Reforming Fetal Surgery: Maternal Autonomy and Fetal Interests

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Abstract

Advances in fetal surgery have intensified longstanding ethical tensions between maternal autonomy and fetal interests, exposing limitations within the current UK legal framework. Despite the increasing clinical use of in utero interventions, the law provides no coherent doctrine specifically addressing fetal surgery, instead relying on fragmented principles drawn from abortion law, consent jurisprudence, and fetal personhood doctrine. This article undertakes a doctrinal and ethical analysis of the existing statutory and case law framework to assess whether it adequately mediates conflicts between pregnant women and fetal interests in surgical contexts. It argues that the current framework obscures rather than resolves these tensions by failing to articulate clear principles governing maternal refusal, fetal benefit, and state intervention. The absence of legal clarity risks inconsistent clinical practice and reinforces conceptual confusion regarding fetal rights. The article concludes that targeted legal reform is necessary to clarify the application of consent principles in fetal surgery while preserving maternal autonomy as the central organising principle. It proposes a principled framework that integrates ethical analysis without conferring independent legal personhood on the fetus, thereby providing clearer guidance for clinicians and safeguarding reproductive rights.

1 Introduction

This article, titled *Maternal Autonomy vs Fetal Rights: Reforming the Legal Framework for Fetal Surgery,* explores how the current UK legal framework, or lack thereof, for fetal surgery heightens the ethical and legal tensions between maternal autonomy and fetal rights. As medicine evolves, the law struggles to keep up, resulting in legal gaps and ambiguity, creating inconsistencies in clinical practice and legal discourse. This article evaluates whether reform is necessary to clarify the law while safeguarding reproductive rights.

1.1 Background

Historically, medical understanding of pregnancy and fetal development was limited, both mothers and clinicians had little insight into the workings of the womb.[1] Women had two choices: continue the pregnancy despite fetal abnormalities or terminate it.[2] However, advances such as ultrasound[3] and fetal surgery[4] now offer a third option: in utero intervention. Conditions treatable by fetal surgery include spina bifida,[5] twin-twin transfusion syndrome,[6] and Sacrococcygeal teratoma.[7]

While groundbreaking,[8] these developments create legal and ethical tensions. Medical practice increasingly recognises both the pregnant woman and the fetus as patients,[9] each with their own distinct needs.[10] This becomes problematic where these needs are in opposition. Fundamental questions arise. Should the fetus be granted legal standing as a patient? Do these

[1] Helen Statham, 'Prenatal diagnosis of fetal abnormality: the decision to terminate the pregnancy and the psychological consequences' (2002) 13(4) FMMR 213.
[2] Ibid.
[3] Mark Van de Velde et al, 'Fetal Pain Perception and Pain Management' (2006) 11(4) SFNM 11(4) 232; Kha M. Tran, 'Anesthesia for Fetal Surgery' (2010) 15(1) SFNM 40.
[4] Jeffrey L Lenow, 'The Fetus as a Patient: Emerging Rights as a Person?' (1983) 9(1) AJLM 1.
[5] Keerthika Sampat and Paul D Losty, 'Fetal surgery' (2021) 108(6) BJS 632.
[6] Mayo Clinic, *Fetal Surgery*, (2025) <https://www.mayoclinic.org/tests-procedures/fetalsurgery/about/pac-20384571 > accessed 8 June 2026.
[7] Ibid.
[8] Jeffrey L Lenow, 'The Fetus as a Patient: Emerging Rights as a Person?' (1983) 9(1) AJLM 1.
[9] Frank A Chervenak and Laurence B McCullough, 'The Fetus as a Patient: An Essential Concept for the Ethics of Perinatal Medicine' (2003) 20(8) AJP 399; Clare Williams, 'Framing the Fetus in Medical Work: Rituals and Practices' (2005) 60(9) SSM 2085.
[10] H Catarina M L Rodrigues and Paul P van den Berg, 'Morally and procedurally justified argument for the moral obligations of physicians toward pregnant women (and fetuses) in the context of maternal–fetal surgery: A Gewirthian precautionary approach' (2012) MLI 142.

advancements justify re-evaluating maternal autonomy? Could fetal surgery undermine protections for pregnant women? These unresolved questions urge the need for reform.[11]

1.2 The Legal Problem: Gaps, Ambiguity and Inconsistencies

UK law on pregnancy-related decision-making is heavily reliant on case law,[12] traditionally prioritising maternal autonomy[13] and establishing that the fetus has no independent rights.[14] However, fetal surgery introduces new complexities that the law has not yet adequately addressed, largely because it is a relatively recent and rapidly developing area of medical practice that blurs the legal distinction between the pregnant woman and the fetus. In the absence of clear statutory guidance,[15] legal principles must be inferred from related areas of law, ultimately creating inconsistencies in application and outcomes for women.

Two conceptualisations dominate the literature;[16] the one-patient model, which treats the pregnant woman as the sole patient,[17] and the two-patient model, which views the fetus as a separate patient.[18]

The current UK legal stance supports the one-patient model.[19] In *Paton v British Pregnancy Advisory Service,*[20] the court held that a fetus 'cannot, in English Law… have any right of its own… until it is born and has a separate existence from the mother.'[21] This was reaffirmed in *Re MB,*[22] which established that a woman's right to refuse medical treatment is absolute, even

[11] H Catarina M L Rodrigues and Paul P van den Berg, 'Morally and procedurally justified argument for the moral obligations of physicians toward pregnant women (and fetuses) in the context of maternal–fetal surgery: A Gewirthian precautionary approach' (2012) MLI 142.
[12] Kevin X Cao et al, 'The legal frameworks that govern fetal surgery in the United Kingdom, European Union, and the United States' (2018) 38(7) PD 475.
[13] *St. George's Healthcare NHS Trust v. S* [1998] 3 All ER 673
[14] *MB (Caesarean Section), Re* [1997] 2 WLUK 313
[15] Kevin X Cao et al, 'The legal frameworks that govern fetal surgery in the United Kingdom, European Union, and the United States' (2018) 38(7) PD 475.
[16] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[17] Ibid.
[18] Jeffrey L Lenow, 'The Fetus as a Patient: Emerging Rights as a Person?' (1983) 9(1) AJLM 1.
[19] *Paton v United Kingdom* [1980] 3 EHRR 408
[20] Ibid.
[21] Ibid.
[22] *MB (Caesarean Section), Re* [1997] 2 WLUK 313.

if it may harm the fetus.[23] The decision in St. *George Healthcare,*[24] further confirms that pregnancy does not diminish a woman's legal right to make autonomous medical decisions.[25]

However, fetal surgery inherently treats the fetus as a separate patient, therefore adhering to a two-patient model. As Howe observes, 'surgical intervention on behalf of the fetus takes place inside a pregnant woman's body; however, there are two patients.'[26] This creates a legal dilemma. If a fetus is treated as a patient in medical practice, should the law acknowledge some form of protection? If a pregnant individual refuses fetal surgery, could this ever justify legal intervention to prioritise fetal welfare? Where should the legal boundary be drawn to ensure maternal rights are not eroded?

This tension remains unresolved in law, in part because recognising the fetus as a right-bearing entity would challenge the long-established legal principle that prioritises maternal autonomy and denies fetal personhood before birth. As a result, the law has been reluctant to directly engage with these issues, leaving a gap between medical practice and legal doctrine.

1.3 Inconsistencies in the Current Law

The absence of statutory guidance means courts must rely upon inference from other legal areas, namely, criminal[27] and tort law.[28] This leads to inconsistency, making it both impractical and confusing in practice.

In criminal law, the fetus is afforded limited protections.[29] The Offences Against the Person Act 1861 and the Infant Life Preservation Act 1929 criminalise unlawful abortion[30] and protect a fetus capable of being born alive.[31] These principles were reaffirmed in *Attorney-General's*

[23] Ibid.
[24] *St. George's Healthcare NHS Trust v. S* [1998] 3 All ER 673.
[25] Ibid.
[26] David Howe, 'Ethics of prenatal ultrasound' (2014) 28(3) BPRCOG 443.
[27] Kevin X Cao et al, 'The legal frameworks that govern fetal surgery in the United Kingdom, European Union, and the United States' (2018) 38(7) PD 475.
[28] Congenital Disabilities (Civil Liability) Act 1976, s.1.
[29] Kevin X Cao et al, 'The legal frameworks that govern fetal surgery in the United Kingdom, European Union, and the United States' (2018) 38(7) PD 475.
[30] Offences Against the Person Act 1861.
[31] Infant Life Preservation Act 1929, s.1.

Reference (No 3 of 1994),[32] suggesting some degree of fetal protection.[33] However, this protection is situational and does not extend to maternal decision-making by the pregnant woman.

In tort law, remedies exist for harm caused to a fetus by third parties,[34] but not by the mother.[35] The Congenital Disabilities (Civil Liability) Act 1976 allows a child born with disabilities to bring a claim for pre-birth harm[36] but explicitly prevents legal action against their mother.[37] The Law Commission later rejected proposals to allow this, reinforcing maternal immunity from liability.[38] This raises a troubling inconsistency: the fetus is protected from third-party harm, but maternal conduct remains legally irrelevant. If the law were to recognise fetal interests in surgery cases, would this set a dangerous precedent for restricting reproductive rights?

1.4 The Need for Legal Reform

The lack of clear legal principles governing fetal surgery creates significant uncertainty for medical professionals and pregnant women. This article argues that reform is needed to clarify the legal status of the fetus during in utero interventions, the scope of maternal consent and refusal rights, and how to resolve conflicts between maternal and fetal interests without undermining autonomy. Legal reform must be comprehensive, yet cautious to avoid unintended encroachment on reproductive rights, particularly abortion.

1.5 Legal Approaches to Fetal Surgery

Hyatt et al argue that the legal status of the fetus as a patient and its implications for the pregnant person's autonomy have been relatively unexamined.[39] This gap in legal recognition creates

[32] *A-G Ref No.3* [1996] 1 Cr. App. R.351.
[33] Ibid.
[34] Law Commission Report No 60.
[35] Congenital Disabilities (Civil Liability) Act 1976, s.1.
[36] Ibid, s.1.
[37] Ibid, s.2.
[38] Law Commission Report No 60.
[39] E Goldblatt Hyatt et al., 'I don't have a telephone to the fetus: Clinicians' conceptions of fetal patienthood in maternal-fetal surgery counselling' (2024) SSM 342 (1982).

uncertainty regarding whether the state can, or should, intervene to compel a pregnant woman to undergo fetal surgery against her will.

The invasiveness of fetal surgery varies, encompassing open procedures (requiring a uterine incision) and minimally invasive fetoscopic techniques.[40] However, legal systems struggle to keep up with evolving medical innovations, relying heavily on preexisting frameworks on bodily autonomy and consent. The principle of informed consent under UK law, as redefined in the landmark case *Montgomery v Lanarkshire Health Board,*[41] dictates that an individual must be made aware of all material risks associated with the proposed treatment and its alternatives.[42] While this principle is well-established in general medical law, it becomes complicated when applied to maternal-fetal surgery as it involves two distinct yet interconnected patients.[43]

This raises the question: if a pregnant woman is well-informed, yet refuses fetal surgery, could the state override her decision based on fetal welfare? While no UK case has directly addressed this issue in a fetal surgery context, precedents involving court-ordered obstetric interventions,[44] such as forced caesareans, indicate a historical judicial reluctance to interfere with maternal autonomy.[45] This judicial stance may be rooted in fear of a slippery slope, as they may not want to risk policing pregnancy. Yet, by not intervening, they risk ignoring complex ethical issues that require guidance. This reflects a deeper structural avoidance which may prevent the evolution of the law, specifically concerning medical advancement. Moreover, the legal recognition of fetal interests has evolved in ways that complicate this issue.

By 1992, UK medical guidance shifted to classify fetal remains as deceased children's bodies rather than medical waste, a move reflecting a growing acknowledgement of fetal personhood.[46] This implies a shift in the perception of fetal status before birth and could perhaps influence arguments for fetal rights in the context of surgery. This highlights that there

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[40] Ibid.
[41] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[42] Ibid.
[43] H Catarina M L Rodrigues and Paul P van den Berg, 'Morally and procedurally justified argument for the moral obligations of physicians toward pregnant women (and fetuses) in the context of maternal–fetal surgery: A Gewirthian precautionary approach' (2012) MLI 142.
[44] *St George's Healthcare NHS Trust v S* (Guidelines) [1999] Fam. 26
[45] Ibid.
[46] E Goldblatt Hyatt et al., 'I don't have a telephone to the fetus: Clinicians' conceptions of fetal patienthood in maternal-fetal surgery counselling' (2024) SSM 342 (1982).

is an inconsistency in how fetuses are viewed across disciplines, which makes it significantly harder to legislate.

Legal approaches to fetal surgery are therefore at a crossroads; while the law prioritises maternal autonomy, state interests in fetal welfare remain a persistent undercurrent. The absence of clear legal protections leaves room for arguments for fetal surgery to remain wholly subject to maternal consent, or, under exceptional circumstances, intervention could be legally justified.

2 The Legal Status of the Fetus and Maternal Autonomy

Courts often avoid engaging directly with this question, instead focusing on what the fetus is not.[47] English law clearly denies fetal personhood,[47] granting legal recognition only after birth.[48] Yet, this clarity fades where medical interventions are performed directly on the fetus in utero, despite its lack of independent rights. The absence of legislative clarity on fetal surgery may be strategic, allowing flexibility while avoiding political backlash over fetal personhood.

In *Attorney-General Reference (No.3 of 1994),*[49] the House of Lords established that the fetus is a 'unique organism,'[50] distinct from the mother, yet without independent legal personhood.[51] The judgment's reluctance to grant personhood, yet acknowledge distinctiveness, mirrors the broader discomfort in bioethics and the law, recognising medical advancements while guarding against politicisation.[52] This ambiguity is problematic concerning fetal surgery. While the law's flexible approach allows for varied judicial outcomes, it also creates uncertainty that can have profound practical implications, particularly in medical practice.

[47] *Re An application by the Northern Ireland Human Rights Commission for Judicial Review* (Northern Ireland) [2018] UKSC 27, [92].
[48] *Attorney-General Reference (No.3 of 1994)* [1998] AC 245.
[49] Ibid.
[50] *An approach approved by the Court of Appeal in CP (a child) v First-tier Tribunal* (Criminal Injuries Compensation) [2014] EWCA Civ 1554.
[51] Ibid.
[52] Benjamin Gregg, 'Political bioethics'(2022) 47(4) JMP 516.

Legal scholars diverge in their interpretation of this ambiguity. While David Nixon supports a strict post-birth threshold for legal recognition,[53] Felice Sorrentino argues that the limited legal status during gestation is ethical and necessary.[54] This comparison reveals a struggle to balance personhood as a conception with practical regulation, urging interpretation from criminal and tort law to clarify the status of the fetus.

2.1 Abortion

Fetal protection under criminal law is limited. Under the Offences Against the Person Act 1861, sections 58 and 59 criminalise unlawful abortion, but they do not recognise the fetus as a separate legal entity. The ambiguity in the statutory language, such as 'intent' and 'procure', raises concerns about potential liability for fetal death resulting from medical intervention, or a lack thereof, especially where the fetus's welfare was at stake. This reinforces societal expectations that pregnant women are subject to greater control over their bodies, potentially leading to liability in unpredictable legal circumstances.

Conversely, the Abortion Act 1967 allows for abortion under specific conditions.[55] Section 1(1)(a)'s 24-week limit[56] reflects viability as a legal framework and indicates a legal approach that attempts to balance maternal rights and fetal interests. This aligns with the Infant Life (Preservation) Act 1929,[57] which criminalises destroying a fetus 'capable of being born alive.'[58] This raises the question of whether the concept of viability should influence the legal approach to fetal surgery. And, if a viable fetus can be surgically treated, should there be formal recognition of its interests, granting more protection?

Recognising fetal interests may risk obscuring maternal autonomy, creating a tension between the rights of the woman and the interests of the fetus, as both may be viewed as patients with competing interests. As fetal surgery becomes more accessible, this in-between position may

[53] David Nixon, 'Should UK law reconsider the initial threshold of legal personality? A critical analysis' (2010) 16(2) HRGE 182.
[54] Felice Sorrentino et al, 'Caesarean section on maternal request-ethical and juridic issues: a narrative review' (2022) 58(9) M 1255.
[55] Abortion Act 1967.
[56] Abortion Act 1967, s.1(1)(a).
[57] Infant Life (Preservation) Act 1929.
[58] Ibid.

become unsustainable long-term due to the lack of legal clarity. In *Re MB,*[59] the court held that physically invasive treatment without consent is assault.[60] Yet, in cases where the fetus is considered a patient, if a competent woman refuses surgery that could save the fetus's life, how far can the law justify intervening? This concern is heightened when considering the disproportionate effect this will have on marginalised women, whose access to healthcare is already restricted.[61]

While English law rejects fetal personhood,[62] it simultaneously offers limited legal protection to the fetus in certain legal contexts. Courts have acknowledged that the state has a role in protecting fetal interests,[63] raising the question of whether this implicitly grants a form of legal status, despite the fetus having no enforceable rights[68] or being capable of having claims brought on its behalf.[64] This question becomes particularly relevant in fetal surgery, where the state may be obligated to ensure medical treatment is provided in utero, particularly to preserve its life or address abnormalities. While this appears paternalistic, it could erode maternal autonomy and reproductive rights.

St George's Healthcare NHS Trust v S[65] provides important insight into the legal complexities surrounding fetal interests. The court held that a competent woman's right to refuse medical treatment, even if it endangers the fetus, must be respected.[66] However, the ambiguous language used by the court, stating the fetus is 'not nothing', suggests a recognition of fetal personhood that complicates the relationship between maternal autonomy and fetal welfare. This ambiguity invites further debate about whether the fetus should be granted legal rights in medical contexts, especially given that it cannot be made a ward of the court,[67] unlike a child.[68] While this respects autonomy, it creates a gap in fetal protection, ultimately confusing accountability.

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[59] *MB (Caesarean Section), Re* [1997] 2 WLUK 313.
[60] Ibid.
[61] Patricia E Stevens, 'Marginalized women's access to health care: A feminist narrative analysis' (1993) 16(2) ANS 39.
[62] *Re An application by the Northern Ireland Human Rights Commission for Judicial Review* (Northern Ireland) [2018] UKSC 27, [92].
[63] *R (Crowther) v Secretary of State for Health and Social Care* [2021] EWHC 2536 (Admin), [62].
[64] *Paton v BPAS* [1978] 2 All ER 987.
[65] (1998) 44 BMLR 160, [163].
[66] Ibid.
[67] *Re F (In Utero)* [1988] Fam 122 (CA).
[68] Family Law Reform Act 1969, s.7.

Additionally, the legal status of embryos, as demonstrated in *Evans v Amicus,*[69] further illustrates the inconsistency in how life stages are treated under the law.[70] Embryos are not recognised as having independent rights, for instance, the right to life,[71] while fetuses are granted some degree of protection at gestational age.[72] The legal distinction between embryos and fetuses raises further ethical concerns, particularly in the context of fetal surgery and the rights of the fetus. This inconsistency not only reflects a complicated approach to the moral and legal status of potential life but also complicates the legal justification for fetal interventions, as it becomes unclear whether procedures are grounded in maternal autonomy or fetal rights. Therefore, complicating legal decision-making.

Judicial perspectives on fetal interests remain unsettled. Lady Hale in *Re NI Human Rights*[73] suggested that categorically denying fetal interests may be overly dogmatic.[74] This observation indicates a potential shift in legal thinking, perhaps opening the door to greater legal recognition of fetal interests. If the law begins to acknowledge the fetus as having a degree of legal significance in medical contexts, this could have profound implications for the regulation of fetal surgery and the balance between maternal autonomy and fetal rights. This leaves the overarching question of how potential legal reform should be balanced.

Ultimately, the legal status of the fetus is inconsistent. While the law affords fetal protections in tort and criminal contexts, it offers little to no protection when maternal autonomy is at stake. This disparity may reflect a reluctance to impose accountability on the state for pregnancy-related harm, particularly given that obstetric violence goes largely undetected and unpunished in the UK.[75] Such selective recognition of fetal interests allows intervention when others cause harm but avoids legislating instances where maternal-fetal harm is called into question, and avoids specific, unnegotiable prioritisation of maternal autonomy. As Smart argues law is inherently male,[76] and this notion persists even within the reproductive sphere. The ambiguity surrounding fetal surgery, and more broadly, the balancing of maternal autonomy against

[69] [2004] 3 All ER 1025.
[70] Ibid.
[71] European Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights as amended), s.2.
[72] *Evans v Amicus* [2004] 3 All ER 1025.
[73] [2018] UKSC 27, [92].
[74] Ibid.
[75] Elaine Storkey, *Scars across humanity: Understanding and overcoming violence against women* (InterVarsity Press 2018.)
[76] Carol Smart, 'The Woman of Legal Discourse' (1992) 1(1) SLS 29.

growing fetal interests, demonstrates how legal structures continue to reflect and reinforce patriarchal assumptions.

2.2 Maternal Autonomy and the Legal Right to Choose

The concept of maternal autonomy lies at the heart of many legal and ethical debates surrounding pregnancy and fetal surgery.[77] Maternal autonomy asserts a woman's right to make medical decisions, including the right to refuse treatment,[78] which is protected under the principles of bodily integrity and informed consent.[79] However, the advancement of fetal surgery complicates this autonomy,[80] as decisions not only impact the pregnant woman's health but also the potential well-being of the fetus.[81]

Nyinawagaba affirms that women's right to choose must be exercised without external interference,[82] with informed consent at the forefront of any proposed procedure.[83] Yet, where a fully informed woman refuses life-saving treatment for her fetus, the law's stance is unsure and unclear. This is particularly damaging as maternal versus fetal interests in opposition could lead to coerced or forced interventions, eroding autonomy.

Rosamund Scott critiques the notion of 'maternal-fetal conflict', arguing that it perpetuates outdated notions of women as self-sacrificing figures whose interests are in opposition to those of the fetus.[84] Indeed, it appears to oversimplify this complex relationship.[85] Chau and Herring propose an alternative perspective, suggesting that the legal framework should consider the relationship between the fetus and pregnant woman rather than positioning them in conflict.[86] This perspective underscores the need for legal reform that balances maternal and fetal interests without diminishing a woman's right to bodily integrity. However, the presence of obstetric

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[77] Davis Isaacs, 'Moral status of the fetus: Fetal rights or maternal autonomy?' (2003) 39(1) JPCH 58.
[78] Rebecca Brione, 'To What Extent Does or Should a Woman's Autonomy Overrule the Interests of Her Baby? A Study of Autonomy-Related Issues in the Context of Caesarean Section' (2015) 21(1) NB 71.
[79] Ibid.
[80] Keerthika Sampat and Paul D Losty, 'Fetal surgery' (2021) 108(6) BJS 632.
[81] Ibid.
[82] Beatrice R Nyinawagaba, 'Reproductive Rights as Fundamental Human Rights: A Feminist Perspective on Bodily Autonomy and Social Justice' (2024) 5(2) EEJHSS 9.
[83] Ibid.
[84] Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (Hart Publishing 2002).
[85] Mary Ann Warren, 'The moral significance of birth' (1989) 4(3) H 46.
[86] Jonathan Herring and P-L Chau, 'My Body, Your Body, Our Bodies', (2007) 15(1) MLR 34.

violence within medical settings[87] goes undetected and is highly criticised as a faddish feminist term,[88] therefore, demonstrating the dangers of coercive practices that prioritise medical authority over maternal choice.

In the landmark case of *St George's Healthcare NHS Trust v S,*[89] the court reaffirmed the principle that a competent woman retains the right to refuse medical treatment,[90] even if such a decision may endanger the fetus. This ruling emphasised the importance of recognising maternal autonomy, asserting that the right to bodily integrity is paramount, even if causing potential harm.[91] However, the court's recognition that the fetus is 'not nothing' adds a layer of complexity to this discussion, raising the question of whether fetal interests should be considered more strongly in future frameworks.[92] Indeed, the court in *St George's* recognised that pregnancy increases the responsibilities of a woman, perhaps this is illustrative of how legal reform, in favour of the fetus, would look, for instance, an increased duty of care owed by mothers in utero. That said, this would strike an uneven balance between protections owed by mothers than by fathers, perhaps exacerbating gender inequality in law. Such an approach risks reinforcing a gendered conception of responsibility that the law has otherwise sought to avoid, suggesting that reform in favour of the fetus may come at a significant cost to women's legal autonomy.

This contradiction may also lead to a complicated compromise that displeases both sides of the maternal-fetal conflict debate; some may see it as a threat to autonomy, and some may see it as insufficient protection for the fetus. Therefore, any reform is at risk of criticism, and considering there is a tendency to over-politicise reproductive rights,[93] reform must be comprehensive, respect autonomy, and not risk oversimplification, and not perpetuate legal ambiguities.

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[87] Rachelle Chadwick, 'The battle for recognition of obstetric violence' (*Centre for Ethics and the Law in the Life Sciences: Durham University*, 1 November 2021) <gttps://www.durham.ac.uk/research/institutes-and-centres/ethics-law-life-sciences/about-us/blogs/obstetricviolence-blog/battle-for-recognition-of-obstetric-violence/> accessed 8 June 2026.
[88] Chuck Dinerstein, 'Obstetric Violence: New Legal Phrase That Hurts More Than It Helps' (*American Council on Science and Health*, 24 August 2018) <https://www.acsh.org/news/2018/08/24/obstetrical-violence-new-legal-phrase-hurts-more-helps-13349> accessed 8 June 2026.
[89] *St George's Healthcare NHS Trust v S* (Guidelines) [1999] Fam. 26.
[90] Ibid.
[91] Ibid.
[92] Ibid.
[93] Anne Marie Goetz and Sally Baden, 'Who needs [sex] when you can have [gender]?' (1997) 56(1) FR 3.

2.2.1 Mental Capacity Act and Mental Health Act Impact

Legal contradictions emerge when maternal autonomy is examined through the lens of the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (MHA). This inconsistency has not gone unnoticed; while the MCA protects capacity-based autonomy,[94] the MHA enables forced interventions, a contradiction critiqued by Clough,[95] who argues it disproportionately affects marginalised women.[96] Disabled women in particular are significantly disadvantaged by these frameworks.[97] If performing a physically invasive medical procedure without consent is assault.[98] The law therefore, reveals a fundamental tension in determining whether, and to what extent, medical intervention can be justified where a competent woman refuses a procedure intended to improve fetal health.

Under the MCA, if a woman lacks capacity, decisions regarding her medical treatment are made in her 'best interests,'[99] a test that considers medical, ethical and welfare factors.[100] This framework prioritises the pregnant woman's rights over fetal well-being. However, the MHA provides a different route:[101] a woman detained under mental health legislation can be compelled to undergo medical interventions,[102] even those affecting her pregnancy. This inconsistency is troubling.[103] While the MCA seeks to protect autonomy through a best interest's framework, although this act is not without scrutiny,[104] the MHA allows for compulsory treatment, thereby undermining a pregnant woman's autonomy.[105]

The tensions between these two frameworks are particularly problematic in the context of obstetric violence, where coercion and forced medical interventions disproportionally affect

[94] Mental Capacity Act 2005.
[95] Beverley Clough, 'Mental Capacity and Decision Making' in Elisabeth Cloth Romanis et al (eds), *Diverse Voices in Health and Ethics: Important Perspectives* (Bristol University Press 2025).
[96] Ibid.
[97] Jenny Hundley et al, 'Dignity and respect during pregnancy and childbirth: a survey of the experience of disabled women' (2018) 18(1) BMCPC 328.
[98] *MB (Caesarean Section), Re* [1997] 2 WLUK 313.
[99] Mental Capacity Act 2005, s.4.
[100] Ibid.
[101] Mental Health Act 1983.
[102] Ibid.
[103] Mathew Hotopf, 'The assessment of mental capacity' (2005) 5(6) CM 580.
[104] Ibid.
[105] Mental Health Act 1983.

pregnant individuals.[106] Obstetric violence, while not legally defined in the UK,[107] includes unnecessary medical interventions, non-consensual procedures, and the dismissal of material preferences.[108] Cases of forced caesarean sections and the use of mental health legislation to justify coercive obstetric practices reveal the extent to which maternal autonomy is undermined and the dangers of doing so. For the original stance to force a caesarean in *St George's NHS Trust,*[109] was that the mother's decision was seen as 'irrational and bizarre,'[110] allowing her detention under section 2 of the MHA.[111]

Fetal surgery presents a legal grey area where medical professionals must navigate whether to prioritise maternal autonomy or fetal well-being. Perhaps creating a space where medical professionals can pressure women into procedures by appealing to the perceived 'best interests' of the fetus. This raises concerns about subtle forms of medical coercion and external pressure on women: where fetal surgery is framed as necessary for fetal survival, the line between voluntary decision-making and coerced medical intervention becomes blurred. Therefore, prioritising fetal rights could increase paternalism in obstetric care, thus undermining autonomy.

Ultimately, while *St George's NHS Trust*[112] reaffirmed that the fetus does not have independent legal personhood, the law simultaneously permits overriding maternal autonomy under mental health legislation.[113] This contradiction highlights an urgent need for legal reform to create a coherent approach that respects autonomy while addressing the complexities of fetal surgery. While the MCA and MHA offer clarity for many medical procedures, fetal surgery presents unique challenges because it involves two patients, one legally recognised (the mother) and one whose legal status is complex (the fetus). The legal prioritisation of maternal autonomy, while ethical, may obscure how subtle coercion operates in practice, especially where clinicians present fetal surgery as necessary.

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[106] Maura Lappeman and Leslie Swartz, 'How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word "Violence"' (2021) 27(8) OS 987.
[107] AIMS, 'Obstetric Violence' (*AIMS*, 23 November 2022) <https://www.aims.org.uk/information/item/obstetric-violence> accessed 8 June 2026.
[108] Maura Lappeman and Leslie Swartz, 'How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word "Violence"' (2021) 27(8) OS 987.
[109] *St George's Healthcare NHS Trust v S (Guidelines)* [1999] Fam. 26.
[110] Ibid.
[111] Mental Health Act 1983, s.2.
[112] *St George's Healthcare NHS Trust v S (Guidelines)* [1999] Fam. 26.
[113] Mental Health Act 1983.

2.3 The Intersection of Abortion Law and Fetal Surgery

The relationship between fetal surgery and abortion laws is legally and ethically complex. Casper argues that the two are deeply entangled,[114] as both involve questions of fetal status, medical intervention and maternal rights.[115] However, while abortion law is based on the right to terminate, fetal surgery operates under the assumption of continued gestation and medical efforts to improve fetal outcomes. This results in inconsistent legal treatment of the fetus across medical contexts.

Scholar O'Donovan critiques the reluctance of the law to define the fetus's legal status, arguing this ambiguity stems from concerns about its implications for abortion law.[116] If the fetus were afforded stronger legal recognition in the context of fetal surgery, this could undermine the legal foundation of abortion rights.

Ultimately, the legal tension between abortion and fetal surgery illustrates how the law struggles to balance maternal autonomy, fetal interests and medical innovation.[117] However, it is important to distinguish discussions on fetal surgery from arguments that could undermine abortion rights. The recognition of fetal interests in medical advancements should not be used to restrict access to abortion but rather to clarify ethical and legal principles governing maternal consent in fetal surgery. The law should continue to prioritise the autonomy of the pregnant person, ensuring that any legal developments in this area reinforce, rather than erode, reproductive rights.

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[114] Monica J Casper, *The making of the unborn patient: A social anatomy of fetal surgery* (Rutgers University Press 1998).
[115] Ibid.
[116] Katherine O'Donovan, 'The Legal Parenthood of the Fetus: A Challenge to Feminism' in Jo Bridgeman and Daniel Monk (eds), *Feminist Perspectives on Child Law* (Routledge-Cavendish 2006).
[117] Monica J Casper, *The making of the unborn patient: A social anatomy of fetal surgery* (Rutgers University Press 1998).

3. The Fetus as a Patient? Ethical and Legal Boundaries in Fetal Surgery

3.1 The Two-Patient Model vs. One Patient Model in Fetal Surgery

As discussed, the legal framework surrounding fetal surgery predominantly adopts a one-patient model, treating the pregnant woman as the sole patient with absolute autonomy over her body.[118] However, Howe introduces the concept of a 'two-patient model', where the fetus is not just a subject of the procedure but the primary patient.[119] Despite being confined to the woman's body,[120] the invasiveness of the surgery could justify legal recognition of the fetus as a patient with some degree of personhood. This presents a significant ethical and legal dilemma, pushing boundaries between maternal autonomy and medical paternalism, raising questions about the extent to which the law should recognise fetal personhood when interests conflict. Furthermore, it raises the question of who decides in the absence of law, the pregnant woman or the medical professional?

Notably, determining patienthood based on invasiveness largely overlooks the woman's experience, particularly how invasive such procedures are for her body. Fetal surgery may entail extensive post-operative care[121] and complications affecting the woman's health and well-being. In *Attorney-General's Reference (No.3 of 1994)*,[122] the judge emphasised that when considering the mother's health, the fetus is irrelevant, reinforcing that the woman's interests should take precedence. Focusing on the fetus as the primary patient risks sidelining the woman, whose autonomy and bodily integrity are also at stake. Begović warns that women may be diminished as patients,[123] with Mclean attributing this to increased focus on the fetus's interests.[124] The two-patient model, therefore, risks disrupting the balance between maternal

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[118] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[119] David Howe, 'Ethics of prenatal ultrasound' (2014) 28(3) BPRCOG 443.
[120] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[121] NHS England, *Open Fetal Surgery to Treat Fetuses with Open Spina Bifida* (December 2018) <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2018/12/Open-fetal-surgery-to-treat-fetuses-with-open-spina-bifida.pdf> accessed 8 June 2026.
[122] *Attorney-General's Reference (No. 3 of 1994)* [1998] A.C. 245.
[123] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[124] Sheila A M McLean, *Autonomy, Consent and the Law* (Dundee University Press 2009).

autonomy and fetal rights. While it claims to reflect medical reality, it risks bestowing a higher paternalistic role on clinicians, where they, not women, may determine best interests. This could be deceivingly coercive in practice.

That said, a middle ground may exist, one that recognises the biological interdependence of the woman and the fetus.[125] As seen in *Re A (Children) (Conjoined Twins),*[126] they are intrinsically linked; therefore,[127] separating them conceptually is problematic. Mattingly advocates a 'two patient ecosystem model',[128] arguing that the fetus being physically inside the woman prevents a clear conceptual division.[129] She cautions that fetal patienthood could reduce doctors' obligations to the woman, leading to uncertainty when duties conflict.[130]

This has serious legal implications. A model where the woman and fetus are viewed as interconnected but as having distinct legal rights offers a way to balance their competing interests. Yet, legally recognising the fetus as a separate patient, even under an ecosystem model,[131] may complicate the prioritisation of rights. A possible solution is recognising that doctors owe beneficence-based obligations to the fetus, but both beneficence and autonomy-based duties to the woman,[132] placing a higher duty of care on the latter.

While Scott argues that maternal autonomy must remain absolute to protect reproductive rights,[133] and Chervenak and McCullough contend that fetal patienthood creates legitimate moral obligations,[134] this binary framing risks oversimplifying pregnancy itself.[135] As Mattingly suggests, pregnancy does not neatly divide into two competing subjects.[136] Yet conceptualising the fetus as a separate patient carries significant consequences. As Lyerly warns, treating the fetus as requiring distinct medical care risks elevating its interests above the

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[125] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[126] *Re A (Children) (Conjoined Twins)* [2000] 1 FCR 561.
[127] Ibid.
[128] Susan S Mattingly, 'The maternal-fetal dyad: Exploring the two-patient obstetric model' (1992) 22(1) HCR 13.
[129] Ibid.
[130] Ibid.
[131] Ibid.
[132] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[133] Rosamund Scott, *Rights, Duties and the Body: Law and Ethics of the Maternal-Fetal Conflict* (Hart Publishing 2002).
[134] Frank A Chervenak and Laurence B McCullough, 'A comprehensive ethical framework for fetal research and its application to fetal surgery for spina bifida' (2002) 187(1) AMJOG 10.
[135] Susan S Mattingly, 'The maternal-fetal dyad: Exploring the two-patient obstetric model' (1992) 22(1) HCR 13.
[136] Ibid.

woman's,[137] a concern that becomes particularly acute in the context of obstetric violence,[138] where interventions may be imposed without full and voluntary consent. The two-patient model risks legitimising precisely this dynamic by normalising fetal-centred reasoning within clinical decision-making.

Rodrigues et al. go further in arguing that the fetus possesses independent value as the future child.[139] While this strengthens arguments for recognising fetal interests, it also raises difficult ethical and legal implications. If fetal patienthood is accepted as more than a moral metaphor, it may invite greater judicial or medical intervention when treatment is refused. This would sit uneasily with the current legal framework, which recognises the pregnant woman as the sole autonomous decision-maker. Any shift toward recognising independent fetal claims must therefore be approached cautiously, given its potential to undermine established protections for maternal autonomy.

Case law strongly affirms that a competent adult cannot be forced to undergo treatment, even if refusal may result in harm to another.[140] In *S. v Mc and M,* the court explicitly rejected the idea that it could authorise medical procedures on a competent adult without consent.[141] Similarly, in *Re F (Mental Patient: Sterilisation),* the court reaffirmed bodily autonomy, stating that treatment can be refused for any reason or none.[142] These precedents strongly suggest that fetal surgery does not justify overriding maternal consent and supports a one-patient model. Unlike cases involving incapacity, a competent pregnant woman retains full autonomy, even where fetal intervention is beneficial.

Moreover, common law imposes no duty to undergo bodily invasion for another's benefit,[143] and the fetus lacks legal personhood to claim independent rights.[144] This reinforces the onepatient model, maintaining the woman as the sole decision-maker. As Mattingly observes, most pregnant women willingly pursue treatment that benefits fetal health, recognising their

[137] Anne Drapkin Lyerly and Mary Briody Mahowald, 'Maternal-fetal surgery: The fallacy of abstraction and the problem of equipoise' (2001) 9(2) HCA 151.
[138] Ibid.
[139] H Catarina ML Rodrigues et al., 'Dotting the I's and crossing the T's: Autonomy and/or beneficence? The 'fetus as a patient' in maternal–fetal surgery' (2013) 39(4) JME 219.
[140] *Airedale N.H.S. Trust v. Bland* [1993] A.C. 789.
[141] *S. v. McC(orse. S.) and M. (D.S. Intervener)* [1972] A.C. 24.
[142] *Re F. (Mental Patient: Sterilisation)* [1990] 2 A.C. 1.
[143] *McFall v. Shimp* [1978] 127 Pitts LJ 14.
[144] In *re F. (in utero)* [1988] Fam. 122.

interconnected well-being.[145] This suggests that the one-patient model doesn't disregard fetal interests, but ensures that interventions respect the woman's autonomy. Legal reform should reflect this balance. Still, ethical concerns, such as fetal pain, complicate this debate, raising the question of whether legal frameworks should evolve in light of emerging medical insights.

3.2 Fetal Pain and Medical Ethics—Should this Influence the Law?

The Royal College of Obstetricians and Gynaecologists' 2022 *Fetal Awareness Evidence Review* concluded that fetal pain perception before 28 weeks' gestation is unlikely,[146] aligning with the prevailing view that cortical development is necessary for conscious pain. However, this threshold remains debated. Some scholars argue pain may be perceived earlier—an argument with significant ethical and legal implications, given that fetal surgery often occurs before 28 weeks.[147] This raises the possibility that limited legal recognition around this stage could be justified, as failure to intervene may neglect viable fetuses without necessarily conflicting with maternal autonomy.

Despite the RCOG's conclusions, the British medical community recommends measures to minimise fetal pain,[148] suggesting an implicit duty of care. Rathnayake interprets this as recognition of a physician's responsibility towards the fetus during fetoscopic procedures.[149] Yet this creates a legal tension: whether such a duty can exist without infringing maternal autonomy. Prioritising fetal pain could risk justifying interference with a woman's choices, increasing scrutiny of maternal decision-making and enabling physician bias to encroach on reproductive rights.

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[145] Susan S Mattingly, 'The maternal-fetal dyad: Exploring the two-patient obstetric model' (1992) 22(1) HCR 13.
[146] Royal College of Obstetricians and Gynaecologists, 'Fetal Awareness Evidence Review' (2022) <www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/fetal-awareness-updated-review-of-research-and-recommendations-for-practice/> accessed 8 June 2026.
[147] Roland Brusseau and Laura Myers, 'Developing consciousness: fetal anesthesia and analgesia' (2006) 25(4) SAPMP 189.
[148] British Medical Association, 'The Law and Ethics of Abortion' (March 2025) <https://www.bma.org.uk/advice-and-support/ethics/abortion/the-law-and-ethics-of-abortion> accessed 8 June 2026.
[149] Rathnayake, Ayodhya Prabhashini, *Fetoscopic procedures to treat the fetus in utero: legal concerns,* (2024). <https://ours.ou.ac.lk/wp-content/uploads/2024/12/ID-192_IRC-OUSL-2024.pdf> accessed 8 June 2026.

Further complicating matters, some researchers suggest fetal pain may occur before 20 weeks.[150] If so, current medical practices may be insufficient. Legal recognition of earlier fetal pain could extend beyond fetal surgery into abortion law, potentially prompting stricter limits or new obligations to prevent fetal pain. This risks tension between evolving science and policymaking, potentially restricting access to abortion, limiting maternal autonomy, and undermining broader human rights.

Derbyshire and Bockmann offer an important counterpoint, arguing that fetal pain need not mirror adult pain to be morally relevant.[151] Even early-stage pain, they suggest, could justify greater legal protection.[152] However, this risks reinforcing the two-patient model[153] and limiting maternal autonomy where fetal surgery is proposed to prevent suffering. Crucially, pain requires awareness,[154] not merely physiological response. Treating all fetal activity as morally significant risks conflating automatic responses with conscious experience.[155]

Although research suggests fetal consciousness develops later in pregnancy,[156] the precise point remains uncertain.[157] Using fetal pain as a basis for legal protection introduces a scientifically unstable standard that may threaten reproductive rights. It also creates inconsistencies with other legal contexts. For example, in end-of-life care,[158] pain relief may be administered even where patients lack consciousness,[159] guided by ethical considerations rather than confirmed awareness.[160] In contrast, fetal pain is often politicised, with debates shaped more by concerns about abortion than medical evidence.

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[150] Roland Brusseau and Laura Myers, 'Developing consciousness: fetal anesthesia and analgesia' (2006) 25(4) SAPMP 189.
[151] Dominic Wilkinson and Julian Savulescu, 'After-Birth Abortion: Why Should the Baby Live?' (2012) 39(5) JME 3.
[152] Ibid.
[153] David Howe, 'Ethics of prenatal ultrasound' (2014) 28(3) BPRCOG 443.
[154] Dong Ah Shin and Min Cheol Chang, 'Consciousness Research Through Pain' (2025) 13(2) H 332.
[155] Ibid.
[156] Hugo Lagercrantz and Jean-Pierre Changeux, 'The emergence of human consciousness: from fetal to neonatal life' (2009) 65(3) PR 255.
[157] Nancy S Jecker and Caesar Alimsinya Atuire, 'Emergent personhood: reply to critics' (2025) 51(4) JME 255.
[158] Diana J Wilkie and Miriam O Ezenwa, 'Pain and symptom management in palliative care and at end of life' (2012) 60(6) NO 357.
[159] Ibid.
[160] Ibid.

While Derbyshire and Bockmann provide a valuable ethical perspective,[161] their argument risks overstating the legal relevance of fetal pain. Grounding legal reform on this basis could inadvertently undermine maternal autonomy and shift the legal focus from the woman to the fetus.

3.3 Utilitarianism vs. Kantian Ethics—When Should Autonomy Override Medical Benefit?

Two dominant moral frameworks, utilitarianism and Kantian ethics, offer contrasting perspectives on whether autonomy should override medical benefit in fetal surgery. This tension is particularly significant when balancing maternal autonomy against potential fetal benefit. While utilitarianism may justify infringing autonomy to maximise overall welfare,[162] Kantian ethics treats respect for autonomy as a moral duty.[163]

3.3.1 Utilitarianism: Maximising Overall Well-Being

Utilitarianism, as articulated by Bentham[164] and Mill,[165] prioritises outcomes,[166] seeking the greatest good for the greatest number. In medical practice, this approach is reflected in policies such as neonatal resuscitation thresholds and the allocation of healthcare resources, where outcomes are weighed in terms of benefit and harm.[167] In fetal surgery, a utilitarian perspective may justify temporary infringements on maternal autonomy if they result in significant long-term benefits. For example, the success of fetal surgery for spina bifida,[168] resulting in improved motor function and quality of life after birth,[169] illustrates this reasoning.

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[161] Dominic Wilkinson and Julian Savulescu, 'After-Birth Abortion: Why Should the Baby Live?' (2012) 39(5) JME 3.
[162] Alvan Alviansyah Lubis and Mochammad Ra'afi Nur Azhami, 'Beyond the 'Greatest Happiness Principle': Exploring the Compatibility of Individual Rights and Utilitarian Ethics in Legal Policy Making' (2025) 3(1) EL 144.
[163] Ibid.
[164] Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (Oxford University Press 1907).
[165] John Stuart Mill, *Utilitarianism* (George Routledge & Sons 1907).
[166] Emily Jackson, *Medical Law: Text, Cases, and Materials* (5th edn, Oxford University Press 2019).
[167] Ibid.
[168] University College London Hospitals NHS Foundation Trust, 'Spina Bifida – Open Fetal Surgery' (*UCLH*, updated 2024) <https://www.uclh.nhs.uk/our-services/find-service/womens-health-1/maternity-services/your-pregnancy/spina-bifida-open-fetal-surgery> accessed 8 June 2026.
[169] Anna L David, 'Improving motor function in fetal surgery for open spina bifida' (2025) 45(1) AD 38.

Utilitarianism can be subdivided into Act and Rule Utilitarianism. Act Utilitarianism, as criticised by Mandal et al.,[170] assesses individual cases in isolation, potentially neglecting broader implications.[171] In fetal surgery, this could lead to hasty or biased decisions, as clinicians weigh harms and benefits case-by-case without sufficient regard to established norms, risking inconsistent outcomes.

In contrast, Rule Utilitarianism, as described by Jackson, evaluates the consequences of following general rules.[172] Wildes suggests such rules could prioritise fetal surgery protocols with favourable outcomes.[173] However, Rule Utilitarianism could also support preserving maternal autonomy if evidence shows this leads to better overall consequences, aligning more closely with the current legal stance.[174]

Nevertheless, the distinction between Act and Rule Utilitarianism complicates decision-making, as both may produce conflicting recommendations. This raises the question of which approach should guide practice and law. Knopoff argues utilitarianism is unsuitable for fetal surgery, as its emphasis on outcomes may legitimise coercive interventions, undermining autonomy.[175] Instead, she advocates for deontological theories, particularly Kantian ethics, which centre the individual in decision-making.[176]

3.3.2 Kantian Ethics: The Duty to Respect Autonomy

Kantian Ethics differs fundamentally[177] in its insistence on autonomy (*Summum Bonum)*.[178] Kant's categorical imperative requires that persons be treated as ends in themselves, never merely as means to an end.[179] Applied to fetal surgery, this entails prioritising the pregnant woman's autonomy over fetal benefit, reinforcing a one-patient model.[180]

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[170] Jharna Mandal et al., 'Utilitarian and deontological ethics in medicine' (2016) 6(1) TP 5.
[171] Ibid.
[172] Emily Jackson, *Medical Law: Text, Cases, and Materials* (5th edn, Oxford University Press 2019).
[173] Kevin W. Wildes S.J., 'Particularism in Bioethics: Balancing Secular and Religious Concerns' (1994) 53(4) MdLR 1220.
[174] Ibid.
[175] Katherine A Knopoff, 'Can a pregnant woman morally refuse fetal surgery' 79(2) CLR 499.
[176] Ibid.
[177] George P Fletcher, 'Law and morality: A Kantian perspective' (1987) 87(3) CLR 533.
[178] Harry Van der Linden*, Kantian ethics and socialism* (Hackett Publishing 1988).
[179] Ibid.
[180] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.

This ideal, however, is challenged in practice. As Gillon notes,[181] Kantian ethics underpins informed consent, requiring patients to be fully informed and give voluntary consent.[182] Yet in fetal surgery, urgent decisions may conflict with these demands, particularly where clinicians view the fetus as a second patient.[183] The shift to a two-patient model complicates this further, creating ethical problems when maternal autonomy and fetal needs diverge.[184]

Secker critiques Kantian autonomy for assuming an unrealistic level of rational decision-making.[185] In reality, medical decisions, particularly in pregnancy, are shaped by urgency, pressure, and emotional strain, which may undermine fully autonomous choice.

Moreover, while Kantian ethics protects individual rights, Mandal et al. argue it may fail to account for collective well-being.[186] However, in fetal surgery, preserving autonomy can be seen as serving broader societal interests by reinforcing legal and ethical norms. Rawls also recognises Kant's framework as a tool for balancing individual rights[187] against societal expectations.[188]

4 Comparative Legal Approaches to Fetal Surgery

International comparisons highlight commonalities and differences between jurisdictions[189] enabling better-informed legal reform and guiding more balanced solutions.[190] Each jurisdiction presents a distinct approach to balancing maternal autonomy and fetal interests, shaped by differing legal traditions, human rights commitments,[191] and societal contexts.

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[181] Raanan Gillon, 'Medical ethics: four principles plus attention to scope' (1994) 309 BMJ 184.
[182] Ibid.
[183] David Howe, 'Ethics of prenatal ultrasound' (2014) 28(3) BPRCOG 443.
[184] Emily Jackson, *Medical Law: Text, Cases, and Materials* (5th edn, Oxford University Press 2019).
[185] Barbara Secker, 'The Appearance of Kant's Deontology in Contemporary Kantianism: Concepts of Patient Autonomy in Bioethics' (1999) 24(1) JMP 43.
[186] Jharna Mandal et al., 'Utilitarian and deontological ethics in medicine' (2016) 6(1) TP 5.
[187] John Rawls, *Lectures on the History of Moral Philosophy* (Harvard University Press 2000).
[188] Ibid.
[189] Alan Watson, 'Comparative law and legal change,' (1978) 37(2) CLJ 313.
[190] Gavin Davidson et al., 'An international comparison of legal frameworks for supported and substitute decision-making in mental health services' (2016) 44 IJLP 30.
[191] Samantha Besson, 'The extraterritoriality of the European Convention on Human Rights: why human rights depend on jurisdiction and what jurisdiction amounts to' (2012) 35(4) LJIL 857.

4.1 United States: State-based Fetal Protections

The United States illustrates the dangers when fetal rights override autonomy, particularly in the absence of statutory guidance for fetal surgery. Federalism fragments the legal landscape,[192] creating constitutional uncertainty and variation across states.[193]

The overruling of *Roe v. Wade*[194] by *Dobbs v Jackson Women's Health Organisation,*[195] eliminated the federal constitutional right to abortion, dismantling fifty years of precedent.[196]

This 'politicisation'[197] of reproductive healthcare disproportionately affects people of colour, those in poverty, or with disabilities.[198] Denied abortions can lead to serious complications, long-term health issues, or death.[199] Therefore, the absence of statutory clarity, especially for fetal surgery, jeopardises human rights and sets a dangerous precedent, particularly in a country with a history of forcing caesareans.[200] Post-*Dobbs,*[201] many states disregard viability as a legal threshold,[202] treating conception as the start of fetal rights.[203] This shift threatens broader constitutional rights[204] and reshapes the U.S's international role. Once cited as a liberalising voice on abortion rights,[205] the U.S is now, as noted by Ambassador Thomas-Greenfield,[206] an

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[192] Jared Sonnicksen, *Tensions of American federal democracy: fragmentation of the state* (Routledge 2022).
[193] Ibid.
[194] *Roe v. Wade*, 410 U.S. 113 (1973).
[195] *Dobbs v. Jackson women's health org*., No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022) (majority opinion).
[196] Risa Kaufman et al., 'Global impacts of *Dobbs v. Jackson Women's Health Organization* and abortion regression in the United States' (2022) 30(1) SRHM 2135574.
[197] E Goldblatt Hyatt et al., 'I don't have a telephone to the fetus: Clinicians' conceptions of fetal patienthood in maternal-fetal surgery counselling' (2024) SSM 342 (1982).
[198] Risa Kaufman et al., 'Global impacts of *Dobbs v. Jackson Women's Health Organization* and abortion regression in the United States' (2022) 30(1) SRHM 2135574.
[199] Advancing New Standards in Reproductive Health, 'The harms of denying a woman a wanted abortion: findings from the Turnaway study' (2020) <https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf> accessed 8 June 2026.
[200] Abbey El Shafei et al., 'The Rise of Pregnancy Criminalization: A Pregnancy Justice Report, Pregnancy Justice' (2023) <https://search.issuelab.org/resource/the-rise-of-pregnancy-criminalization-a-pregnancy-justice-report.html> accessed 8 June 2026.
[201] *Dobbs v. Jackson women's health org*., No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022) (majority opinion)
[202] *Roe v. Wade*, 410 U.S. 113 (1973).
[203] *Dobbs v. Jackson women's health org*., No. 19-1392, 2022 WL 2276808 (U.S. June 24, 2022) (majority opinion)
[204] Ibid
[205] Ibid.
[206] Risa Kaufman et al., 'Global impacts of *Dobbs v. Jackson Women's Health Organization* and abortion regression in the United States' (2022) 30(1) SRHM 2135574.

outlier in protecting sexual and reproductive health.[207] Despite clear international consensus that abortion access is a human right,[208] *Dobbs* risks increasing debates about disregarding maternal autonomy for fetal protection. The erosion of maternal autonomy raises particular concerns in fetal surgery, where consent and timing are crucial.

Maternal rights have often been compromised, including instances where fetuses are made wards of the court,[209] a precedent the UK is reluctant to set. In *Marlise Munoz,*[210] the court debated keeping a brain-dead pregnant woman on life support to sustain the fetus, reducing her to a vessel.[211] This issue remains current; in 2025, *Adrianna Smith,*[212] who was declared brain-dead for over 90 days, was maintained on life support due to Georgia's strict abortion laws.[213] Treating the fetus as a separate entity obscures maternal autonomy and weakens reproductive rights. To ensure consistency and align with international human rights standards, UK reform needs to take a cautious approach.

4.2 Germany: Strong Legal Fetal Protections

Germany's framework, shaped by constitutional provisions[214] and the criminal code,[215] strongly protects fetal life while attempting to uphold maternal autonomy. Germany highlights potential overemphasis on fetal personhood in law, which could limit discretion, create ethical problems, and stifle medical innovation. While Germany's protection of fetal life may stem from its constitutional history post-WWII,[216] incorporating such a model into UK law risks ignoring the distinct cultural and legal history that has prioritised bodily autonomy in the UK and internationally.

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[207] Ibid.
[208] Ibid.
[209] Wisconsin Statutes 48.135, 48.981(3) (1997).
[210] Manny Fernandez, 'Judge orders hospital to remove pregnant woman from life support' *The New York Times* (25 January 2014) <http://www.nytimes.com/2014/01/25/us/judge-orders-hospital-to-remove-life-support-from-pregnant-woman.html> accessed 8 June 2026.
[211] Ibid.
[212] Saihaj Madan, 'Who is Adriana Smith? Pregnant Woman Brain Dead for 90 Days Forced to Live Due to Georgia Abortion Law' *Times News* (14 May 2025) <https://www.timesnownews.com/world/us/us-news/who-is-adrianasmith-pregnant-woman-brain-dead-for-90-days-forced-to-live-due-to-georgia-abortion-law-article-151642000> accessed 8 June 2026.
[213] Ibid.
[214] The German Basic Law (Grundesetz), Article 2(2).
[215] German Penal Code (Strafgesetzbuch).
[216] Hashiloni-Dolev, Yael, (2007) *A life (un) worthy of living: Reproductive genetics in Israel and Germany,* Vol. 34. Springer Science & Business Media.

The Basic Law's Article 2(2)[217] upholds the right to life for both the fetus and the pregnant woman.[218] However, by granting the fetus constitutional protection from conception,[219] conflicts arise over whose rights take precedence. This is especially problematic in fetal surgery, where physicians may face legal and ethical liability when balancing competing interests. Legal reform should avoid defining personhood from conception and instead focus on practical and ethical consequences.

The Embryo Protection Act 1990 regulates reproductive technologies and embryos.[220] Deutsch argues it reflects a strong societal consensus on fetal status.[221] Yet, it avoids explicitly prioritising maternal or fetal interests, implying that fetal protections may be stronger. This creates a risk of overstating and interpreting autonomy versus fetal interests in fetal surgery. Instead, a more balanced framework would better account for the practical and emotional impact on all involved.

4.3 Canada: Balanced Maternal-Fetal Framework

Canada prioritises maternal autonomy and informed consent, while recognising ethical considerations of fetal interests.[222] Under the *Criminal Code,*[223] fetuses gain legal personhood only at birth, a legal definition upheld by courts.[224] Attempts to redefine fetal status have been rejected as violations of Section 7 of the Charter of Rights and Freedoms,[225] which protects life, liberty and security.[226]

[217] *Basic Law for the Federal Republic of Germany* (Grundgesetz), art 2(2).
[218] BVerfGE 39, 1 (1975) – Abortion I.
[219] Ibid.
[220] Erwin Deutsch, 'Fetus in Germany: the Fetus Protection Law of 12.13.1990' (1992) 3(2) JIB 85.
[221] Ibid.
[222] Abortion Rights Coalition of Canada, 'Fetal Rights in Canada' (2019) <https://www.arcc-cdac.ca/media/position-papers/63-fetal-rights-in-canada.pdf> accessed 8 June 2026.
[223] Criminal Code of Canada, R.S.C., 1985, c. C-46, s.223(1).
[224] Ibid.
[225] *R. v. Morgentaler* [1988] 1 S.C.R. 30.
[226] Ibid.

However, systemic discrimination exists.[227] Coercive sterilisation,[228] especially among indigenous, disabled, and racialised women,[229] undermines reproductive autonomy.[230] Current investigations involve about 100 affected women,[231] raising urgent concerns about informed consent and the need for rights-based legal protections,[232] particularly in fetal surgery contexts.

While Canada's legal framework appears balanced, in practice, vulnerable women still face discriminatory practices.[233] Legal reform must address these gaps, reinforcing autonomy through safeguards against coercion.

Cases like *R v Sullivan*[234] and *Dobson v Dobson*[235] reject the legal separation of maternal and fetal interests,[236] protecting bodily integrity by recognising their indivisibility.[237] This counters the maternal vs. fetal framing underlying the majority of ethical tensions in fetal surgery. Still, anti-choice critics argue that focusing solely on maternal autonomy may underplay fetal interests.[238] Reluctance to acknowledge fetal rights risks preventing legal development alongside medical innovation. Therefore, any reform needs to effectively weigh the risks associated with the legal stance.

Canada's framework, favouring autonomy yet allowing ethical space for fetal interests, offers a useful contrast to the U.S and Germany. It may serve as a valuable model for UK reform in balancing competing interests in fetal surgery.

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[227] Sharol Malekobane Maila et al., 'Informed consent and ethical issues pertaining to female sterilization—Scoping review' (2025) 169(3) IJGO 1037.
[228] Mirabel Akbari, 'Forced Sterilization of Indigenous Women: An Act of Genocide or Policing Women's Bodies?' (2021) 3(1) YUCR 1.
[229] Sharol Malekobane Maila et al., 'Informed consent and ethical issues pertaining to female sterilization—Scoping review' (2025) 169(3) IJGO 1037.
[230] Ibid.
[231] Chaneesa Ryan et al., 'Forced or coerced sterilization in Canada: an overview of recommendations for moving forward' 16(1) IJIH 275.
[232] Sharol Malekobane Maila et al., 'Informed consent and ethical issues pertaining to female sterilization—Scoping review' (2025) 169(3) IJGO 1037.
[233] Ibid.
[234] *R. v. Sullivan* [1991] 1 S.C.R. 489.
[235] *Dobson (Litigation Guardian of) v. Dobson* [1999] 2 SCR 753.
[236] *R. v. Sullivan* [1991] 1 S.C.R. 489.
[237] *Dobson (Litigation Guardian of) v. Dobson* [1999] 2 SCR 753.
[238] Abortion Rights Coalition of Canada, 'Fetal Rights in Canada' (2019) <https://www.arcc-cdac.ca/media/position-papers/63-fetal-rights-in-canada.pdf> accessed 8 June 2026.

4.4 Lessons for the UK

Together, these approaches inform how the UK might develop a more consistent, ethically balanced legal framework for fetal surgery. Unlike the U.S and Germany, where fetal protections may override autonomy, Canada's model treats autonomy as non-negotiable. This distinction is instructive for UK lawmakers, where codifying a clear stance or legal mechanisms ensuring informed consent would benefit ethical complexity in fetal surgery. Therefore, preventing the ambiguity seen in Germany's framework.

5 Reforming the Legal Framework

5.1 Fetal Surgery Act

While the absence of legal clarity around fetal surgery urges statutory reform, a distinct 'Fetal Surgery Act' may not be the most suitable option. A better alternative may involve embedding a framework into existing legislation, for instance, amending the General Medical Council's professional standards,[239] the MCA[240] or the Human Tissue Act.[241] Adding a dedicated section for fetal surgery in existing frameworks would aim to maintain flexibility while improving clarity. However, it could potentially further enhance the ambiguous legal status of the fetus.

Indeed, the creation of a single act creates the opportunity to offer clarity for practitioners and patients in one place, for instance, by defining legal thresholds such as viability and risks. It would aim to effectively guide decision-making and improve the regulation of the procedures. However, it could symbolically risk granting legal personhood to the fetus, perhaps giving interest groups, like anti-abortion supporters, a tool to push for stricter laws, which would obscure reproductive autonomy. Moreover, it could lead to legal rigidity, limiting discretion in time-sensitive cases, which could contribute to more harm than good. Ultimately, by embedding the fetal surgery framework into existing policy or legislation, it ensures a more

[239] General Medical Council, 'Good Medical Practice' (2024) <https://www.gmc-uk.org/ethical-guidance/ethicalguidance-for-doctors/good-medical-practice accessed 1 May 2025> accessed 8 June 2026.
[240] Mental Capacity Act 2005.
[241] Human Tissue Act 2004.

balanced approach, and importantly, one that allows for specific regulation of fetal interventions, without altering the status of the fetus or creating unintended precedents.

The comparative analysis supports this cautious approach. While the United States shows the dangers of fragmented and politically charged fetal protection post-*Dobbs*,[242] Germany demonstrates how strong legal protections constrain maternal choice.[243] In contrast, Canada offers a more balanced approach that emphasises maternal autonomy,[244] while incorporating ethical review and professional guidance without legally recognising the fetus as having personhood.[245] The UK could integrate clear safeguards and regulatory oversight while maintaining that autonomy and reproductive rights should be prioritised. Ultimately, legal reform needs to extend beyond ensuring clarity, but also actively avoid granting the fetus rights that could overshadow maternal rights.

5.2 Regulation and Protection of Autonomy

Legal reform must centre maternal autonomy, even when fetal surgery may offer significant benefit to the fetus, as might be emphasised under utilitarianism.[246] Any proposed regulatory framework needs to protect informed, uncoerced consent as, ultimately, it should support, not restrict, pregnant individuals' decision-making. This aligns with either a one-patient model[247] or an ecosystem approach,[248] both of which preserve the pregnant woman's autonomy while recognising the interdependence between the woman and the fetus.

Current UK law, *Montgomery v Lanarkshire,*[249] already requires doctors to describe material risks to patients,[250] but fetal surgery has unique risks that justify even stronger protections.

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[242] Risa Kaufman et al., 'Global impacts of *Dobbs v. Jackson Women's Health Organization* and abortion regression in the United States' (2022) 30(1) SRHM 2135574.
[243] Erwin Deutsch, 'Fetus in Germany: the Fetus Protection Law of 12.13.1990' (1992) 3(2) JIB 85.
[244] Abortion Rights Coalition of Canada, 'Fetal Rights in Canada' (2019) <https://www.arcc-cdac.ca/media/position-papers/63-fetal-rights-in-canada.pdf> accessed 8 June 2026.
[245] Ibid.
[246] Alvan Alviansyah Lubis and Mochammad Ra'afi Nur Azhami, 'Beyond the 'Greatest Happiness Principle': Exploring the Compatibility of Individual Rights and Utilitarian Ethics in Legal Policy Making' (2025) 3(1) EL 144.
[247] Dunja Begović, 'Maternal–Fetal Surgery: Does Recognising Fetal Patienthood Pose a Threat to Pregnant Women's Autonomy?' (2021) 29(4) HCA 301.
[248] Susan S Mattingly, 'The maternal-fetal dyad: Exploring the two-patient obstetric model' (1992) 22(1) HCR 13.
[249] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[250] Ibid.

Perhaps a Fetal Surgery Consent protocol could be introduced, requiring full disclosures, mandatory multiple consultations to avoid rushed decisions and required formal ethics reviews before experimental procedures are performed. This would ensure fully informed decision-making and does not impose obligations on pregnant women to act in the fetus's best interest over their own.

There are serious ethical concerns about the risk of women being pressured into fetal surgery. To address this, amendments to the MCA[251] could be introduced to account for the specific vulnerabilities pregnant women may face in this context. While the MCA[252] provides basic safeguards to ensure that consent is given voluntarily and with capacity, it does not currently reflect the nuanced pressures that may arise in the case of fetal surgery,[253] including coercion from family members, medical professionals or even societal expectations.[254] The case of *Re A (Capacity: Refusal of Contraception)*[255] illustrates that the courts are willing to consider contextual factors and introduce additional protections for those who may be particularly vulnerable, namely, in this case, those lacking capacity.[256] Similarly, fetal surgery cases may need enhanced legal safeguards to prevent vulnerability from being taken advantage of. Explicitly recognising that coercion or undue influence exists in cases of fetal surgery, and by increasing legal protections, such as requiring an independent advocate for women in suspected cases, may help to reduce instances of coerced consent and ensure women are empowered to make autonomous decisions.

In any instance of reform, there needs to be a formal statement that separates fetal surgery law from that of Abortion law. This distinction is necessary to affirm that fetal surgery is for the pregnant woman's health and the future child's benefit, not for the legal recognition of personhood for the fetus. The Abortion Act should remain untouched; they are two separate medical procedures that need to be governed by separate legal principles. This distinction will prevent any legal reform from being misused to restrict reproductive rights.

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[251] Mental Capacity Act 2005.
[252] Ibid.
[253] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA Civ) 113 (Lord Donaldson MR).
[254] Ibid.
[255] *Re A (Capacity: Refusal of Contraception)* [2020] EWCOP 39, [73].
[256] Ibid.

5.3 Policy and Legal Reform Recommendations

A coherent framework for fetal surgery in the UK requires statutory and policy reform that prioritises clarity, consistency and respect for maternal autonomy.[257] Reform could be achieved through amendments to existing legislation, as well as updates to GMC guidance[258] or NHS policy. In April 2025, the NHS updated its 'Saving Babies Care Bundle', aiming to reduce prenatal mortality through surveillance and earlier risk assessment.[259] While not legally binding, it demonstrates how internal policy changes can support decision-making in fetal surgery cases. Similar approaches could be implemented to better support women.

These reforms should clarify that fetal surgery is a unique and complex innovation requiring specific safeguards and guidelines that respect the pregnant woman as the primary decision-maker. In cases where the individual lacks capacity,[260] amendments and stricter regulation of the 'best interests'[261] test may be necessary to ensure it reflects her wishes and needs,[262] rather than external influences.

Alongside this, professional bodies should adopt national standards outlining eligibility criteria and thresholds, such as gestational viability and procedures involving significant maternal or fetal risk and require multiple consultations to ensure transparency and reduce error. Hospitals could also incorporate clinical ethics committees into decision-making,[263] allowing for greater oversight where ethical tensions arise, particularly in high-risk cases. Ultimately, legal reform requires a comprehensive reassessment of how legislation and policy can better reflect the unique ethical and legal challenges posed by fetal surgery.

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[257] William H Clune III, 'A political model of implementation and implications of the model for public policy, research, and the changing roles of law and lawyers' 11(1) BJBB 20.
[258] General Medical Council, 'Good Medical Practice' (2024) <https://www.gmc-uk.org/ethical-guidance/ethicalguidance-for-doctors/good-medical-practice accessed 1 May 2025> accessed 8 June 2026.
[259] NHS England, 'Saving Babies' Lives Version 3.2: A Care Bundle for Reducing Perinatal Mortality' (April 2025) <https://www.england.nhs.uk/long-read/saving-babies-lives-version-3-2/> accessed 8 June 2026.
[260] Mental Capacity Act 2005.
[261] Ibid, s.4.
[262] Ibid.
[263] Chiara Crico et al., 'Evaluating the effectiveness of clinical ethics committees: a systematic review' (2021) 24(1) MHCP 135.

6 Conclusion

While fetal surgery complicates ethical and legal boundaries, reform must centre maternal autonomy, resist fetal personhood, and provide clearer regulatory protections without compromising reproductive rights.

While the UK prioritises maternal autonomy[264] over fetal interests,[265] its lack of a consistent framework for surgery carried out for the fetus's benefit creates uncertainty for medical professionals and pregnant women.[266] The lack of clear guidance causes professionals to operate in medically grey areas, and women to not fully understand their rights.[267] There is significant debate over gestational age,[268] whether the law should recognise fetal pain,[269] and whether the fetus should be granted separate legal rights.[270] In practice, medical professionals treat the fetus as a patient,[271] often using fetal surgery to correct abnormalities or offer life-saving treatment, however, they are unclear of their legal obligation, especially where ethical tensions arise.

Ethical perspectives, such as those arising from a one-patient versus two-patient model,[272] were evaluated and applied to Utilitarian[273] and Kantian theories. This revealed tensions between respecting autonomy and acknowledging fetal interests. Comparative analysis supports a

[264] Beatrice R Nyinawagaba, 'Reproductive Rights as Fundamental Human Rights: A Feminist Perspective on Bodily Autonomy and Social Justice' (2024) 5(2) EEJHSS 9.
[265] *Attorney-General Reference (No.3 of 1994)* [1998] AC 245.
[266] Frank A Chervenak and Laurence B McCullough, 'A comprehensive ethical framework for fetal research and its application to fetal surgery for spina bifida' (2002) 187(1) AMJOG 10.
[267] Jonathan Herring, *Medical Law and Ethics* (9th edn, OUP 2022).
[268] Royal College of Obstetricians and Gynaecologists, 'Fetal Awareness Evidence Review' (2022) <www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/fetal-awareness-updated-review-of-research-and-recommendations-for-practice/> accessed 8 June 2026.
[269] Roland Brusseau and Laura Myers, 'Developing consciousness: fetal anesthesia and analgesia' (2006) 25(4) SAPMP 189.
[270] *Dobson (Litigation Guardian of) v. Dobson* [1999] 2 SCR 753.
[271] David Howe, 'Ethics of prenatal ultrasound' (2014) 28(3) BPRCOG 443.
[272] Ibid.
[273] Alvan Alviansyah Lubis and Mochammad Ra'afi Nur Azhami, 'Beyond the 'Greatest Happiness Principle': Exploring the Compatibility of Individual Rights and Utilitarian Ethics in Legal Policy Making' (2025) 3(1) EL 144.

cautious, non-personhood approach to reform, as demonstrated by Canada's model[274] and the legal rigidity in Germany[275] and the US.[276]

This paper concludes that the UK legal framework requires reform to regulate fetal surgery and protect reproductive rights and autonomy, but not through a standalone 'Fetal Surgery Act.' Instead, amendments to existing legislation and policy would provide appropriate regulation while safeguarding reproductive rights. Reform must centre autonomy, with an emphasis on informed and uncoercive consent and safeguards to prevent vulnerable women from being subjected to obstetric harm.

Looking forward, continued medical advancements,[277] such as artificial womb technology[278] and developments in fetal viability, may further challenge current legal frameworks.[279] Following the emergence of Artificial Intelligence, there has been increased use in healthcare, contributing to innovation worldwide.[280] The law must keep pace,[281] and ensure that any legal framework remains adaptive and underpinned by ethical commitments to autonomy, fairness and transparency. This urges higher focus on reproductive justice, which enables not just consent, but empowerment. Ultimately, the law must be capable of evolving with medical advancement,[282] like fetal surgery, without compromising the rights of individuals, especially in this case, pregnant women.

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[274] Abortion Rights Coalition of Canada, 'Fetal Rights in Canada' (2019) <https://www.arcc-cdac.ca/media/position-papers/63-fetal-rights-in-canada.pdf> accessed 8 June 2026.
[275] German Penal Code (Strafgesetzbuch).
[276] Jared Sonnicksen*, Tensions of American federal democracy: fragmentation of the state, (*Routledge 2022).
[277] Kevin Doxzen, 'Future Technological Advancements' in Diana Bowman et al. (eds), *Reproduction Reborn: How Science, Ethics, and Law Shape Mitochondrial Replacement Therapies* (Oxford University Press 2023).
[278] Seppe Segers and Elizabeth Chloe Romanis, 'Ethical, translational, and legal issues surrounding the novel adoption of ectogestative technologies' (2022) 24(15) RMHP 2207.
[279] Kevin Doxzen, 'Future Technological Advancements' in Diana Bowman et al. (eds), *Reproduction Reborn: How Science, Ethics, and Law Shape Mitochondrial Replacement Therapies* (Oxford University Press 2023).
[280] Carey Beth Goldberg et al., 'To do no harm—and the most good—with AI in health care' (2024) 30(3) NM 623.
[281] Steven M. Williamson and Victor Prybutok, 'Balancing privacy and progress: a review of privacy challenges, systemic oversight, and patient perceptions in AI-driven healthcare' (2024) 14(2) AS 675.
[282] Ibid.