

2014

Hospitality and Maternal Consent

Jane Lymer
University of Wollongong

Fiona Utley
University of New England

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Recommended Citation

Lymer, Jane and Utley, Fiona, Hospitality and Maternal Consent, *Law Text Culture*, 17, 2013, 240-272.

Available at: <https://ro.uow.edu.au/ltc/vol17/iss1/12>

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Abstract

'Law is not justice. Law is the element of calculation, and it is just that there be law, but justice is incalculable, it demands that one calculate with the incalculable; and aporetic experiences are the experiences, as improbable as they are necessary, of justice, that is to say of moments in which the decision between just and unjust is never insured by a rule' (Derrida 2010: 244). There is a growing literature outlining deep concerns that a woman's basic right to give informed consent and, consequently, the capacity to determine what happens to her body, that is, herself, in the course of her own medical care, is being compromised. Covering a range of jurisdictions, but in particular reflecting on the US situation, concerns range from a perceived extortion of consent from uninformed and often unwilling women (Baker 2009-2010), to accusations of the perpetuation of violence against women by the obstetric profession as a whole (Charles 2011), and, in some cases, obstetricians and hospitals are choosing to request court orders to perform medical interventions that override an autonomous women's informed consent on the basis of a growing conception of 'foetal rights'. These moral rights are situated as being in perceived conflict with a woman's legal right to decide what happens to her body and, increasingly, there is medical and political pressure being brought to bear upon the law to attend to this moral dilemma in a range of cases.

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Jane Lymer and Fiona Utley

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There is a growing literature outlining deep concerns that a woman's basic right to give informed consent and, consequently, the capacity to determine what happens to her body, that is, herself, in the course of her own medical care, is being compromised. Covering a range of jurisdictions, but in particular reflecting on the US situation, concerns range from a perceived extortion of consent from uninformed and often unwilling women (Baker 2009-2010), to accusations of the perpetuation of violence against women by the obstetric profession as a whole (Charles 2011), and, in some cases, obstetricians and hospitals are choosing to request court orders to perform medical interventions that override an autonomous women's informed consent on the basis of a growing conception of 'foetal rights'. These moral rights are situated as being in perceived conflict with a woman's legal right to decide what happens to her body and, increasingly, there is medical and political pressure being brought to bear upon the law to attend to this moral dilemma in a range of cases.

In this article we will approach the issue of conflicting legal maternal rights and foetal moral rights through Jacques Derrida's

conception of hospitality as a way of opening up discussion of what is at stake, ethically, when force is used, in the form of legal interventions to do with pregnant women's choices. While there is seemingly some sort of a continuum between what is ethical and what is legal, for Derrida, the two areas compete for recognition, and can thus interfere with the instantiation of the other. As such, this framework is particularly apt to this ethical dilemma as it is currently unfolding in multiple jurisdictions albeit at differing levels of substantiation.

Hospitality for Derrida is a negotiation that, while being defined by an unconditional welcome to the guest who enters, must become conditional in order to function. That is, the welcome offered to the guest must be limited by the conditions that govern how the guest will 'properly' use the house in order to *be* welcome. For Derrida, ethics is the capacity to unconditionally welcome or to remain open to the guest in such a way as to allow the guest to be himself, comfortable within his particularity and his particular quirks, while experiencing as the host, a sense of strangeness that does not attempt to reduce or limit or eroticise the unfamiliar, what is foreign about this guest. To be in a relationship of ethical hospitality is thus to be in a relationship of ethical proximity with this strangeness which, put simply, is respect for a particular and personal embodied experience.

Negotiating the practical conditions for an ethical and yet functioning hospitality must lead to a bounded 'indeterminacy' in the practice of the ethics of hospitality because an ethical host cannot, due to the strangeness of the guest, ever be sure what conditions or limits placed upon their behaviour will be most harmful. There should always be a tension which, Derrida claims, limits intervention; it is this held indeterminacy that actually defines the site of responsible decision in legal interventions and constructions of rights. Ethics thus occurs at the intersection between the conditional and unconditional aspects of hospitality and is defined by the conditions or what Derrida calls the proximity given to the Otherness of the guest. Within this framework of hospitality what we articulate in this article is the manner in which, for the institutions of the law, and perhaps even more so for medicine,

increasingly this ethical proximity and respect for a particular and personal embodied experience is being denied pregnant woman. At the same time, there is an increasing proximity to the foetus that draws attention, consideration and ethical negotiation.

This denial of proximity in relation to the pregnant woman, we argue, is primarily the result of a growing technological approach to medical intervention which conceives the woman as holding within her body an Other body which *needs* medical and, at times, legal hospitality. The focus of legal discourse in response to this evolution has been to give increasingly greater moral and legal weight to the value of the foetus to society and, consequently, to the pregnant woman herself. However, conceptualizing foetal Otherness as foetal rights not only gives rise to the situation of competing rights, but also locates the site of ethical play and determination *within* the body of the pregnant woman. Thus, viewing cases through the structures of hospitality we can see how and why pregnancy draws public social commentary, interest, and ultimately moral judgements that construct the pregnant body as public space and a site of legitimate intervention.

Through a process of deconstruction, the lens of hospitality can reveal the territory that must be carefully negotiated in cases of medical and legal intervention. On the one hand any ethical limitation on intervention would allow the threat of violence to decide who will be welcomed and, more importantly, who will be excluded from seeking hospitality. On the other hand, a boundless intervention would erase the threshold between unconditional and conditional hospitality on which the ethics of hospitality are premised. Such an argument necessarily examines the practice of intervention as it relates to specific medical and legal cases of hospitality rather than the ethics of hospitality to medical and legal intervention as a practice.

The overall thesis presented in this article is that ethical decision-making in regards to the validity of pregnant women's choices must recognise that responsive and responsible decision-making must remain welcoming of the woman's moral voice. In specific cases of legal intervention that overrules a woman's refusal to consent to a medical

procedure, the findings are usually arrived at through a reduction of the circumstances to a standpoint of universality. That is, a legal conception of personhood is a universal theory of what it is to be an individual within a social order, underpinning notions of rights, autonomy and duty, which are in turn applied to all legal persons. Yet for Derrida there is an inherent violence that is perpetrated upon the individual whenever universals are enforced, even the most honourable among them, such as human or moral rights. This is because in reducing the Other to the same, we deny each person their unique and irreplaceable life and experience.

The reduction of pregnant embodiment to a conception of embodied universality, which can be framed as a 'right', or to a generalised condition that is 'pregnancy' as an absolute condition, reduces the complexity and proximity of the ethical situation as experienced by a pregnant woman. From the perspective of hospitality we see the ethical challenge *is* how to respond to the unique Otherness of pregnancy without reducing this particularity to sameness through legislation or an application of 'rights' that *is* the universal *par excellence*. Such a reduction evades the tension and undecidability inherent in ethical decision making and acts to silence the particularity of pregnant women's lives. As Shildrick identifies, 'To bring the irreducible other under the remit of law is always to effect a certain reductive violence against her difference' (Shildrick 2005: 41).

Exploring how and why the maternal-foetal relation has been constructed as adversarial and dissociative to the degree that it can frame denial of a woman's autonomy as benevolent (and thus ethical) suggests that this is only possible because of a way of thinking that is underpinned by conceptions of what is acceptable through a hospitality that is conditional.

1 Hospitality

For Derrida there is no culture or social bond that operates outside the principle of hospitality although what is considered ethical across cultures may differ. Derrida states that

Insofar as it has to do with the ethos, that is, the residence, one's home, the familiar place of dwelling, inasmuch as it is a manner of being there, the manner in which we relate to ourselves and to others, to others as our own or as foreigners, *ethics is hospitality*' (Derrida 2001: 16).

Within a culture where respect for the individual as individuated is paramount, as it is within the cultures that we will speak about in this article, an ethical hospitality is one that most preserves the individual choice and freedoms of all the concerned participants; in other words, their subjectivity, their singularity. An ethical hospitality that holds this aim in mind, for Derrida, concerns itself with the capacity to approximate an unconditional welcome, as far as possible, of an unknown stranger.

In order to approximate an unconditional welcome that preserves the singularity of the persons involved, one must negotiate two hospitalities: an unconditional and unlimited hospitality and a conditional hospitality most often understood as rights and obligations, especially as they are set out in the law. Such a negotiation Derrida describes as 'a formidable challenge because if these two hospitalities do not contradict each other, they remain heterogeneous at the very moment that they appeal to each other, in a disconcerting way' (Derrida 2005: 6). In order to preserve the subjectivity and freedom of the foreigner one must welcome them unconditionally. To welcome a complete stranger unconditionally would mean opening our home and giving over our place in welcome to whoever arrived with no restriction upon their behaviour or attitude. Pure hospitality 'consists in welcoming whoever arrives before imposing any conditions on him, before knowing and asking anything at all, be it a name or an identity "paper"' (Derrida 2005: 7). To welcome unconditionally would thus mean that sooner or later, as the strangers continued to arrive, I would surely lose my position as host and possibly even my home. To undertake such a venture would therefore be impossible and, so, as Derrida (2005: 6) explains, in order for hospitality to function practically there must be thresholds in place; there must be conditions or rules that outline the 'proper' use of the home and the home must remain the property of the host, with all

that this implies. Thus for Derrida, although the essence of a hospitable relation demands that I welcome strangers without limit, reserve and without calculation, I must also and in order 'to render this welcome effective, determined, concrete' impose conditions upon these strangers and in doing so 'transform the gift into a contract' and the stranger into a guest through the regulation of their behaviour (Derrida 2005: 6).

The conditions of hospitality offered by the host must, in the name of unconditional hospitality, be *carefully* calculated because each one comes at a cost to this stranger's singularity. For Derrida, each condition violates the individuality, the freedom, of the guest because it must by its nature involve mastery, control, and appropriation. It is also, however, through the conditions of hospitality that the stranger is made *known* through assimilation, as the conditions enshrined by the host will, by necessity, reduce the foreignness of the stranger to the familial domesticity that is deemed proper. Thus, it follows that the more severe the conditions of hospitality, the greater the reduction of the Other into a sameness that denies the guest their unique and irreplaceable life and experience.

This erasure of subjectivity is the violence that Derrida identifies as inherent within the structure of hospitality and as such why the principle of hospitality, if it is to seek justice, must always address itself to singularity. Claims that universalise human experience are the realm of conditional hospitality and although they may aim at the substantiation of a humanitarian norm, will nonetheless perpetuate violence should they be forcefully upheld in each and every instance. So for Derrida the task is to 'try to determine the *best* conditions, that is to say some particular legislative limits, and especially a particular application of the laws' (Derrida 2005: 7); the difficulty being in how to sustain a welcome that is respectful to the individuality, the foreignness, of the guest.

Derrida calls the required negotiation between conditional and unconditional hospitality the 'double law' of hospitality; it is through their dialectical engagement that a 'site of strategy and decision' is generated as a possibility for responsible decision-making (Derrida

2005: 7). Derrida argues, if one merely accepts one into their hospitality as a duty, or as a pre-prepared expectation that does not displace or disrupt, then no real welcome has been extended and there is no hospitality. It is an act performed ‘unwillingly, against my natural inclination, and therefore without smiling’ (Derrida 2010: 361). This reveals a contradiction at the heart of hospitality: through the anticipation of welcoming, and built into the *culture* of hospitality and its instituted structures of welcoming, we might no longer perform a welcome. Therefore, in the case of legal judgements, a decision, if it is to be called just, must comprise a ‘reinstating act of interpretation, as if ultimately nothing existed of the law, as if the judge himself invented the law in every case. No exercise of the law can be just unless there is a ‘fresh judgement’ (Derrida 1990: 963). In practicality what this means is that in order for a judgement to be ethical it needs to sustain as paramount the singularity, the Otherness of the foreigner, and so must be a *particular* decision that will be relative to each case.

2 Pregnant Embodiment and the Law

On the face of it, a pregnant woman’s right to self-determination is firmly entrenched in and protected by the common law in Australia, the UK and the US. Within the medical setting, self-determination is upheld through the doctrine of informed consent. Informed consent requires a patient to not only consent to medical treatment freely but that she be given a sufficient amount of knowledge of the risks, benefits and possible burdens of undertaking any procedure. The situation of pregnant embodiment does not alter a woman’s right to consent. Any medical treatment that is considered ‘invasive’ to the person must have the consent of that person – this is a legally binding duty within the professional practice of doctors and other medical staff. The right to refuse medical treatment logically follows such a principle. The right to refuse treatment is expressed in *Rogers v Whitaker*, endorsing a previously expressed principle recognising a person’s autonomy (Thampapillai 2005: 455).

In the United States, Canada and Great Britain, early case law

supported what were purported to be the interests of the foetus and, consequently, often resulted in court ordered obstetrical intervention. However, the early cluster of judicial determinations that supported intervention and foetal rights in the US and Great Britain have been reversed and autonomy and thus consent has been clearly identified as the over-riding legal principle (Werren 2007: 267; 270). In current research by Matevosyan (2012; 2013) exploring whether there is or has been a predominant focus or trend in hearings focused on forced obstetrical intervention, she identifies that of 37 hearings across the US, Canada and Great Britain (with 83.8% or 31 of these cases being in the US), 18 cases concerned maternal-foetal conflicts. Of the 18 cases regarding maternal-foetal conflict, maternal autonomy was preserved in 7 (38.9%) (Matevosyan 2013: 514). The research found that where interventions were upheld, maternal autonomy was impaired and consent was not judged to be that of a competent adult, thus supporting previous research identifying that, in cases where coercive policies were upheld, these cases concerned 'the most vulnerable women, including those with mental illnesses, poor economical and social support' (Matevosyan 2013: 510).¹

Matevosyan includes the case of *Re AC* (both its initial judgement and its reversal) in the 18 cases identified, emphasizing in her brief description the recognition articulated in the reversal, that a Court must determine the woman's wishes and protect maternal rights 'by any means available' (Matevosyan 2013: 517). In the case of *Re AC*, a young woman named Angela Carder, pregnant but dying from cancer, was ordered by a district court to undergo a caesarean against her express wish. The 1987 judgement was vacated in 1990 in the District of Columbia Court of Appeal after the death of the defendant, who, along with her foetus, died post-operatively; the caesarean section being identified as a contributing factor in Carder's death. The earlier decision was described as a violation of Carder's rights to informed consent and the bodily integrity inherent in this right. Thus, *Re AC* has become central to the development of law around maternal autonomy and consent vs foetal rights. In the US, where case law had supported forced intervention in the interests of the foetus, the judgement to

vacate this order firmly re-established a pregnant woman's autonomy. This case remains significant to the law, despite it now being over 25 years in the past. Its significance however belongs to a longer historical chain of events whereby the foetus has come into being as having interests deemed ethical to support, with this position increasingly creating debate over whether foetal interests should be protected by law. While intervention in a woman's pregnancy has generally been seen to be within the doctor's purview (Featherstone 2008: 454-455), at the particular time and place of the *Re AC* rulings, the issue of protecting an individual's autonomy was on the rise, and vigorously pursued by feminist activists and scholars as well as foetal rights activists.

The overriding ethical and legal position from this case is that 'the pregnant woman is deemed morally responsible to attempt to preserve foetal health and rights, however, she is not legally compelled to accept medical treatment for her foetus' (Matevosyan 2013: 510). Matevosyan's review highlights the way that some court orders have made errors in making a legal judgement in supporting obstetric intervention. While such cases are often overturned, and importantly so, as in the *Re AC* case, judgements have still been made that impact the woman's right to self-determination and it is these cases that reflect not only contested views on foetal identity and foetal rights, but the use of the public sphere of the law to argue issues regarding the legal status of the foetus. It remains that while the foetus may be *perceived* to have a right to life, practitioner actions that take this perceived right, held to be in conflict with a woman's fundamental autonomy, and often resulting in the case being heard in court, are, Burrows claims, 'basically an illegal concern with the right of the foetus to life' (Burrows 2001: 690).

Burrows also identifies *Re MB*, where a woman with a needle phobia refused an emergency caesarean, as confirming the born alive rule; that is, a court cannot take the purported interests and purported rights of the foetus into consideration until it is born alive (Burrows 2001: 691). Kristen Savell notes that 'for the purposes of the criminal law, the born alive rule has been traced to Coke who defined the common law offence of murder by reference to the killing of a 'reasonable creature in

rerum natura' (Savell 2006a: 627). While the born alive rule has been confirmed in a number of cases, the courts acknowledge that while the legal position is determined, the ethical dilemma of foetal 'interests' clearly remains. This ethical dilemma is exemplified in the UK case of *Re S*, where a mother who had refused to consent to a caesarean section on religious grounds had her refusal overruled; the baby was stillborn. While overruled in the Court of Appeal, with the decision being subsequently described as 'logically untenable' (Mason et al 1999 in Meredith 2005: 266), such cases as this clearly express the power of the ethical dilemma.

That there is no legal protection of the foetus, remains a situation of particular concern in cases where deliberate actions, or actions incidental to criminal activity, cause the death of the foetus in utero. Some states in the US have discarded the born-alive rule in favour of establishing a legal identity for the foetus primarily in response to these types of situations. With regard to feticide laws, in the US and as at 2005, Sheena Meredith (2005: 14) identifies that 31 states have enacted foetal homicide laws and/or other legislation that identifies the foetus as having a value worthy of state protection. Under these legislations it has been estimated that by 1992 around 50 cases of court ordered caesarean sections had been performed against the mother's wishes (Seymour 1994b: 77). The most extensive legislation to date is the *Unborn Victims of Violence Act (UVVA)* that came into effect in the US in 2004. The *UVVA* 2004 specifically grants the foetus legal rights in the event of being harmed as a consequence of a crime committed under federal or US military jurisdiction. This legislation describes the victim as a 'child in utero' who is defined as a member of the species *Homo sapiens*, at any stage of development.

In Australia, NSW currently does not have legislation making the deliberate or incidental killing of a foetus due to a criminal human act ('foetal homicide' or 'child destruction') illegal, standing out as the only Australian state in this regard. However, the case of *R v King* (hereafter *King*) was significant in its impact on law relating to grievous bodily harm to the foetus. In *King*, a woman who had refused an abortion

following an unplanned pregnancy was subsequently violently attacked by the biological father, resulting in the foetus being stillborn at 24 weeks. In the Criminal Court of Appeal the judge ruled that this violent act constituted grievous bodily harm to the mother. Thus, the *Crimes Amendment (Grievous Bodily Harm) Act 2005* (NSW) was formulated in response to *King* in order to recognise that the infliction of grievous bodily harm extended to the destruction of the foetus, 'other than in the course of a medical procedure, whether or not the mother suffers any other harm' (Uppal et al 2012: 182). This allowed for recognition of the gravity of such offences, distinguished criminal acts from third parties resulting in foetal death from therapeutic terminations of pregnancy, and avoided 'the common law question of a "creature in being" to which harm can be done' (Uppal et al 2012: 182). However, it must be noted that cases of third party harm appear to be cases where law needs to make a determination if justice is to occur in the form of either compensation, should the action be deemed negligent, or a sentence to the third party should the action be deemed criminal. These do not *protect* the foetus as much as provide justice after the fact.

However, this sense of protection of the foetus is potentially conflated and the possibilities of such conflation add to fears of a slippery slope effect whereby such recognition of the foetus has the potential to disrupt the legal position around maternal consent. In reviewing the current legal situation in NSW, Uppal et al (2012: 183), for example, advocate for full legal recognition of the foetus in NSW law. They also claim that the law in NSW does not 'match community expectations' or the need to recognize maternal loss in cases where third party assaults or accidents result in foetal loss (Uppal et al 2012: 183). In an attempt to address such concerns, there currently exists in NSW a Private Member's Bill: the *Crimes Amendment (Zoe's Law) Bill 2013* (NSW), introduced by Liberal MP Chris Spence on 29 August 2013. At the time of writing the Bill had just been passed the NSW Legislative Assembly (on the 21st November 2013), by 63 votes to 26, despite opposition by the New South Wales Bar Association and the Australian Medical Association. The impact of this Bill, if passed as legislation, is to have grievous bodily harm to the foetus recognised in

law by conferring personhood on the foetus. The cases contributing to the conceptualization for the need for these legislations and for the introduction of such a Bill in Australia have not involved the consideration of the pregnant woman's consent or refusal of consent to actions that affect her body and her life. Rather, these are cases where the trauma undergone is the result of circumstances beyond her control and involve the charge of grievous bodily harm. Where death of the foetus has occurred, the woman has had little opportunity for her loss to be recognised in law because the foetus she has been carrying has no identity in law and thus the harm is recognised as harm to her. These cases have, however, pushed courts to consider the impact of medical technologies on how we understand foetal existence as well as to recognize and respond to growing community concern for the foetus, regarding its purported rights, the question of 'who' is harmed, the recognition of what is lost when a woman loses her foetus in traumatic circumstances, and thus the bigger question of whether this entity has rights.

The born alive rule also comes into play in another significant area of law concerning the termination of a pregnancy. The landmark case in the US is that of *Roe v Wade* where the United States Supreme Court ruled that the foetus does not constitute an entity until it is born alive and thus is not entitled to Constitutional protection. Those lobbying against legislation which aims to remove or modify the born alive criterion, claim that it would undermine reproductive rights of women in relation to access to abortion; they also claim that these types of legislation potentially place a woman's right to consent or refuse consent to treatment in opposition to perceived rights of the foetus, which has certainly been the case in the US. While proposed legislation such as the Australian Bill currently excludes medical procedures and 'anything done by, or with the consent of, the pregnant woman concerned', the women's lobby coalition recognizes that such a position is 'open to interpretation and may not be sufficient to protect the rights of the woman involved' ('Our Bodies, Our selves: Crimes Amendment Zoe's Law Bill 2013 Factsheet'). Such legal conflict does not currently exist in Australia, however it is not difficult to recognise that increasingly in

the US, where the born alive rule ‘has been abandoned and the foetus is recognised as a legal person, distinct from the mother, [this has led] to the policing of pregnancy’ (Uppal et al 2012: 181).

3 Past Analysis

Past analyses of such cases clearly identify problems arising because, while the legal position is clear, an ethical dilemma remains ‘in play’. The relationship between law and ethics as it exists regarding cases of foetal welfare, is understood in the context of an ‘emerging’ relationship between the foetus and the pregnant woman, one where the law has, potentially, ethical obligations to both ‘parties’ with developments being contingent on ‘the foetus gaining some level of legal status’ (Thampapillai 2005: 455).

The interplay between the ethical and legal in cases concerning forced obstetrical intervention, as it currently stands in Australia, is seen in the UK case of *St George’s Healthcare NHS v S*, where the legal outcome asserts that the pregnant woman’s autonomy takes precedence over the interests of the foetus. However, the foetus may be considered in the context of the ethical dilemma the pregnant woman faces. Consent is thus both an ethical obligation and a legal obligation (Werren 2007: 266). This makes clear that discussion of legal cases regarding forced obstetrical intervention, and therefore the differences between Committee or judiciary positions in different countries, centre around ‘their respective approaches to the debate over the recognition of “foetal right” which itself creates the concept of “foetal abuse/neglect,” or “maternal/foetal conflict”’ (Matevosyan 2013: 511). This conceptualization reflects the legal importance of individualistic approaches to personhood but fall short in being able to properly capture the unique maternal-foetal relationship, its complexities and challenges.

Seymour (1994a) has characterized the theoretical approaches to the maternal-foetal relationship as falling under either single entity theory, two entity theory or indivisibly linked entity theory. This characterization has been used in further scholarly debate on the continuing relevance of the born alive rule in Australia and

internationally (for example Savell 2002; 2006a; 2006b; Thampapillai 2005). The early conceptualization of the foetus as being part of the woman's body, seen as underlying the born alive rule, has been understood as a form of single entity theory, that is, that the foetus and the pregnant woman are one entity. This approach is identified by Seymour as no longer having much force (Seymour 1994a: 35; Seymour 2002: 36). The single entity approach denies the possibility that the foetus has interests, and is generally attacked on the premises that as a 'body part', the foetus is distinct from any other such part – it receives support from the mother but plays no role in supporting the life of the mother, it has a fixed term existence as a part, and has its own emerging body shape and genetic code (Thampapillai 2005: 456).

Conceptualised in seeming opposition to the single entity approach, and introducing the potential for an adversarial relationship between two parties, is the separate, or two entity approach to defining the status of the foetus; this approach distinguishes between the mother and the foetus as two separate parties (Seymour 1994a: 29, 2002: 38). The conceptualization of two entities, however, and the question of whether this best captures the relevant ethical concerns as well as what is legally implicated remains fraught.² Under the proposed Private Members Bill in NSW, destruction to the 'unborn child' would be recognised and thus, *Zoe's Law*, as such, draws on a two entity approach to defining the essential characteristics of the foetus, distinguishing between the personhood of the mother and that of the foetus. This identification allows legal recognition of the ethical weight of significant *losses* to the mother/parents; that is, the loss to the mother is of a different nature to her losing a body part. In Australia, objection to the proposed *Zoe's Law* includes its conceptualization of personhood of the foetus, stating that this is 'the first step towards prosecutions of women where they are deemed to have acted contrary to the interests of the foetus they are carrying' ('Our Bodies, Our selves: Crimes Amendment Zoe's Law Bill 2013 Factsheet'). Seymour, however, sees that fear of a slippery slope effect, whereby the recognition of the legal status of the foetus in one situation will lead to its recognition in another, often leads to advocating for a definition of the foetus as a body part (Seymour 2002:

39), a view that is now seen as ‘unsustainable’ (Seymour 2002: 39).

Judicial decisions that emphasise the conceptualization of the foetus as ‘a unique organism’, not having the attributes that make it a person, but neither being a part of the mother as an arm or a leg (Seymour 2002: 31) articulate important intuitions and support the identification of the foetus as ‘not a legal person, but ... considered to be both human and alive, and hence worthy of protection in both criminal and civil law’ (Kerridge et al 2013: 559). At the same time, the conceptualisation that there is only ‘room for one person with full and equal human rights inside a single human skin’ (Warren 1990 cited in Burrows 2001) is also important, and centrally so. While the foetus may be more than a part of the mother’s body, it is not a person, as we conceptualise personhood – especially legally. Analysis of legal cases where conceptualization of the foetus is involved makes central such intuitions, and there has developed what is referred to as the indivisibly linked theory of pregnancy (Seymour 1994a cited in Thampapillai 2005: 457-458). Such theory recognizes that there are two sets of interests, but rather than pit these as adversarial, it emphasises that ‘interdependence means that there is no clear solution to be applied when the rights of the foetus and the mother are in conflict’ (Thampapillai 2005: 458). Seeing the relationship as one of being indivisibly linked, however, ‘leaves open the question of how competing rights will be balanced against each other’ (Thampapillai 2005: 458). It also allows for the conceptualization of the foetus as ‘a unique organism’ not having the attributes that make it a person, but neither being a part of the mother as an arm or a leg is.

Savell’s analysis of the Australian cases is pertinent here—she supports the view that these two entities be viewed as indivisible because ‘the ‘connected’ and ‘distinctive’ configurations [of the maternal body] both contain plausible elements’ (Savell 2006b: 203). Savell advocates for a contextual approach to the maternal body (Savell 2006b: 203-204), claiming that such an approach can support the born alive rule, recognising its enduring significance in law. She sees that retaining the born alive rule, despite its seeming outdatedness, ‘is a crucial

factor in safeguarding the autonomy of women in decisions concerning pregnancy termination and obstetric treatment (Savell 2006b: 205). As indivisible entities, legal autonomy of the pregnant woman and thus consent can still be clearly identified as the over-riding legal principle.

The continuing play between powerful ethical dilemmas and the position of the law has led to errors in legal judgement that have been overturned. These legal determinations then point us back to the actions of the medical practitioners who encounter the threshold of ethics and the law in their practice. While having clear guidelines on their role as being to support the woman's decision-making, some practitioners appear to take actions to contest what they see as grey areas of this law, driven by a growing perception of the 'interests' of the foetus.

The significance of the ethico-legal nature of the problem is particularly emphasised in some of the literature surrounding cases in the US. Giving a partial overview of commentary on how case law proceeds in the US, Burrows, who sees the concern over the right to life of the foetus as an 'illegal concern' (Burrows 2001: 690), suggests that the practical implementation of the legal principle of informed consent is 'a different matter altogether' (Burrows 2001: 692) to the principle as it is articulated. The legal articulation is often after the fact, in an appeal, and in a situation where urgency no longer prevails and both parties – the pregnant woman and her medical practitioner – have representation and thus support to present their case (Burrows 2001: 692-693). Burrows suggests that, in practice, 'judges use other means to enable them to justify the medical intervention' most typically referring to the capacity and competence of the pregnant woman in making her health care decisions (Burrows 2001: 692).

The broader significance of this is that the nature of the ethico-legal problem is such that the law is not sufficient to prevent some medical practitioners and some of the judiciary from finding a way to intervene.³ It is also the case that this desire is not necessarily matched to the capacity of the profession. Matevosyan identifies that there is room for a more advanced reflection on the part of physicians who have the discretion to initiate such legal intervention, in particular,

regarding their 'potential impact on the practice of medicine and the ability of physicians to maximize foetal health in an aggregate population' (Matevosyan 2013: 526). She quotes the American College of Obstetricians and Gynecologists (ACOG) as acknowledging that 'medical knowledge and predictions of obstetrical outcomes have limitations' (Matevosyan 2013: 511).

It is also clear from the research that while professional codes for medical practitioners clearly identify a medical duty to abide by the consent of the pregnant woman, the interdependent relationship between the pregnant woman (mother) and the foetus creates 'confusion and tension' (Kruske et al 2013). While the law and professional Codes of practice guide professional behaviour, there is, for some, a perceived gap between what the Code of Ethics as a guide to action demands and the actions that some practitioners perceive are needed in some circumstances.⁴ Recent research on hospital practices in Australia demonstrates that midwives and obstetricians, who are in closest contact with the pregnant woman receiving medical care and who 'can significantly influence women's ability to exercise their legal rights', do not see their situation in relation to the ethico-legal principle of autonomy as clearly defined (Kruske et al 2013). The confusion is apparent in that while the participants recognised autonomous decision-making and agreed that the final choice regarding treatment rested with the woman, doctors (obstetricians and GPs more so than midwives) were more likely to see themselves as being more competent (than the pregnant woman) in decision-making about medical care. Overall, the study found that 'maternity care providers have a poor understanding of their own legal accountability, and the rights of the woman and her foetus' (Kruske et al 2013). More specifically, the study found the following: that doctors (obstetricians and GPs) were more likely than midwives to see themselves as being more competent (than the pregnant woman) in decision making about medical care; that doctors were more likely to see that the needs of the pregnant woman 'sometimes have to be overridden' and that they were ultimately legally responsible for the health of the foetus, even if a collaborative decision-making process was undertaken (Kruske et al 2013).

It remains the case that in ensuring that the autonomy of the pregnant woman is upheld, the health professional's role is to provide her with all the information required to make any hard choices that she must make and to support her in these choices. In providing this information, the health professional must put aside any subjective moral concerns. Kruske et al's (2013) research tells us that doing this is not that easy and this should be of concern to the law. For Burrows, referring to the cases arising in the US, it is quite clear: 'The dangers of health professionals becoming immersed in subjective moral decision making cannot be overstated' (Burrows 2001: 690).

4 Hospitality and the role of technology in medical decision-making

Margaret Shildrick, in looking at how Derrida's understanding of the *aporia* of justice, and his notion of hospitality as it relates to transgressive bodies, focuses on cases of conjoined twins in order to tease out how the issues of singularity, duty towards 'best interests' and medical intervention are viewed in law (Shildrick 2005). While clearly differentiated from the cases looked at in this article, and Shildrick herself sees cases of pregnancy and the maternal foetal relationship as ones where the 'normalising power of law is sufficient to regularise and contain many forms of anomaly', she also acknowledges that 'even the everyday slippage between mother and foetus inherent in pregnancy is sometimes problematic' (Shildrick 2005: 39). Her use of Derrida's notion of hospitality and justice as a justice 'to come' in relation to laws that deal with difficulties arising out of cases of anomalous embodiment problematising the application of notions of legal individuality are relevant here to this extent: she argues that in cases of anomalous embodiment, 'where transgressive corporeality may resist [the law's] disciplinary drive altogether' this will generally be at the expense of the positive value of legal protection (Shildrick 2005: 39).

The embodiment that is pregnancy is not only normal and healthy, but at the basis of all humanity. While the foetus is not given a legal identity and thus is not afforded the positive value of legal protection,

in cases where foetal interests are pitted against maternal rights, the drive is to reverse this situation, with the legal protection of maternal consent being 'temporarily suspended'. What is of interest here is that while her embodiment is not anomalous in the way that Shildrick takes this up, when the foetus is given rights, and we tend towards a sense of there being 'more than one person with full and equal human rights inside a single human skin' (Warren 1990 cited in Burrows 2001), we tend towards the conceptualisation of pregnancy as a transgressive corporeality.

While at first glance it is the identification of the foetus in law that is most pressing and urgent as perhaps most potentially threatening to the pregnant woman's autonomy, it is the particular practices of some members of the medical profession that are also of concern here. Actions in this arena focus on the question of what constitutes a legitimate response to avoiding a *potential* harm to the foetus, as an individual entity, or patient, with interests, when the *potential* harm could *potentially* be avoided through medical intervention. While all of the facts of a case and its possible outcomes are to be presented to the pregnant woman for consideration and her ultimate decision-making, the actions of medical practitioners, in initiating legal interventions, challenge *when* the law can override a valid consent. In this initiating practitioner's view, *there is* a limit to the woman's autonomy that is determined by the situation and interests of the foetus. While this is only a perceived limit, it nonetheless drives current questions, conceptualisations and debate over foetal 'interests' and 'rights' rather than representing a perspective that might enlarge our understanding of pregnant embodiment and underpin support for the woman who might have to make a difficult moral choice.

What is important here is the recognition that there are several levels of hospitality that become operative when a woman discovers herself to be pregnant. In the first instance, culturally, she is seen to extend hospitality to her foetus. In recent times, the nature of this hosting, the conditions of hospitality that she offers, has come under an increasing degree of medical surveillance and ultimately regulation,

offered as a medical hospitality. Medical hospitality, through the development of new technologies that allow us to see the foetus, is now also offered to the foetus, as a patient, through a hospitality that is separate and separable from that offered to the mother; a practice termed foetal medicine. For medical hospitality to be delivered directly to the foetus, the pregnant woman has not only become subject to surveillance, but this has progressively become a condition of medical hospitality for the mother; a situation which by its being *a condition*, acts to significantly alter her experience of carrying her foetus 'within her own home' and subject to her own conditions. This impacts her particularity, for herself and others. Imagery that results from such medical surveillance has encouraged the public to view the foetus as what Savell describes as a 'hope for the limitless future and tragedy where his imagined future does not come to pass' (Savell 2007: 116). This imagining has elicited a shift in the way that the public witnesses the role of a woman as host to her foetus.

In extending medical hospitality to the foetus as a welcome that recognises the foetus as singular, the particularity of pregnant embodiment is rendered as expected, predictable and known; the welcome extended to the mother of this foetus is curtailed and she is expected to support the conditions of medical hospitality, to not disrupt but rather provide the resources for the fraternity of others. Her invitation to the medical profession, provided through her consent, to participate in her pregnant embodiment is put out of play. In the terminology of hospitality, she is rendered as a resource to another's experience of *feminine* hospitality.

This requires that we unpack Derrida's notion of hospitality further, recognising that at the very base of the structure is what is termed feminine hospitality. Feminine hospitality, Derrida acknowledges, is what gives hospitality a patriarchal structure because it is the 'feminine' that provides the ground upon which the ethical interplay between conditional and unconditional hospitality is able to function. The roots of the feminine as hospitality are in habituated dwelling – the feeling of being at home with oneself that acts to create a feeling of attachment

to the home that a host requires in order to claim a space as a home from which a welcome can be extended. For Derrida,

the home is not owned. Or at least it is owned, in a very singular sense of this word, only insofar as it is already hospitable to its owner. The head of the household, the master of the house, is already ... a *guest* in his own home. This absolute precedence of the welcome ... would be precisely the femininity of 'Woman', interiority as femininity – as 'feminine alterity'. (Derrida 1999: 42-43)

For the individual, this feminine welcome does not refer explicitly to actual women but rather to a feeling or memory, a recollection of being unconditionally welcomed within one's own home – as a metaphor for feminine qualities. Yet despite this conceptual rendering as metaphorical, Derrida admits that feminine hospitality, in providing the ground for others to have time for hosting and the resource base for hospitable fraternity, is problematic because although feminine hospitality is supposed to be metaphorical, and as such does not refer to particular women or even women per se, it conceptually continues to work to delimit the possibilities and opportunities for women, and as we shall see, pregnant women in particular.

Understandably then, this aspect of hospitality has been a focus of feminist scholarship (in particular see Diprose 2009), the primary charge being the capacity of the structures of hospitality to be able to include, exclude and/or regulate the public participation of certain Others through manipulation of the conditions of hospitality at a state level. Those excluded from participation in the social contract, the ethical interplay between conditional and unconditional hospitality, find themselves relegated to tasks of support or nurturing, the expectation being that in the absence of their capacity to participate, they will support those who can (and should).

As we shall clearly see in the ensuing deconstruction, to shift the welcome of medical hospitality from the woman to the foetus not only relegates the pregnant woman's embodiment function to that of a support, but also denies the woman what is needed for her to have her own experience of feminine hospitality in relation to her foetus

and her pregnant embodiment. The pregnant woman, especially those who may need to negotiate difficult aspects of her pregnancy that call for the making of hard decisions, is denied the feeling of familiarity and intimacy and the feeling of being at home in her own pregnant body. Thus the very conditions she requires to make a hard decision are put out of play, by practitioners who have a clear ethical directive to provide for this very need.

Technological advances that mediate the stages of pregnancy more clearly have also been recognised as important in legal decision-making, most particularly in the application of the born alive rule where it is recognised that community expectations do not match the discursive reasoning of the law. We offer the following deconstruction of an example of how, through this technology, the structures of medical hospitality frame the manner in which our culture currently responds to, and develops expectations around the maternal-foetal relation. Our aim is to highlight the concern that these perceptions construct a situation whereby the ethics of a conditional medical hospitality become related to medical and legal intervention as a practice, rather than the ethics of intervention in specific cases. What we discern is that the re-situating of the ethical question in such a way as to construct intervention as normative and even heroic is achieved through the positioning of woman's pregnant embodiment as belonging to the realm of medical feminine hospitality, rather than as a woman who not only offers hospitality to her foetus but who also invites medicine to participate in this experience.

In order for the question of justice in the difficult decisions that face the medical and legal institutions to do with maternal-foetal conflicts to be properly considered, this positioning of the medical profession as host to the foetus as patient needs to come into view. For justice to occur, as opposed to an application of the law, there needs to be a recognition that the maternal welcome is silenced. Subsequently, not only is her ability to give a truly informed consent compromised, but so is the medical profession's ability to hear and give due credit to her dissent.

The particular example we will deconstruct is an image that was

labelled ‘the hand of hope’. Here, Samuel, a 21-week-old foetus undergoing surgery to treat spina bifida, supposedly reached through the uterine incision and ‘grasped’ the surgeon, Dr Bruner’s, finger ‘as if in thanks for his life’ (Lymer, 2010: 180). Samuel, the story tells, was subsequently born ‘normal’, rescued from a difficult life by Dr Bruner (Davis, 1999 – see Figure 1).⁵

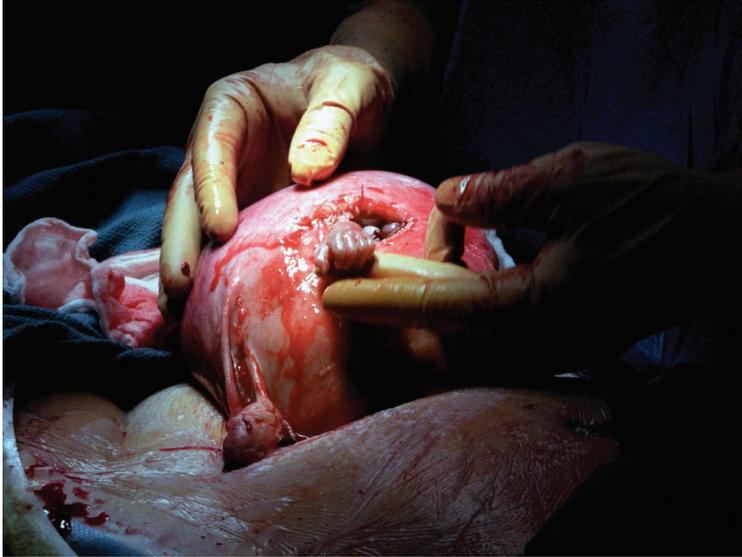


Figure 1: The Hand of Hope

Catherine Mills has argued that ‘taking the possibility of a ‘visual bioethics’ seriously requires that more attention is paid to the emotive or affective impact of images on ethical intuitions’ (Mills 2008: 61). Mills identifies that it is the ‘affective or emotive force of ultrasound images that make them crucial in ... debate’ (Mills 2008: 62). Images such as this one, that show a single particular foetus, have circulated within our culture since Lennart Nilsson’s 1966 iconic image on the cover of *Life* magazine of a foetus floating in vacant space. The twelve-week old foetus floating in space not only exists as a separate being, and thus separable, from the maternal body but the replacement of

the woman's body with vacant space extends an invitation to man, to medicine, to 'discover', to explore and perhaps even to conquer. It is no mistake that when this image first appeared in a 1966 edition of *Life* magazine it was surrounded by nationalist photographs and articles showing the space ship Gemini, a helicopter-gunship over Vietnam and Frank Sinatra (Lymer 2010: 180). Barbara Duden describes the image as a 'haunting symbol of loneliness' (Duden 1993: 7); small, vulnerable and alone, this foetus appears also as either abandoned or even as hostage when applied to cases of maternal dissent.

The image of the disembodied foetus has, through its circulation, allowed us to not only express the possibility of foetal subjectivity, and thus as having 'interests', but also frames debates surrounding foetal rights and maternal duties of care which act to persuade the public. Mills, in arguing for the 'polemical force of ... imaging technologies' as being 'in the emotive effect that seeing the foetus induces', cites Julia Black, the documentary film-maker of *My Foetus*, a controversial film on abortion, as suggesting that 'if anything is to lead her to take an anti-abortion position, it is this capacity to see the foetus, particularly as it is performing activities normally associated with babies, such as thumb sucking' (Mills 2005: 427). In the case of abortion, the emotive effect leads to the conclusion that abortion is immoral (Mills 2005: 427). Following this, in cases where foetal interests are pitched as in opposition to maternal rights, the emotive effect is that any dissent from supporting these interests is construed as immoral. Savell has extended analysis in relation to the birth of 4D foetal ultrasound techniques observing 'that this technology has 'democratised' foetal images by rendering them more accessible to the public' and in doing so creates hope for the future for this foetus in the eyes of the public and constructs the narrative that not attaining this future represents a tragedy (Savell 2007: 116). The political possibilities of this democratisation will become evident shortly.

The 'hand of hope' imagery further extends the threshold of what has become a normative foetal image. Firstly, by extending the available surgical options to non-lethal foetal malformations, in this case spina

bifida, the foetus is accorded 'an even more robust moral status as a *bona fide patient* for whom there is a separate set of risks and benefits distinguishable from those of the mother' (Lymer, 2010: 180, see also Fleischman et al 1998 for a similar argument). Surgeries such as these are on the increase and so mothers become at least morally obliged to consider them as options despite the risk to her health and even though the procedures are still considered experimental. Yet the image and narrative are devoid of the pregnant woman's name and face, her pregnant body reduced to primarily a severed uterus, and then some flesh that seems indistinguishable from the operating table. Although it is Samuel's mother who has borne the risks and consequences of this medical intervention, indeed it is her hospitality that welcomes them in, it is Samuel and Dr Bruner who are named as having a special intersubjective fraternity, extending a medical hospitality that is presented to the world. The mother's hospitality on the other hand is silent and compliant. She is reduced to her body; to that which will resource the medical hospitality that Dr Bruner offers this foetus and because of the lack of evident maternal subjectivity, we are not ethically drawn to have concern for her. Rather, it is Samuel who represents our hopes and the imagined future.

This image went viral on the internet, exposing the severed and opened uterus as the image of 'mother' to the world. Hospitably positioned as she is within the generic of feminine being, the cultural expectation is that she will act as resource to the medical hospitality being offered her foetus and so the image captures her bodily acceptance of this procedure as a moral proclamation of 'good' because Samuel was born 'normal'. She has put aside her voice, as so many women would do in this situation, and will remain compliant throughout this process – quite literally anaesthetised. What is most important to discern here is the way in which the structures of hospitality as medical hospitality both condition and demand maternal compliance through the moralising role that this sort of imagery preaches. Within the structures of hospitality, acknowledging foetal singularity *depends upon* the generalisation of the maternal body and the universalising of maternal experience into a conceptualising framework that medicine

(still a male dominated institution) authoritatively comprehends.

However, Samuel is a socially constructed image of a patient, what Derrida (2002: 3) terms an ‘artificiality’ – a ‘fictional fashioning’ that is performativity selective, and edited – a rendering.⁶ Not only is Samuel not at this stage a person he is also not viable and so his life depends much more upon his mother than on Dr Bruner. What our emotive responses overlook is the propaganda; the maternal-foetal relation portrayed is *neither reasonable nor factual*. In the above image, this foetus is at 21 weeks gestation, and so although the neural connections between the spinal cord and the thalamus are usually completed by 20 weeks, it is not until 24-26 weeks that thalamocortical connections will have grown into the cortex (Anand & Hickey 1987: 1322). As such, ‘Samuel’ is not a conscious being, he is not a subject that can engage in intersubjective relationships; his cortex is ‘not a functional unit’ (Fitzgerald 1994: 153); he was also apparently anaesthetised at the time. Thus, the seemingly grasping hand is a form of rhetorical play, an act of persuasion to an ultimately sentimental sociality. We should then not be surprised to find that Samuel’s story was cited during congressional debates on the Partial-Birth Abortion Ban Act, which passed in the US in 2000. Today, a Google search using the term ‘hand of hope’ returns over one and a half million results, including a follow up story of Samuel by FoxNews 10 years after the photograph went viral where he advocates the right to life of disabled fetuses. A Wikipedia entry links to the photographs and the announcement of the Hand of Hope clinic in Georgia – all on the first page.

The manner in which this kind of imagery presents the privacy of a pregnant woman’s internal body as a universal and generalizable public space, and the absence of her subjectivity from the imagery and thus from the position of a singularity whose particular embodied experience warrants consideration, denies her welcome. The result is a representation of pregnant embodiment that at once universalises pregnant experience, generalising particular women’s experience of pregnancy and opening these to public discourse, scrutiny and ultimately leaving them vulnerable to coercive and regulating moral

judgement, which, as Kruske et al (2013) have shown, the Codes of medical practice are not sufficient to hold off.

5 Conclusion

Derrida describes justice as the experience of a state of suspension and indeterminacy; as an event that opens itself to the impossibility that experience can be reduced to institutional law. It is the recognition that justice is not the result of such a reduction that opens up the possibility for a transformation of law and yet this transformation does not necessitate an absolute rejection of the existing order. Rather, it is a recognition that unmasks, exposes, and ultimately gives ethical regard to the violence and lawlessness of its origins. As Derrida says: 'There is an *avenir* for justice and there is no justice except to the degree that some event is possible which, as event, exceeds calculation, rules, programs, anticipations and so forth' (Derrida 2010: 257).

For the pregnant woman who invites medical care and receives medical hospitality, the *avenir* of justice is not indefinitely deferred as it is pregnant embodiment that must be suspended and becomes the vehicle through which what is possible comes into being. In cases of contested rights, it is only through pregnant embodiment that foetal rights are possible and so their inscription instigates a disruption to the maternal body, from its own sense of feminine hospitality which is then appropriated to support medical hospitality and its authoritative rendering of the foetus as patriarchal citizen.

The legitimacy of this avoidance of the ethical is, of course, highly ethically questionable, especially in the hard cases that we have described above, and this is evidenced by the controversy that currently surrounds the concept of foetal rights. In most of these cases, the campaigns ask, demonstrate and continue to challenge the legal profession to hear and respond to the welcome that gestation embodies as a concrete and particular embodiment that cannot be reduced. We would hope that these challenges are met with some success.

Notes

- 1 Healthy adults are generally presumed to be competent in regard to decision making within both the medical and legal professions and so the issue is usually raised only in cases where a condition will generate a temporary lack of competency or in cases where a recommended treatment has been refused. Assessment of capacity in law requires the patient to clearly understand the nature of the proposed treatment and the consequences of refusal (Meredith 2005: 123). McLean (2010) argues that this test of competence leaves pregnant, and particularly labouring women, whose 'condition' can be read within a paternalistic and historical environment as compromised, vulnerable to being deemed incompetent on the basis that they disagree with medical recommendations. While this investigation is relevant to the argument that we articulate here, we will not pursue this matter further primarily due to word count restrictions, and also because the cultural treatment of women *per se* as emotional and lacking a capacity for proper moral judgement is deeply related to the position they hold within the structures of hospitality (see for example, Diprose 2009).
- 2 Under the proposed Private Members Bill in NSW, destruction to the 'unborn child' would be recognised. Zoe's Law, as such, draws on a two-entity approach to defining the essential characteristics of the foetus, distinguishing between the personhood of the mother and that of the foetus. This Bill includes an identification of the foetus as being more than a body part for the purpose of cases where the foetus is harmed or, after being born, dies due to actions of third parties, and thus refers to cases of actual harm, or death, these being identified as either negligent or criminal. This identification allows legal recognition of the ethical weight of significant losses to the mother/parents; that is, the loss to the mother is of a different nature to her losing a body part. It must be noted here however, that legally recognising significant losses, other than those of losing a body part, to legally recognised persons differs however from articulating legal entities whose perceived interests are in fact the interests as construed by and through the social institutions and the state. This Bill excludes medical procedures and 'anything done by, or with the consent of, the pregnant woman concerned', however, advocates state that this clause remains 'open to interpretation and

may not be sufficient to protect the rights of the woman involved' ('Our Bodies, Our selves: Crimes Amendment Zoe's Law Bill 2013 Factsheet').

- 3 This is supported by Burrows with reference to a range of US cases.
- 4 This finding reflects the reality that actions by the profession are always those of an already interested party, that is, one party with interests in relation to another party whose perceived interests are viewed through the interests of the first. This reality, that personal moral judgements might interfere with treatment and the practitioner needs to be aware of such instances, is recognized in both the AMA Code of Ethics and the AMA Position Statement on Maternal Decision Making that supports the thrust of the Code of Ethics in sustaining maternal consent as the boundary. Section 1.1 of the AMA Code of Ethics on Patient Care, Point 16, states: 'When a personal moral judgment or religious belief alone prevents you from recommending some form of therapy, inform your patient so that they may seek care elsewhere' (AMA Code of Ethics: <https://ama.com.au/codeofethics>). In the Position Statement, and following quite lengthy description of the sorts of circumstances where the interests of the foetus and the mother may diverge, and how this may cause significant distress for the doctor and challenge the doctor's viewpoint, Point 9 is as follows:

The doctor must respect the woman's informed decision, even if it is not consistent with the doctor's advice, and continue to provide patient support. In the event that the doctor cannot in good faith continue to care for the patient, they have a duty to make timely arrangements for that patient's ongoing care. (AMA 2013)

While the law, the Code of Ethics and the Professional Body's Position Statement are all quite clear with regards to practices that need to be followed in order that the professional remain within the law at all times – that is, remains accountable to her institutional practice--this remains an area of confusion, even in Australia, where no cases of forced obstetrical intervention have occurred.

- 5 There has ensued a media debate surrounding the possibility of Samuel actually doing this as he was supposedly anaesthetised at the time. Also, while the narrative declares the surgery a success and

Samuel to be born ‘normal’, a follow up of the case 10 years later by FoxNews reveals that Samuel cannot walk without leg braces and is very often wheelchair bound. He also has a three year old brother with spina bifida.

- 6 Both ‘patients’ and ‘interests’ are mediated by parties within these institutions who themselves have ‘interests’. Actions by the profession are always those of an already interested party, that is, one party with interests in relation to another party who has interests. Featherstone argues that this interest developed not only from medical technologies but, and especially in Australia, around ‘social, political and economic discourses stressing the need for population growth’ (Featherstone 2008: 454). At the end of the 19th century and the beginning of the 20th Century science and medicine were taking more interest in the *life* of the foetus, stimulated in part by the earlier discoveries of the human egg and the mechanics of fertilization (Featherstone 2008: 453). The foetus was a potential child, and as such there developed a morality and legality around its *presence*. Significantly, as the foetus became not only conceptually and linguistically present, but, eventually visible, with such visions ‘mediated, even distorted, through the lens of culture, but were nonetheless naturalized and seemingly made coherent’ (Hartouni cited in Featherstone 2008: 459). At the same time, ‘the mother’s bodily autonomy [was] undermined. She became the “host”, an invisibilised “backdrop”, while the foetus has moved from being a “passenger” to becom[ing] the active player’ (Franklin cited in Featherstone 2008: 459).

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