although most literature fails to distinguish the two.[43] This affects women's autonomy because they are not seen as persons in their own right, with choices to make about ways of being and living, including (and especially so) during their pregnancies.

Known pregnancy invokes state intervention, transforming the classical representation of the individual in the private sphere making their own choices to the public sphere regulated by law. The private person with rights over their own body becomes state property

[37] See Nedelsky 1989; MacKenzie and Stoljar 2000; Jackson 2001.
[38] See analysis in O'Donovan and Marshall 2006; O'Donovan 1985; Pateman 1988; Olsen 1995; Lacey 1998.
[39] Okin 1979; 1989.
[40] Plato 1997: 167.
[41] Olsen 1995.
[42] Beauvoir 2015.
[43] See O'Donovan and Marshall 2006.

(or at least someone for whom there must be state involvement in the pregnancy process). Such involvement may be well-meaning, wanted, and supportive: nurses, medical profession, welfare provisions in the form of medical treatment, so forth. It may, however, be unwanted and intrusive: effectively policing pregnancy, with bodily surveillance. The pregnant person gets transformed from a private individual as an autonomous agent with rights over their own body into public property who is expected to act in specific ways and make decisions about their body, which contravenes individual agency and autonomy. Pregnancy, which should be sovereign to the private space of the pregnant person, becomes a public experience influenced by several (f)actors, as we will now evidence through examples of case law.

6. The Principle of Bodily Autonomy in Medical Law

UK case law has firmly defended the rights of those of sound mind to determine what shall be done with their bodies. In *Airedale NHS Trust v Bland*, Lord Goff confirmed "the principle of self-determination requires that respect must be given to the wishes of the patient"[44] and those wishes are respected even if they are to result in the individual's death.[45] A refusal of medical treatment by a person of sound mind must be respected irrespective of whether such a decision is "rational, irrational, unknown or even non-existent".[46]

Additionally, the principles of self-determination and autonomy form the guiding philosophy of the Mental Capacity Act 2005 (MCA 2005), which governs decision-making for those who lack capacity. An overriding principle of the Act is that every person must be assumed to have capacity unless established otherwise.[47] With the provision of appointing a Lasting Power of Attorney[48] or preparing an advance directive,[49] individuals are empowered to exercise their desires and wishes after the point at which they have lost capacity.

The principle of autonomy has also become more evident in the relationship between doctors and patients. Cases surrounding issues of medical negligence and failure to disclose risks were largely determined by the views of medical professionals,[50] emphasising a 'doctor knows best' approach. However, the courts began to move away from a blind reliance on the views of medical experts and became open to questioning illogical evidence.[51] The centralising of patient autonomy was then firmly established in the case of *Montgomery v Lanarkshire Health Board*.[52]

As such, the principle of bodily autonomy is a key pillar in medical law. However, as we shall show in the following sections, this is often overruled in practice when it comes to considerations of capacity (section 7), considerations of the foetus (section 8), and considerations of mental health (section 9).

7. Considerations of Capacity

Despite the theoretical universality of the principles of autonomy and agency, in practice, these are not fully upheld for pregnant persons. Pregnancy is first delineated from the general legal position that competent individuals are free to refuse medical treatment in

[44] [1993] AC 789, 864.
[45] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 120-121. For an example of how this principle has been upheld, see *Re B (Adult: Refusal of Treatment)* [2002] EWHC 429 (Fam).
[46] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102.
[47] MCA 2005 s 1(2).
[48] MCA 2005 s 9.
[49] MCA 2005 s 24.
[50] Bolam v Friern Hospital Management Committee [1957] WLR 582.
[51] Bolitho v City & Hackney Health Authority [1997] 3 WLR 1151.
[52] [2015] UKSC 11 [108]

Re T (Adult: Refusal of Treatment).[53] This case concerned the refusal of a blood transfusion. However, in confirming that those with capacity have an absolute right to refuse medical treatment, Lord Donaldson stated that "the only possible qualification is a case in which the choice may lead to the death of a viable foetus".[54] This remark left open the possibility that a pregnant person refusing medical treatment may have their decision (and thereby their bodily autonomy) overridden for the benefit of a foetus. Such a case came to fruition in *Re S (Adult: Refusal of Treatment)*,[55] when S refused to undergo a caesarean section at full term. In finding that doctors could perform the caesarean despite S's refusal, there was no assessment of her capacity and the decision was heavily weighted towards saving the life of the foetus.[56] These cases suggest that in being pregnant, an individual's autonomy to refuse medical treatment is compromised.

In cases that followed, capacity assessments were undertaken, but were criticised for rendering pregnant persons as "a new class of incompetent adults".[57] In *Norfolk and Norwich Healthcare (NHS) Trust v W*, a pregnant woman was considered unable to exercise capacity due to the "acute emotional stress and physical pain"[58] associated with labour. This created a presumption that anyone in labour did not have the capacity to refuse medical treatment.

In the relatively rare case that a pregnant person lacks capacity, decisions will be made on their behalf by the courts, with a highly significant, if not leading, role for expert medical evidence. Under s4 MCA 2005, those decisions should be made in the pregnant person's best interests, as they are the person upon whom the decision focuses. That said, the foetus has emerged as a central consideration in the application of the best interest's test. This is not in itself inherently morally objectionable, but it does raise legal difficulties in the further enforcement of normative ideals, presented as objective decision making. One such norm is the attachment of the welfare of the pregnant person to the delivery of a healthy child, and the assumption that a caring social motherhood will follow, to the benefit of the mother. This is a recurrent theme across the case law, as seen in *Re MB (Adult: Medical Treatment)*;[59] *Re L (Patient: Non- consensual treatment)*;[60] *Re AA*;[61] *in the matter of P*;[62] and *Great Western Hospitals NHS Foundation Trust v AA*.[63] In *Norfolk and Norwich v W*.[64] Johnson J went so far as to say he wished to protect W from future feelings of guilt, which he imagined would follow, should W's refusal of treatment be accepted.

These cases are complex and involve a wide spectrum of what it means to 'lack capacity'. In *Re MB*, MB's needle phobia prevented her from accepting anaesthesia, which would enable a caesarean section. Elsewhere, in *Bolton Hospitals NHS Trust v O*,[65] O wished for the Court to declare her without capacity, so that she could receive medical treatment despite her Post Traumatic Stress Disorder, which caused her to refuse the necessary obstetric care.

[53] [1993] Fam 95.
[54] [1993] Fam 102.
[55] [1992] 3 WLR 806.
[56] [1992] 3 WLR 807; at para C the judge places emphasis on the caesarean being the only means of saving the life of the unborn child.
[57] Wei 2016.
[58] Norfolk and Norwich Healthcare (NHS) Trust v W [1996] 2 FLR 613, 616; see also Rochdale Healthcare NHS Trust v C [1997] 1 FCR 274.
[59] [1997] 2 FCR 541.
[60] [1997] 2 FLR 837.
[61] [2012] EWHC 4378 (CoP).
[62] [2013] EWHC 4541 (CoP).
[63] [2014] EWHC 123 (Fam).
[64] [1997] 2 FCR 269.
[65] [2003] 1 FLR 824.

In contrast, W in *Norfolk and Norwich v W* did not recognise her pregnancy, despite being fully dilated. In such a case, to tie the welfare of a vulnerable patient to the safe delivery of a child and the promise of future motherhood seems at best wishful thinking and at worst a transformation of a gestator into a public good, rather than a private person with potentially considerable healthcare needs. The same end of an enforced caesarean section would have been possible to reach by alternative means, such as a stronger appeal to the risk to W's own life or a wish to spare W the considerable distress of going through labour while also in denial of the pregnancy. As can be seen in these cases, the foetus has become central to the decisions made about pregnant person's bodies and it is to this heightened status of the foetus that we now turn.

8. Considerations of the Foetus

It is hotly debated in philosophy and law as to whether the foetus meets certain conditions to qualify as a 'person'.[66] Despite there being no consensus on this, in practice, some have emphasised the transformation of the foetus to 'super subject',[67] which places the foetus beyond 'person' and beyond 'second patient'[68] and thereby beyond the pregnant person. This demonstrates the widening gap between the perceived importance of the foetus and the importance of the pregnant person and the rights they enjoy. This point is well put by Purdy, who describes pregnant persons as "second-class citizens who are tacitly excluded from supposedly universal rights whenever convenient,"[69] which is perhaps both true relative to the 'first-class' status of the foetus and true objectively within society and legal practice more generally.

It is important to note that the foetus is not a legal person in its own right, though it is protected by law in some regards.[70] For example, under section 58 of the Offences Against the Persons Act 1861, the administration of drugs or use of instruments to procure a miscarriage are proscribed. In order for a pregnant person to obtain an abortion, they must seek the approval of two registered medical practitioners.[71] Whilst the courts have confirmed that a foetus is not a person and does not have legal personality,[72] they have conceded that the foetus is a "unique organism"[73] and (quite unhelpfully) that it is "not nothing".[74] What this overlooks, however, is that regardless of the uniqueness of the organism, and regardless of its potential status as a person, it is quite literally within and of another organism—a person—namely, the gestator.[75] Furthermore, if we were to understand the foetus as being *a part of* the gestator, as Kingma has recently argued, then flanking considerations of the foetus as opposed to considerations of the pregnant person no longer makes sense.[76]

Judicial findings of a lack of capacity, linked to the health of the foetus in many of these cases, can be interpreted as being driven by an underlying assumption of what a 'good'

[66] This is most clearly evident in the abortion debates where the moral status of the foetus as a person is questioned. See, for example, Marquis 1989; Tooley 1972; and Boonin 2003: chapters 2 and 3.
[67] Bordo 1993: 88.
[68] See Chervenak and McCullough 1996.
[69] Purdy 1990: 289.
[70] For example, via the Abortion Act 1967, HEFAs etc.
[71] Abortion Act 1967, s1. Amongst other things the provisions include that the pregnancy has not surpassed 24 weeks and continuing with the pregnancy would cause injury to the physical or mental health of the pregnant individual.
[72] *Paton v British Pregnancy Advisory Service Trustees and Another* [1978] 3 WLR 687, 279.
[73] *Attorney General's Reference (No. 3 of 1994)* [1998] AC 245, 256.
[74] *St. George's Healthcare N.H.S. Trust v S; R v Collins and Others [1999] Fam 26*, 45.
[75] "Literally, if not conceptually, the pregnant woman incorporates the fetus, so direct medical access to the fetal patient is as remote as ever" (Mattingly 1992: 16).
[76] Kingma 2019.

mother would do. For example, in *Rochdale Healthcare NHS Trust v C*, the judge implied that any woman willing to accept her own death and that of the foetus could not possibly have capacity.[77] On appeal, when it was found that a pregnant woman had been subjected to unlawful detention and treatment, her refusal of a caesarean section was still described as "unusual and unreasonable".[78] This presents an ideal of the good pregnant mother: an abstracted idealised version of a gestator, one who should behave in a particular way for her own good and for the good of the foetus. Rather than the decision-making remaining within the remit of the pregnant person's wants and desires, decisions are subject to external normative ideals. This is particularly evident when the state intervenes due to considerations of mental health or the mental state of the pregnant person, which we will now consider in more detail.

9. Considerations of Mental Health

Mechanisms by which public and state interest can be exercised over pregnant persons include the use of the mental capacity law (as discussed in section 7 above) and mental health law as we will now describe. The extent to which these legal powers may be used can, in more extreme instances, go so far as physical restraint or even a deprivation of liberty.[79] The physical integrity of the person is protected by law through the principle of consent, and this remains, officially, the case for the pregnant person. However, the extent to which this is true in practice alters when the discussion is framed around the brain or the mind of the pregnant person.[80]

Historically, law has given credibility to the popular notion of the 'hysterical woman'.[81] This narrative found particularly fruitful ground in the context of women's reproductive lives. An example of this prejudice against pregnant women receiving legitimacy in statute can be found in the Mental Deficiency Act 1913 (for which at that time it was legally impossible and more-or-less unthinkable for men to be pregnant). Under s2(b)(vi), "feeble-minded"[82] unmarried women who gave birth while also receiving poor relief were to be confined to an asylum. Local authorities at the time could take the co-existence of these facts as proof enough of 'feeble-minded' mental status.[83] While the views of state and society have changed dramatically in many respects since 1913, the intermingling of perceptions of mental health and mental capacity with how pregnancy ought to be conducted remain.[84]

The use of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (MHA 1983) and the MCA 2005, show that the law no longer uses terms such as 'feeble-mindedness' to describe pregnant persons who are brought within state control. However,

[77] Rochdale (n 11) 275.
[78] St. George's Healthcare N.H.S. Trust v S; R v Collins and Others [1999] Fam 26, 56.
[79] See NHS 1, NHS 2 v FG (2014) for the first time this was formally identified as a category, which also gives an indication of numbers.
[80] The use of mental health and mental capacity law also features in medical interventions for non-pregnant persons, but the means by which this happens is highly specific and, we would argue, under-explored for pregnant persons.
[81] As Romanis et al 2021 state: "Once human dissection showed plainly that wombs were not apt literally to suffocate or wander around the body, Victorian doctors recast the womb as the cause of hysteria. The womb disordered the female brain. We hear a great deal about 'baby brain' today and cognitive impairment in the menopause" (822). See also Abbott 1993.
[82] 'Feeble-minded persons' are defined by the Act at s1(c) as "persons in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision, and control for their own protection or for the protection of others…".
[83] Zedner 1991: 275.
[84] Bartlett and Sandland 2014: 16.

treatment for long term psychiatric care has, in the case of those who are pregnant, been extended so far as to include enforced caesarean sections and obstetric care.[85]

Law controls many persons on the basis of their mental state. However, the way it treats those who are pregnant is especially worthy of consideration because mental health law is used to control their physical treatment, in a way which does not apply to other persons who are detained under the MHA 1983 or lack capacity under the MCA 2005. For example, in *Tameside and Glossop v CH*[86] and *NHS Trust 1, NHS Trust 2 v FG*,[87] pregnant women were forced to receive a caesarean section, on the grounds of their psychiatric condition, using MHA 1983. They therefore lose the protection of the right to refuse medical care under the MCA 2005, at a time when they may yet have capacity to do so. This is because detention under the MHA 1983 does not necessarily mean that a person lacks capacity. An individual can suffer from a psychiatric condition, while also being able to hold, and act upon, legitimate values as to how they wish to live.

The pregnant person who receives enforced obstetric care via detention under the MHA 1983 is therefore transformed, in law, from an individual who needs psychiatric care to one who also needs physical care. Again, it is not inherently the outcome which is the problem here, but the means by which law achieves that outcome.

Recall Lady Hale in *Montgomery v Lanarkshire Health Board (2015)*: "Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being".[88] Here, Lady Hale indicates that there was a time when pregnancy did transform a woman in this way. Prima facie, this is no longer true. However, the complicated contemporary use of mental health and mental capacity law outlined above suggests that some pregnant persons may still be vulnerable to this transformation in law.

10. Transformations through Medicine and Technology

As we have seen, our concept of pregnancy transforms and differs with respect to time and place. An emerging site of transformation is within the technological realm of medicine, which not only transforms what pregnancy can be like, but further transforms the agency that the pregnant person has over their body through the involvement of external factors such as medical professionals and technological interventions.

Before the advance of reproductive technologies, particularly prenatal tests and ultrasound scans, the pregnant person was the main information provider in relation to how the pregnancy was progressing.[89] It was their description of bodily sensations and symptoms which would lead doctors to determine whether and which treatment was necessary. However, as technology advanced, pregnant persons became reliant on medical professionals to interpret the results of tests and scans.[90] Rather than relying on their own bodies, pregnant persons sought assurance of foetal health through these technologies[91] and, as a result, the doctor's presence during the pregnancy became more pronounced. This has led to what has become known as the "medicalisation of pregnancy",[92] which follows on from a long history

[85] Tameside and Glossop v CH [1996] 1 FLR 762; St Georges Healthcare NHS Trust v S [1998] £ WLR 936; NHS Trust 1, NHS Trust 2 v FG [2014] EWCOP 30.
[86] *Tameside and Glossop v CH* [1996] 1 FLR 762.
[87] *NHS Trust 1, NHS Trust 2 v FG* [2014] EWCOP 30.
[88] Montgomery v Lanarkshire Health Board [2015] UKSC 11.
[89] Jackson 2001: 126-8.
[90] Adkins 2020: 239-40.
[91] Harpel 2008; Hammer and Burton-Jeangros 2013.
[92] Holm 2009.

of women's reproductive processes firstly falling outside of the medical domain to then being classified itself as disease.[93]

As Young has described it, pregnancy becomes "an objective, observable process coming under scientific scrutiny…as a 'condition' in which the pregnant person must 'take care of herself'".[94] But care-taking implies a level of agency, which, as Young goes on to point out, is diminished as a result of "the control over knowledge about the pregnancy and birth process that the physician has through instruments".[95] Therefore, rather than individuals expressing their full agency during their pregnancy, their experience and decision-making is moulded by the interpretation of test results by doctors, and thereby the management of their pregnancy is influenced strongly by or, in some cases, even delegated to others.[96]

Sometimes these outside interventions are called for in the name of the health of the pregnant person, whose pregnancy becomes medicalised. Romanis et al have detailed how the reproductive system has, throughout history, been subject to "outside interference", causing the womb to become centred as the cause of "female ills".[97] As a result, we have seen huge advancements in assisted reproductive technologies that seek to 'free' the female population from the 'ills' of pregnancy by outsourcing reproduction to machines. In addition, evolving practices such as in-vitro fertilisation (IVF) and pre-implantation genetic diagnosis (PGD) mean that even the *conception* of pregnancies can be managed by technology and medical practitioners. Doctors and specialists therefore become key to the reproductive journey from its very beginning. At the conclusion of a pregnancy, midwives and obstetricians are often heavily involved in childbirth and, in unfortunate cases where the infant is born prematurely, neonatologists play a key role in ensuring the survival of the resulting child. We can then see quite easily how the advancement of medical technology in the reproductive sphere has encouraged pregnancy to become a joint enterprise between the pregnant person and their healthcare professionals.

The progression of ultrasound technology in particular has resulted in the foetus becoming more visibly present during gestation, leading to the foetus being considered as a second patient, separate from its embodiment within the pregnant person.[98] Indeed, rather than the foetus being seen *as* a foetus (as opposed to, say, the baby that the foetus may in some sense become), ultrasounds are presented as the "baby's first picture".[99] An effect (or arguably also a purpose) of these sonograms is to "see through" the pregnant person's body so that they can "hardly be seen at all".[100] Sandelowski argues this manifests in "minimizing pregnant women's special relationship to the fetus while maximizing their responsibility for fetal health and well-being".[101]

Prior to ultrasounds, there was no such public 'access' to the foetus, which remained private and unique to the pregnant person, and historically this inaccessibility contributed to "rampant speculation about women and their pregnancies".[102] As Romanis et al describe: "From classical times, the womb garnered suspicion and fear among 'medical men', theologians and ordinary people partly because it was obscured from their view".[103]

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[93] "Indeed, by the mid-19th century, at least in Victorian England and America, being female itself was symptomatic of disease" (Young 1984: 55).
[94] Young 1984: 45.
[95] Young 1984: 46.
[96] Adkins 2020.
[97] Romanis et al 2021: 820-1.
[98] Jackson 2001.
[99] Mitchell 2001.
[100] Sandelowski 1994: 240.
[101] Sandelowski 1994: 231.
[102] Romanis et al 2021: 822.
[103] Romanis et al 2021: 820.

Twentieth-century advances in medical technology brought the womb into view, but this did not end the suspicion that pregnant persons faced, rather it served the narrative of suspicion and resolved it by taking the pregnancy into the medical practitioner's hands.[104] Furthermore, this "increased public presence of the foetus"[105] contributed to shaping the public discussion of abortion[106] in the late twentieth century, resulting in further control over the pregnant person's body.

If twentieth-century technology, which grants visual access to the womb, has allowed interference with the agency and autonomy of the pregnant person, what will be the impact of our more recent technology, namely, 'ectogenesis', which seeks to replicate the womb entirely? It has been claimed by some that ectogenesis, particularly in its fullest form, will free women from the tyranny of their pregnancies and grant them the freedoms enjoyed by men.[107] But how do these narratives correlate with those who argue against the heavy involvement of healthcare professionals in natural pregnancies? Whilst the medicalisation of pregnancy has resulted in the involvement of healthcare professionals now being considered the 'norm', it is noteworthy that the success of technology such as ectogenesis, whether it be full or partial, will depend on the involvement of large teams of healthcare professionals and specialists. In order for individuals to enjoy the apparent freedoms associated with ectogenesis, the responsibility for the foetus during its gestation must therefore be transferred to those managing the technology. As a result, it seems that in gaining one type of autonomy (the freedom from gestation), individuals would be sacrificing the autonomy relating to the care of their foetus. Is this what liberation looks like? Or rather does this technology represent a new form of control in allowing medical institutions further power over the reproductive processes?

This analysis suggests, then, that we should be wary of heralding technology as the route towards liberation, given its propensity towards the "exacerbation of maternal-fetal conflict and medical hegemony over women's choices"[108] and the "pathologisation of aspects of female physiology",[109] which lead to the "labelling of the female body as a source of danger and an 'imperfect' site of gestation".[110] It is oppressive to women and pregnant persons to limit the autonomy, agency, and control that they are afforded and, as we have shown, advancements in technology have contributed (among other things) to limiting it further.

Conclusion

We have provided a historical account of the transformation of pregnancy through philosophical theory and legal practice. What has remained seemingly consistent, though, is the lack of rights the pregnant person can enjoy. Whilst it may manifest differently across time and place, unfortunately "patriarchy has not dissolved and neither have the traditional stereotypes of pregnancy and maternity".[111] Misogynistic attitudes persist, and this is reflected in the continual degrading of the gestator (and gestation) which is reinforced by

[104] Romanis et al 2021: 822.
[105] Hartouni 1998: 131.
[106] See Baron 2019: 495.
[107] See, for example, Smajdor 2012; Kendal 2015; MacKay 2020; Cavaliere 2020. Most notably, Firestone 1974 declared the processes of pregnancy and birth "barbaric" (198), and concluded that full ectogenesis (although she did not call it by this name) was a necessary, though not sufficient, part of the solution. See Finn and Isaac 2021 for arguments against this.
[108] Romanis et al 2021: 820.
[109] Romanis et al 2021: 822.
[110] Romanis et al 2021: 820.
[111] Oliver 2010: 761.

certain philosophical theorising and technological advancement. We must therefore be cautious in making philosophical claims about the epistemic transformation in pregnancy, given the epistemic (and other) injustices already faced by pregnant people.[112] We have recognised that there *are* transformations that occur because of pregnancy, but we have argued that there *ought not be* with respect to the pregnant person's autonomy, agency, and control over their bodies. Through an analysis of legal cases, we can see that the practice falls out of line with the theory regarding how pregnant people are treated. But perhaps it is both the theory and the practice that need to change so as to bring them in line. How we theorize about pregnancy is intertwined with our cultural views, our technological advancements, and our medical and legal practices, requiring multi-disciplinary study for a more holistic overview. In this paper, we hope to have contributed to this endeavour in bringing some such strands together, regarding the transformation that pregnancy *is*, that pregnancy *makes*, and that pregnancy has *had* historically, in philosophy, and legal practice.

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[112] Barnes 2021 argues that pregnancy as epistemically transformative can be a matter of epistemic injustice.

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