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Obstetric Autonomy and Informed Consent

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Abstract I argue that public officials and health workers ought to respect and protect women's rights to make risky choices during childbirth. Women's rights to make treatment decisions ought to be respected even if their decisions expose their unborn children to unnecessary risks, and even if it is wrong to put unborn children at risk. I first defend a presumption of medical autonomy in the context of childbirth. I then draw on women's birth stories to show that women's medical autonomy is often ignored during labor. Medical interventions are performed during childbirth without women's consent. Childbirth is risky and some coercive medical interventions may be understood as attempts to protect children and to prevent mothers from acting impermissibly. However, even if it is wrong to make risky choices during childbirth, women have rights to do wrong in these cases. Therefore, coercive medical interventions are impermissible during childbirth and institutions should adopt specific protections for obstetric autonomy.

Keywords Childbirth · Rights · Informed consent · Moral risk

The doctrine of informed consent protects patients' medical autonomy, meaning that patients are entitled to make treatment decisions against medical advice. If a patient is competent, then she has a right to information about her treatment options and to choose in the absence of coercion (Dolgin 2010). Most developed countries protect patients' rights to make decisions for themselves in accordance with informed consent requirements. Patients are not entitled, however, to make risky treatment decisions for others, even their young children. Courts are generally authorized to make medical decisions in the interest of a child even when the child's parents disagree (Dare 2009). Competent adult patients have the right to refuse lifesaving chemotherapy, for example, but parents do not have the right to refuse lifesaving chemotherapy for their children.

During childbirth, the presumption in favor of medical autonomy can conflict with public officials' interest in protecting the well-being of children. If a woman in labor makes a choice

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that endangers the life of her unborn child, I argue that health workers and public officials ought to respect patients' medical autonomy even when a patient's decisions endanger an unborn infant and even if it is morally wrong to expose unborn infants to unnecessary risks. When a woman makes a medically inadvisable choice during childbirth she may act wrongfully, but she has a right to do so. Though there are strong moral reasons for women in labor to mitigate the risks to unborn infants, they would not violate anyone's rights by failing to do so whereas forced interventions during childbirth would violate the mother's medical rights. Therefore, legal institutions ought to respect mothers' treatment choices even when women make life-threatening choices during childbirth.

Further discussion about the ethics of childbirth is particularly urgent as legislatures and courts worldwide are rethinking how to balance maternal rights and the interests of unborn infants. In 2010, Venezuelan legislators passed a law protecting women's rights against violence, including 'obstetric violence' (D'Gregorio 2010). In contrast, women in the United States can be ordered by courts to undergo forced medical interventions such as cesarean sections and blood transfusions and are subject to arrest and legal penalties if they refuse to follow medical advice or to obtain prenatal care (Cook 2002; Paltrow and Flavin 2013). Some US states also prohibit midwife-assisted home birth on the grounds that it poses unacceptable risks to unborn infants.[1] The UK also enforces strict regulations regarding women's birthing decisions such as local prohibitions of assisted home birth, which limit women's labor options (Moorhead 2004). In a recent survey of women in the UK, 24 % claimed that medical procedures were performed during childbirth without their consent (Turner 2013). Legal limits on women's obstetric options have been proposed or are present in several other countries as well.[2]

The following argument supports legal protections for obstetric autonomy on the grounds that forced cesarean policies, anti-home birthing laws, and other forced medical interventions are wrong even if they are in the interest of a pregnant patient or an unborn infant. I proceed as follows. I first defend a general presumption of medical autonomy and the doctrine of informed consent. Second, I discuss medical autonomy in the circumstances of childbirth. While the pain of labor may change a woman's reasons during childbirth, it does not undermine her capacity to give informed consent. Therefore, a presumption of medical autonomy is appropriate during childbirth. I then draw on women's birth stories, which are self-reported testimony of childbirth experiences, to illustrate how women's medical rights are ignored during labor. One seeming justification for forced interventions during childbirth is that a woman in labor is not entitled to

[1] These states include Alabama, Georgia, Hawaii, Indiana, Iowa, Illinois, Kentucky, Maryland, North Carolina, South Dakota, Wyoming, and Washington D.C. Twenty seven states explicitly allow midwife-assisted home birthing. No states prosecute women for attempting an unassisted home delivery, but courts have ordered cesareans for women who attempted vaginal births at home. In one case this involved physically restraining and transporting a patient to the hospital where surgery was performed despite her explicit refusal (Paltrow and Flavin 2013).

[2] For example, a woman in Ireland was recently forced to undergo cesarean section surgery when she threatened a hunger strike to protest the state's abortion policies (McDonald 2014). In Brazil, forced cesarean can also be ordered by courts (Filipovic 2014). Lawmakers have introduced proposals to potentially limit childbirth choices for the sake of unborn infants in Canada (Martin and Coleman 1994) and Australia (Anolak), but those legal efforts have so far been unsuccessful. Throughout, I will focus on the United States' legal system since the US has a well established body of case law that sets clear guidelines for informed consent and medical autonomy, and since the country's approach to medical autonomy has informed practices in other countries throughout the twentieth and twenty-first century. Nevertheless, the general philosophical argument in favor of legal protections for obstetric autonomy are not limited to the United States, and indeed my thesis justifies a significant departure from current practice in the United States in favor of laws like Venezuela's recent prohibition of obstetric violence.

make decisions that risk an infant's life. Yet even if some childbirth decisions were morally risky or morally wrong, medical rights would entail rights to do wrong in these cases. Last, I propose several institutional solutions that reconcile women's rights of medical autonomy with states' interest in medically advisable birthing decisions.

1 The Doctrine of Informed Consent

The doctrine of informed consent states that patients have rights to make treatment decisions even if those decisions are medically inadvisable. Most countries affirm a general presumption that patients are entitled to make their own medical decisions. This presumption is warranted when the patient meets the following conditions. The patient must be mentally competent when making a medical choice. This means that she must have the capacity to understand information that is relevant to her choice, communicate a choice, appreciate the consequences of her choice, and compare her choice to alternatives (Appelbaum 2007). A patient must also have access to whatever information a reasonable patient would find relevant to the treatment decision in order to freely decide. The patient also must be allowed to decide freely, meaning that threats or coercion should not dictate a patient's treatment choices (Young 2010).

Three kinds of justifications are commonly cited in favor of the doctrine of informed consent. First, some bioethicists claim that medical outcomes will be better *on balance* if physicians are prohibited from coercing or lying to patients. Informed consent is an integral part of a trusting and respectful doctor-patient relationship, which in turn is an important element of good patient care (Gillon 2003). For example, with norms of informed consent in place, patients are more willing to seek medical care and more likely to honestly disclose their symptoms and medical histories to physicians (Laine and Davidoff 1996).

A second justification for the doctrine of informed consent is epistemic. While physicians may have a better understanding of patients' health, patients are the experts about their interests all things considered (Veatch 1995; Young 2010). For example, while a physician may rightly judge that a treatment involving blood products is in a Jehovah's Witness's medical interest, given her values and religious commitments the patient may rightly judge that using blood products is not in her interest *overall*. This justification is a species of Mill's oft-cited argument against paternalism as well. In general, people are the best judges of their own well-being as long as they decide freely and with adequate information (Mill 2008). This justification assumes that health is only one of many values, and that medicine should promote patients' overall well-being, not just their health. Importantly, this justification for medical autonomy is limited because the normative force of a patient's rights would not apply if a physician could be certain that violating her medical rights would promote better outcomes overall, despite the patient's beliefs to the contrary.

The third and strongest justification for a presumption of medical autonomy states that patients have the normative authority to make medically inadvisable treatment decisions *even if* those decisions are not in their overall or medical interests. There are several versions of this justification. Some ethicists have argued that patients have particularly strong bodily rights or that patients own their bodies. Others focus on a general principle of autonomy, drawing on the familiar Kantian notion that coercive interference and deception undermine people's dignity and are offensive to the value of an autonomous will. Egalitarian ethicists condemn paternalism because it is incompatible with expressions of our moral equality (Shiffrin 2005). When a

physician substitutes his own judgment for a patient's he renders a judgment about her that she is unequal, and he is motivated by considerations that are grounded in an assumption that his decisions are superior to hers (Quong 2011).

I will remain mostly neutral with respect to these three kinds of justifications for medical autonomy. The three justifications show that the principle rests on a wide base of support in medical ethics. As Miller and Wertheimer write, there is a near universal consensus that patients have rights to be fully and accurately informed about treatment and rights to refuse treatment (Miller and Wertheimer 2007). Though this consensus calls for an extremely strong presumption in favor of medical autonomy, it is not an absolute constraint on the conduct of health workers. Medical rights do not entitle patients to violate other people's rights against unwanted interference. For example, policymakers and physicians may therefore override a patient's choice during public health emergencies if a contagious person threatens to transmit a serious disease to innocent bystanders.[3] With the doctrine of informed consent in hand, let us now turn to the circumstances of childbirth.

2 Childbirth and Consent

The course of labor and delivery raises a series of questions about medical treatment. Should a pregnant woman schedule a cesarean section? When should she go to the hospital? Epidural or natural delivery? As labor progresses, a patient's decisions may systematically depart from her initial birth plans. If a patient meets the criteria for informed consent, then health workers must obtain informed consent for treatment at each stage. The aforementioned justifications for medical autonomy justify consent requirements during childbirth. Some health workers or public officials may be skeptical that the requirements of informed consent apply to women in labor on the grounds that women in labor are not competent, that they cannot be adequately informed, that they often decide under duress, or that some childbirth situations are emergencies. Yet these concerns about competence, information, coercion, and emergencies do not justify violations of obstetric autonomy.

Like other patients, pregnant women have significant interests in making intimate and personal treatment decisions that merit deference. Women's interests in making decisions about labor and delivery are not only informed by their medical needs, but also by their values, tolerance for risk and pain, and how they weigh health against other elements of well-being. Pregnant patients generally understand their own interests better than health workers who have only known their patients for a few months at most.[4] A general practice of respecting

[3] In cases of contagious pandemics, compulsory vaccination policies or quarantines may be justified even though they limit medical autonomy. Nevertheless, the duty to respect a patient's treatment decision can only be outweighed when refusing medical interventions violates the rights of many non-liable bystanders in significant ways. Even in these circumstances, officials must take care to ensure that compulsory treatment is necessary and proportionate to the potential harm, and that treatment is minimally burdensome to the patient. Elsewhere, I argue for compulsory vaccination in more detail (Flanigan 2014).

[4] This epistemic justification for informed consent is even more limited in the case of childbirth than it is in other treatment situations because even if pregnant women are experts about their overall well-being, they may not be experts about the overall well-being of their fetus. For this reason, unlike other patients, a woman in labor could be in a relatively worse position to assess the overall consequences of a treatment choice precisely because she is so closely aware of her own interests. Insofar as informed consent is justified on the grounds that medicine should promote good consequences on balance, the claim that patients are experts about their overall well-being will not be decisive in the childbirth case if we grant that a child's well-being is morally significant as well.

women's rights to consent to treatment is also likely to discourage women from opting out of medically assisted childbirth in favor of non-medical approaches such as home birth, and in this way respecting informed consent requirements during labor and delivery may also promote better medical outcomes on balance insofar as medically assisted childbirth is safer.

Yet the presumptive case in favor of medical autonomy during childbirth would not succeed if women in labor lacked the mental faculties to make an autonomous choice. The doctrine of informed consent does not forbid paternalism toward children, unconscious patients, and people with cognitive disabilities who cannot give meaningful consent to treatment. One may suspect that women in labor are incompetent because labor often involves pain and emotional distress. Health workers may interpret suffering as a barrier to voluntarism if a patient is seen as making her decision out of desperation rather than her previously held values (Roberts 2003). In this vein, one may argue that just as we would not judge that a tortured spy voluntarily revealed state secrets, perhaps women in labor similarly cannot be expected to voluntarily make decisions insofar as the pain of childbirth is phenomenologically equivalent to torture.[5]

It would be a mistake, however, to infer from the intuition that a tortured spy should not be held responsible or blamed for revelations that pain renders a person incompetent to consent. Recall that the criteria used to assess a patient's capacity to consent require that a patient demonstrate that she understands the relevant medical information about different treatment options, appreciates the consequences of her choice, and is able to communicate a choice (Appelbaum 2007). Empirical research into the effect of pain on deliberative competence shows that pain does not undermine patients' ability to meet these criteria, though pain potentially changes how patients make decisions. A study of patients in extreme pain, as measured by the Generalized Distress Index, found that there is *no relationship* between a patient's ability to make decisions and his or her distress index scores (Casarett et al. 2003). Specific tests of the relationship between labor pain and ability to understand also found no relationship between physical incapacity and decision-making capacity (Jackson et al. 2000). Although childbirth often involves pain and anxiety, there is no reason to think that women in labor should be presumed less competent to consent to interventions, including anesthesia and surgery, than other patients who suffer from stressful or painful conditions (Ladd 1989). For these reasons, a presumption of competence during labor is supported by the American Congress of Obstetrics and Gynecology (Committee on Ethics 2005).

Since pain during childbirth does not undermine competence to consent, insofar as pain mitigates responsibility it is not because pain undermines voluntariness but because pain can give a person new reasons that excuse his or her conduct. A woman in labor might experience significant pain that causes her to make different medical choices than she would have made in the absence of pain. In these cases, new information (e.g., information about how labor feels) changes the woman's judgment

[5] Similar claims are sometimes advanced regarding terminally ill patients who might choose to end their lives. Terminally ill patients, especially those who suffer from painful conditions, often suffer from severe depression. Physicians, bioethicists, and psychologists have therefore suggested that patients with these kinds of physical and mental health problems cannot consent to voluntary euthanasia, or at least that heightened psychological scrutiny is warranted for patients seeking deadly treatments (Ganzini et al. 2008).

about what she has reason to do. Pain does not undermine a woman's ability to make a voluntary treatment choice.[6]

It is also important to bear in mind for assessments of competence that a patient should not be deemed incompetent on the basis of her treatment choice. That is, whether a person is competent to make a medically risky choice should not depend on whether she chooses in accordance with medical advice. Observers may think that a woman who makes life-threatening choices during labor cannot be competent. But judgments of incompetence must be based on a patient's capacity to choose, not on what she in fact decides. If a woman understands her situation and treatment options and communicates a medically inadvisable treatment choice, she should not be retroactively deemed incompetent on the grounds that she didn't make the 'correct' choice. If informed consent requirements are to have any practical significance in protecting patients from unwanted medical interventions they must protect patients' ability to make choices that depart from their physicians' judgments without being subsequently labeled incompetent.

The circumstances of childbirth may also call into question the informational requirements of the doctrine of informed consent. Childbirth decisions are complex. Birth involves complicated assessments of risk and massive uncertainty about the effects of any given decision (Enkin et al. 2006). For this reason, one might wonder whether women in labor can make a truly informed choice. Yet informed consent requires only that all information that a *reasonable patient* would require be presented to a patient.[7] The informational requirement aims to prevent physicians from paternalistically committing acts of fraud or deceptive reticence when securing consent for medical procedures. Patients are not expected to achieve the same understanding of risks and benefits as medical professionals (Laurie 1999; Andorno 2004).

In any case, laboring women are typically *more* informed than patients who seek other medical procedures because most pregnant women receive some prenatal care that gives them the opportunity to explore treatment options in advance and women are encouraged to develop a birth plan prior to labor.[8] When researchers investigated whether women in labor were capable of understanding information about anesthesia and recalling that information later, they found that the presence of labor does not undermine a patient's ability to understand or recall information about their treatment options (Gerancher et al. 2000). It is only in rare instances that pregnant women lack the capacity to make treatment decisions. For example, a

[6] Advance directives can be resolved with mutual consent. For example, if a woman with an advance directive changes her mind during labor, her birth plan does not entitle physicians to act contrary to her present will because the birth plan is not a contract between the physician and the patient but rather a list of requests that the patient previously specified to inform medical personnel (Ladd 1989). Even if advance directives were understood as binding contracts on laboring women, if the physician agrees to dissolve the contract then the contract is void. Physicians who are bound by informed consent requirements ought to dissolve the contract by request because the purpose of an advance directive or contract is to facilitate the patient's choice by constraining the actions of the physician, not to constrain the patient's choices once in labor. For an analogous discussion of the permissibly of paternalistically maintaining advance directives and contracts see (Husak 2009).

[7] This standard is the legal norm in the US, where states are currently divided regarding the strength of disclosure standards. About half require physicians to disclose any information a reasonably prudent physician would give and half require physicians to disclose any information a reasonable patient would find relevant. Nevertheless in practice the 'reasonable patient' standard has defined the standards of care despite legal variation (King and Moulton 2006).

[8] Evidence suggests that the recent adoption of birth plans has led to more empowered and informed decision making by laboring mothers, though they do not necessarily improve the experience of childbirth overall (Moore and Hopper 1995; Lundgren et al. 2003).

woman who is in a persistent vegetative state after a virus or an accident would be incapable of giving consent to treatment (Ceccaldi et al. 2005). Unconscious women are not entitled to the protections of the doctrine of informed consent because, like other incompetent and unconscious patients, they cannot consent.

Respect for medical autonomy also requires that patients give informed consent freely in the absence of coercion or social pressure. Though women in hospital settings are vulnerable to social pressure and coercive influences, the remedy for this vulnerability is to treat them as competent and to fully inform them about their treatment options, *not* to render them unable to consent and then to justify breaches of informed consent requirements on those grounds (Lyerly 2006). The potential for coercion does not invalidate socially vulnerable women's medical rights. Rather, the potential for coercion requires that health workers take even more care to ensure that they are respecting a patient's choices.

Finally, some health workers or medical ethicists may interpret the circumstances of childbirth as a medical emergency, at least in some cases, and then argue that informed consent requirements therefore ought to be relaxed or waived in these circumstances as in other emergencies.[9] I grant that some births are indeed emergencies that endanger the life of a patient or an unborn infant, and that medical personnel are in some cases better placed to judge whether a circumstance is an emergency. But patients retain their medical rights even in emergencies as long as they are competent to give consent. Informed consent requirements are less stringent in emergencies either because the patient is incompetent or because the time demands of informed consent conflict with the imperative to provide immediate treatment (Easton et al. 2007). When a patient is unconscious, medical personnel are still required to consider whether there are good empirical reasons to presume that the patient would consent if she were asked (Veatch 2007). Furthermore, women in labor are more likely than other patients in emergency situations to have a prior relationship with physicians, to take the opportunity to prepare medical directives in advance, or to designate a surrogate decision maker.

For conscious and competent patients in emergency situations, if the time demands of informed consent conflict with the need to provide speedy treatment, physicians must at least seek implied consent, such as the patient's active participation in the administration of treatment (Veatch 2007). If a patient actively refuses treatment, even during an emergency, informed consent requires that physicians respect her decision. For example, competent patients who express religious objections to using blood products should not be administered blood products in emergency situations on the grounds that they require prompt treatment. Similarly, it would be wrong to provide life-saving treatment to a patient who refuses it solely on the grounds that her life is in danger. As in these emergency circumstances, it is also impermissible to forcibly administer unwanted interventions when a woman is in labor, even if her life or her unborn child's life is in danger (Levy 1999).

3 Obstetric Violence

Women in labor are capable of making treatment decisions even when they are in pain and even in emergencies, so the presumption of medical autonomy protected by informed consent

[9] I am grateful for an anonymous reviewer for prompting me to consider this potential exception to the doctrine of informed consent.

requirements should extend to pregnant women as well. Yet despite widespread affirmation of medical autonomy, contemporary childbirth practices remain at odds with a commitment to medical autonomy. Consider the following self-reported accounts of childbirth from women's publicly posted birth stories (emphasis added):

> "They did (an episiotomy) for no apparent reason and I was SO pissed. I was actually saying "No Don't" and *the guy did it anyway*…. It still makes me angry when I think about it" (Eclipse 2010).
>
> "We were told that we were going to be moved to the OR "just in case" while being monitored more closely…my husband & I were separated. As soon as I reached the OR, the staff began prepping me for surgery. I stated that I did NOT want a C-section. I demanded to see my husband and stated that IF I was to receive a C-section my [husband] & I would make that decision together. I was told that my husband was on his way. I was also told that my baby needed more oxygen & I was told to breathe deeply in a new mask because it had a better seal on my face (the oxygen I was breathing before was through a smaller mask). The new mask wasn't oxygen; *I was gassed against my will*. I am unaware of what was done to me from the time I was gassed up until I awoke in recovery" (Luehrs 2012).
>
> "I didn't have a medical emergency that required intervention, my life, and the life of my baby weren't in danger, I just wasn't in labor. *My caregivers were either unwilling or unable to support a wait and see approach* so despite there being no medical need, I was given an induction which ultimately ended in a C-section. I sit here, several months on and my anger is still undiminished that I was robbed of the chance to give birth" (Anonymous 2010).
>
> "I told (my obstetrician) I was considering avoiding the epidural, she told me that was not an option. *It would be mandatory* once I was 3 or 4 cm dilated," (Llewellyn).
>
> "The doctors, concluding that a baby delivered at 26 weeks probably would not survive, attempted to prolong [the mother's] life instead of saving it. As [the mother] fought, saying "*No*, *no*, *no*. *Don't do that to me*," a tube was inserted into her throat and sedatives were used to silence her."[10]
>
> "I was 42 weeks and *felt forced to be induced*. I was only 1–2 cm, not completely effaced, and they did a full Pitocin induction. I was hooked up from the time I arrived and pretty much sat in the hospital bed for 26 h laboring with the Pitocin. I pushed for 3 h (doctor only came in a few times) and then I was told they had to do a C-section," (Amanda 2011).
>
> "I visited with the doctor in his office and asked whether or not I could skip the IV, whether or not I could push in any position I wanted. *He said no*… then he said he'd had a bad experience during his residency wherein he was splashed," (Blair and Jessica 2010).

Women in labor, like other patients, are entitled to refuse medical treatment. Yet these stories illustrate that women's choices are too often ignored during childbirth. From big decisions about whether to have a cesarean, to small decisions about laboring positions, the medical personnel in the above cases substituted their judgment for their patients'. Sometimes

[10] In this case the patient died during a forced cesarean surgery (Olson 2012). This account is taken from Kristin Olson's detailed account of forced cesareans. The two cases most significant for her analysis are In re A.C., 533 A.2d 611 (D.C. App. 1987) and In re A.C., 573 A.2d 1235 (D.C. App. 1990) (en banc).

physicians cite the patient's own interest in a speedy labor. In the final story, the physician's only reason was to avoid getting 'splashed'. Both these kinds of reasons clearly offend against patients' rights to make treatment decisions.

Moreover, these stories illustrate that the experience of non-consensual medical intervention is often extremely traumatic for patients. Forced obstetric and gynecological procedures can be even more traumatic for women who have been victims of sexual violence insofar as interventions during labor are experienced as victimization. Some critics of medicalized childbirth have coined the term 'birth rape' to describe unwanted interventions during childbirth, though this term is controversial (Clark-Flory 2010). Even if we do not characterize such violations as rape, they are breaches of women's bodily integrity and qualify as a form of violence. The term 'obstetric violence' also captures the nature of this violation as a form of wrongful violence against women.

On the other hand, these stories do not reflect the experience of health workers who may have intervened in some of the cases for reasons of conscience rather than convenience. For example, health workers in some of the aforementioned accounts most likely sincerely believed that Pitocin, an epidural, or a cesarean section was necessary to preserve the life or health of their patients. Yet just as benevolence cannot justify other violations of informed consent, even if a physician who violates a woman's medical autonomy is benevolently motivated by a sincere concern for her health, his good intentions do not license obstetric violence. Historically, legal and ethical commitments to patients' rights developed in circumstances where health workers had medically informed, evidence-based reasons for discounting a patient's treatment decision (Dolgin 2010). Those are just the circumstances where informed consent matters most.

Some health workers may judge that supporting a medically risky plan during labor and delivery violates their conscience. Though all medical interventions during the childbirth process require the patient's consent, health workers should not be compelled to perform medical procedures that violate their ethical commitments, such as abortions, euthanasia, or elective cesarean sections. However, toleration of physicians' rights to refuse to participate in treatment plans for reasons of conscience does not require that hospitals or legal institutions tolerate violations of informed consent requirements or other patient rights, such as the right to privacy (Wicclair 2000). Respect for obstetric autonomy, like respect for medical autonomy more generally, generates negative duties that health workers respect a patient's choices during birth. But medical autonomy does not require that health workers provide any medical treatment on demand. In this way, the same principle of respect for persons that provides the strongest justification for medical autonomy also justifies respect for physicians who morally object to certain treatment plans. In some cases, a physician's objection to a treatment may effectively limit a patient's access to treatment, if the patient cannot be transferred to a physician who will respect her decision. In light of this possibility, the British Medical Association advises that physicians inform patients of any absolute moral commitments that may limit their patients' access to treatment so that patients have the opportunity to change physicians or re-consider their own treatment preferences (Wicclair 2000).[11]

[11] Discussions about physician's conscience may also provide an opportunity for patients to learn about alternatives. For example, if a physician is reluctant to perform a cesarean hysterectomy for a Jehovah's Witness who objects to the use of blood products, the patient may decide to accept bloodless interventions or to appoint a family member to decide on her behalf rather than refusing a cesarean hysterectomy (Karkowsky 2013).

In practice, respect for obstetric autonomy therefore requires only that health workers do not interfere with an unassisted delivery, even if refraining from intervening violates their conscience.[12] For this reason, protections for obstetric autonomy do not entail that pregnant women must be fully in control of their birth choices in all circumstances. For example, if a willing physician is unavailable then a pregnant woman with a serious disease may be unable to access treatment that endangers a fetus, but she would be entitled to refuse treatment even if doing so was dangerous (Lyerly et al. 2009).

4 Moral Risk

I have argued that a general presumption of medical autonomy protects obstetric autonomy. One may reply that a presumption of medical autonomy protects patients from paternalistic interventions, but it does not justify a presumption of obstetric autonomy because physicians may make treatment decisions on behalf of an unborn child. In rare cases, hospitals have obtained court orders for forced intrauterine transfusions (IUTs), mandatory cesarean sections, and forced hospital detention when a woman's medical choices threatened to endanger her unborn child's life or health. Courts in some jurisdictions granted requests for mandatory cesarean sections in 14/15 of all cases where a mother's decisions endangered a fetus (LaCroix 1989). When courts find that, "with an unborn child, the state's interest in preserving the health of the unborn child may run squarely against the mother's interest in her bodily integrity," they presume that health workers or public officials are entitled to balance those interests.[13] In this way, while informed consent requirements clearly extend legal protections to women in labor who seek to make their own treatment decisions, informed consent does not as clearly protect women's rights to make decisions that endanger unborn children.

In assessing these legal standards, let us assume that a late-term fetus has the same moral status as a person, as Judith Thomson did in an influential discussion of abortion (Thomson 1971).[14] Recall Thomson's famous thought experiment. You awaken and find yourself hooked up to an ailing violinist who needs to remain temporarily attached to you in order to survive. Thomson argues that it is permissible (though perhaps indecent) to unplug from the violinist, even if it will cause him to die, because you have a right that your body not be used against your will to sustain another's life. The same argument can be deployed to justify respecting a woman's medical autonomy during childbirth. Even if it is indecent to make a risky childbirth choice, patients are entitled to make decisions about their own bodies even if those choices put others at risk.

[12] Many of the reasons that justify medical and obstetric autonomy also are moral reasons in favor of supporting a patient's choice by providing treatment, even though informed consent does not require that health workers provide treatments that violate their conscience. For example, insofar as a presumption of medical autonomy is justified on the grounds that patients have strong interests in making significant intimate decisions, there are moral reasons in favor of supporting patients' treatment decisions even if health workers are not required to do so. Or, if informed consent is justified in part because respecting a patient's choice will likely promote a patient's overall well-being even if the choice is medically risky, then that justification for informed consent also is a moral reason in favor of providing patients with effective access to treatment.

[13] Judge Frank Q Nebeker in In re A.C., 533 A.2d 611 (D.C. App. 1987) as cited in (Cudd 1990).

[14] The assumption that a fetus has moral status is controversial, but more plausible in the circumstances of childbirth than abortion because it is far less controversial that infanticide is wrong than that abortion is wrong, and a viable late-term fetus is physically more similar to a newborn child than an early-term fetus.

Many philosophers find Thomson's analogy persuasive as an argument for the permissibility of abortion. But we should concede that even if it is permissible for you to unplug yourself from the violinist, it is morally risky (Moller 2011). Thomson's argument denies that there is a duty to provide lifesaving assistance, but anyone who did find himself hooked up temporarily to an ailing violinist would presumably have serious reservations about unplugging. Even if it is most likely permissible to unplug, it would be surprising to encounter someone who didn't have some feelings of guilt, who wouldn't feel compelled to apologize to the dying violinist as he strolled out of the hospital room. These reservations are good reasons to refrain from unplugging unless he had a really good reason to unplug.

Like abortion, or unplugging from a violinist, making a medically inadvisable choice during childbirth is morally risky. Dan Moller argues that a person should avoid moral risks even if she is fairly sure she is acting permissibly (Moller 2011). Specifically, it can be wrong to act in ways that are likely to be very wrong if avoiding the risk of wrongdoing is not very costly. According to Moller, whether an act is too morally risky depends on five factors: 1) the likelihood that it is wrong, 2) the severity of the potential wrongdoing, 3) the cost of avoiding potential wrongdoing 4) the agent's responsibility for the wrongdoing and 5) the moral risks of not acting. On this account, abortion is morally risky because the severity of potential wrongdoing is substantial (killing someone with moral status) and the likelihood of wrongdoing increases as the pregnancy progresses. Therefore, abortion is morally risky and especially risky for late-term abortion. If so, and if one ought to avoid taking moral risks when those risks can be avoided, then women should avoid abortions and especially late-term abortions.

The same argument extends straightforwardly to dangerous birth choices. Even if a woman is fairly certain that it is permissible to make a dangerous birth choice, it is morally risky to endanger a very late-term fetus. Not only is it risky because it is controversial whether women have duties to promote the health to their unborn children, but also because a late-term fetus may have moral status. To further motivate this intuition, consider another analogy. You and your friend are hunting, when you spot some movement in a distant bush. You think it may be a deer, and if it is you would really love to shoot the deer and make the hunting trip a success, but there is some chance that your friend is behind the bush.[15] Should you shoot? You are certain that your friend is a person with full moral status, but uncertain about whether shooting will kill him. It's morally risky to shoot because if you do you might do something seriously wrong.

Now consider the parallel case of abortion. A woman is certain that an abortion will kill the unborn fetus, but is unsure about whether the fetus has moral status and whether she has a duty to continue to provide lifesaving assistance to the fetus. Or, in the case of a dangerous delivery, a woman may be certain that her decision puts a late-term fetus at risk but unsure about whether it is permissible for her to do so. In both cases, a woman should avoid taking serious moral risks if avoiding those risks is not extremely costly and the alternative is not morally risky.

5 Rights to Do Wrong

Since it is morally risky to make a dangerous birth choice against medical advice, pregnant women should generally listen to a physician's advice during labor and delivery. Taking a

[15] This analogy is sometimes offered by critics of abortion, though I am unsure of its origin.

moral risk by failing to decide in accordance with medical advice may be a morally permissible moral mistake (Harman 2014), or it may be impermissible. If making a risky childbirth choice is impermissible, then one might think that the moral considerations against making dangerous childbirth choices would make women liable to intervention on behalf of the fetus. In general, it is permissible to stop people from wrongfully injuring innocents or subjecting them to serious risks. Yet even if it is immoral to make dangerous childbirth decisions that threaten the health or life of an unborn child, forced cesareans and other court-ordered obstetric interventions are not justified, just as considerations of moral risk would not justify a prohibition on abortion. In these cases, laws should protect wrongful conduct because coercively interfering with that conduct would constitute an even greater violation.

People have rights to do wrong in cases where the balance of moral considerations entails that it is wrong for A to X but that a coercive law that interferes with A's ability to X would threaten important interests or violate rights (Waldron 1981). For example, it is wrong to publish racist newsletters, and to engage in other forms of nonviolent speech that disparages and disadvantages already vulnerable groups. Still, states ought to protect even hate speech as a part of free speech because it is even worse for public officials to establish themselves as censors. Similarly, it is morally risky to eat meat, but legally prohibiting the sale of meat would infringe upon citizens' legitimate interests in making dietary choices. It would be wrong for a lottery winner to spend his winnings on racehorses and champagne instead of donating it to a lifesaving charity. But it would also be wrong for the state to force him to donate his winnings in addition to the taxes he already pays (Waldron 1981). In this case, even if donating his winnings could save a life, if a person's wealth was fairly acquired then he has a right to wrongfully keep it.

Respect for personal autonomy grounds a right to do wrong, but the value of autonomy is not the only consideration in favor of some protections for wrongdoing. Permitting some acts of wrongdoing may *on balance* have better outcomes. Some tolerance for wrongdoing is required for citizens to pursue important projects in a free society. There are also epistemic reasons to protect rights to do wrong just as there are reasons against taking moral risks. Public officials should recognize the possibility that they could be wrong about their own judgments of wrongdoing and err on the side of permissiveness rather than risk unwarranted coercion. The concept of rights to do wrong does not presuppose a deontological moral framework. Any moral theory that would judge that in some cases a person morally ought not act in a certain way but the state (or another person) would also be wrong to interfere is a moral theory that accepts the possibility of rights to do wrong. Cases of rights to do wrong often share in the feature where a person's conduct is morally wrong, but it doesn't violate anyone's negative rights, whereas interfering with that conduct would violate the negative rights of the wrongdoer. For example, it is immoral to publish racist newsletters but publishing them does not interfere with people the way that restrictions on speech would. In these cases, rights to do wrong may rely on the premise that it is often worse to violate someone's negative rights than to allow him to fail to provide assistance.

In some childbirth cases, respect for patients' rights protect rights to do wrong in this way. Insofar as it is wrong to make morally risky childbirth decisions it is because the mother is not acting in the interest of the unborn child. Nevertheless, the wrongness of failing to promote a child's interest does not justify forced cesareans or other compulsory medical interventions. These cases are parallel to other life and death 'right to do wrong' cases. For example, it is wrong to fail to provide assistance to people in need, such as a drowning child who could easily be saved (Singer 1972). Still, despite the fact that refusing to save the child would be

morally wrong, it would also be morally wrong for a third party to threaten or to physically force someone to save the child.[16] One may object that pregnant women do not refuse assistance, but rather that they actively endanger or harm their children when they make risky childbirth decisions. Yet the language of killing is moralized—it reflects the judgment that the killer was responsible for violating another person's negative rights (Quinn 1989; Scheffler by 2004). Risky childbirth choices would only qualify as wrongful killings (as opposed to failures of assistance) if the mother's choice was a culpable form of interference against the child. Even if we accept that unborn children have rights against interference, this characterization of childbirth is suspect because unlike abortion, childbirth decisions rarely involve intentional injury to the child.

The reasons against forcing mothers to make safer childbirth choices are especially strong because obstetric interventions can be very traumatic and burdensome to mothers. A cesarean section is major abdominal surgery and the recovery takes weeks and can be painful and debilitating. Cesareans also can compromise the safety of mothers who plan to have more children (Karkowsky 2014). Cesareans require anesthesia, they introduce risks of infection, and they leave women with permanent scars and damage to their abdominal muscles. Even relatively safe procedures, like in-utero transfusions (IUTs) for infants with inherited red cell disorders, infections, or RH disease, are significantly burdensome when they violate women's deeply held religious convictions (Levy 1999). Women who are given episiotomies are six times more likely to suffer fecal incontinence than women who are not (Signorello et al. 2000). In birth settings that routinely preformed episiotomies, patients experienced significantly more perennial trauma, pain, and healing complications (Carroli and Mignini 2009).

Here I am not defending the claim that there is nothing morally wrong with refusing relatively safe and potentially lifesaving procedures like episiotomies, IUTs, or even cesarean sections. Where these medical procedures could save a child's life, these refusal decisions are morally risky. If infants have moral status, then refusing a lifesaving intervention is wrong in the same way that it is wrong to refuse to provide lifesaving assistance. Nevertheless, a policy that empowers hospitals and public officials to force these treatments on women when an unborn child's health is at stake is wrong too. To motivate this intuition, consider how a court-ordered cesarean works. In essence, it involves drugging and cutting a woman open, performing major surgery, often violating her religious convictions, and fully trespassing the boundaries of the body, in order to save another's life (Cudd 1990). In other circumstances, courts are extremely deferential to people's closely held convictions, even when those convictions are misguided and impose some burdens on the community. Conscientious religious objections are respected and controversial speech is tolerated. Yet public officials do not respect pregnant women's deeply held convictions and reasonable concerns about the risks and costs of surgery, even though overriding a woman's childbirth choice involves a significant violation of her bodily integrity.

One may object that risky childbirth choices are not like other wrong or potentially wrong decisions because women have special obligations to their children beyond their general duty

[16] As Thomson argues, even if good Samaritanism or minimally decent Samaritanism were obligatory, assisting others should not be an enforceable obligation. Thomson writes, "Minimally Decent Samaritan laws would be one thing, Good Samaritan laws quite another, and in fact highly improper." She then argues that laws that compel women to carry a fetus to term would be more like Very Good Samaritan laws that require people to provide assistance even when it is extremely costly (Thomson 1971). Similarly, laws or hospital policies that force women to undergo procedures without their consent for the sake of unborn infants are also akin to Very Good Samaritan policies.

to assist those in need. However, even if pregnant women do acquire special obligations to their unborn children, they do not cede their rights of informed consent by becoming pregnant and acquiring those duties. Consider an analogous thought experiment that illustrates this point. An aging couple, Jamie and Andy, have been together for 50 years. Early in their relationship, Jamie introduced Andy to the joy of drinking fine wine and together they spent the course of their relationship indulging in at least one bottle of wine per person per night. When Andy develops a liver disease from his years of heavy drinking, the doctor finds that Jamie is the only available match for a liver transplant. In this case assume that Jamie has special obligations to Andy, their relationship is intrinsically valuable, and further that Jamie is responsible for Andy's compromised health. Perhaps Jamie has a moral obligation to donate part of his liver to save Andy's life. But *even if* Jamie does have a duty to donate to Andy, if Jamie refused to assist Andy it would be wrong for a physician or the state to force Jamie to undergo major surgery to extract a part of his body on Andy's behalf. Courts have upheld this judgment in similar cases. For example, patients are not legally entitled to compel their relatives to donate lifesaving bone marrow even if the patient would die without a bone marrow transplant and even if his or her relative is the only available donor (10 Pa. D, C. 3d 90 1978).

A relevant asymmetry between Andy and an unborn child, for our purposes, is that Andy also consented to drink to excess with Jamie, while a child does not consent to the risks posed by his or her mother. We might think then that Andy waived his rights to health or life whereas the child did not. Imagine another case. Mark placed some bear traps on his property and failed to label the boundaries of his land to keep out or warn potential trespassers. Alice wanders onto his land and her leg is caught in a bear trap. Mark takes Alice to the hospital where he is told that Alice will only survive if Mark donates his blood to save her and that he is the only suitable blood donor. Mark refuses and so the hospital staff straps him down, sedates him, and forcibly takes his blood. Mark ought to donate his blood to Alice. And perhaps he should have taken precautions that prevented Alice from ending up in such a risky situation. Still, hospital workers act wrongly if they forcibly take his blood.[17]

Another asymmetry between childbirth cases and other examples of forced assistance is that an unborn child would not exist, at least in some cases, were it not for his or her mother's choices. When a woman carries a fetus to term, one may think that she has committed to sustaining the child's life through childbirth.[18] Yet the fact that a person initiates a benefit and continues to provide it does not necessarily generate an obligation to continue providing the benefit or to provide as much of a benefit as possible. Imagine Jane sends Dan monthly checks so he can pay his rent, but then decides that doing so is too burdensome. If Jane never agreed to send checks indefinitely, then Dan cannot claim that Jane is required to continue to pay his rent whatever the price simply because she did so in the past. Similarly, a woman who has carried a fetus for over 9 months may not consent to sustaining her child's life through childbirth even if she seemed committed to doing so.

Forced obstetric interventions are generally justified on the grounds that states have a legitimate interest in the welfare of unborn children. In the US, courts use a balancing test to weigh a child's welfare against a mother's autonomy (Davenport 2010). Parents are not

[17] Even if Mark had invited Alice onto his property, forcibly taking his blood would be wrong. Legally, if a person is injured while on my property, that doesn't entitle the victim or public officials to forcibly perform medical procedures on me, and it would be immoral for them to do so.

[18] I am grateful to an anonymous reviewer for raising this objection.

entitled to risk their newborn infants' and grown children's lives. In these cases, medical decisions should be made in accordance with the child's interests rather than the parent's preferences (Dare 2009). However, though parents are not entitled to endanger their child when making medical decisions on their child's behalf, a woman who refuses medical interventions during pregnancy and childbirth need not claim to be exercising parental authority.[19] Refusing to make a safe childbirth choice is not the same as refusing treatment for one's child. During childbirth the mother's authority to refuse treatment for herself is sufficient to justify her refusal choice. It is only in those cases where a woman does not have the capacity to make decisions about her body that public officials or health workers may decide in the interest of her unborn child, because in those cases doing so would not violate the patient's medical autonomy.

Most pregnant women are competent to exercise their medical rights. In these cases, to justify a balancing test, one would need to show that unborn children had entitlements to use their mothers' bodily services to sustain their lives, which the state must weigh against mothers' entitlements to make choices about their bodies. This logic would have counterintuitive extensions. For example, it may also imply that states could balance diabetic citizens' entitlements to treatment against the bodily rights of healthy relatives who are particularly well placed to contribute their kidneys and save the lives of family members on dialysis. If a patient's need were great enough, such a balancing test would potentially justify forced kidney donations. But even in cases where a patient's life is in danger, it would be impermissible for states to force healthy citizens to undergo major surgery simply because their bodies are particularly capable of providing lifesaving assistance to others.[20] The application of a balancing test for pregnant women therefore deprives women of the medical rights that the courts grant other people who are well-placed to provide family members with lifesaving assistance. Even if pregnant women should not make choices that endanger their unborn children, public officials should not force pregnant women to undergo medical treatment for the benefit of their children.

6 Institutional Solutions

So far I have argued that pregnant women are competent to consent to or refuse treatment, and that they have the right to make risky treatment choices even though in some cases they may act wrongly by acting against medical advice. In practice, this argument calls for two kinds of institutional reforms. First, public officials and hospitals should abandon any practices of nonconsensual medical interventions on behalf of unborn children. Second, obstetric violence ought to be specifically prohibited, given predictable threats to women's rights to obstetric autonomy.

Foremost, courts, hospitals, and policymakers ought to abandon the 'balancing test' that weighs women's medical rights against the unborn child's right to life (Davenport 2010). Even

[19] In this way, my argument is not incompatible with a principle of *parens patriae*, which could require the state to take an interest in the health of infants. Parents with religious objections to medical treatment are not entitled to refuse treatment on behalf of their infant children. However, women with religious objections to medical treatment are entitled to refuse treatment during labor and delivery even if that refusal choice endangers their children, just as religious patients may refuse to provide their relatives with other lifesaving medical services, such as organ and tissue donation.

[20] A few ethicists disagree with this claim, most notably, Cecile Fabre (Fabre 2006).

if an unborn child does have the same moral status as a person, in no other area of public policy does one person's right to life entitle the state to forcibly require another to undergo a risky medical procedure that may violate her deeply held commitments. Policies such as compulsory IUTs, mandatory cesarean sections, and forced hospital detentions are all impermissible even if women who refuse medically advisable treatment act wrongly. One especially troubling aspect of forced medical interventions is that they are more common among low-income, minority, and non-English speaking mothers, and they always restrict *women's* medical autonomy (Davenport 2010). These issues of race, class, and gender are relevant to the policy question at hand. Against a historical backdrop of patriarchy, where women are socially and economically disadvantaged, pregnant women are especially vulnerable as patients.

Instead of a balancing test, public officials and physicians should adopt a presumption of obstetric autonomy just as there is a more general presumption of medical autonomy for all patients. Health workers who aim to secure informed consent from women in labor should not only respect pregnant women's medical autonomy, they should also take care to communicate to pregnant women that they are entitled to make their own birth choices. Continuous affirmation of informed consent is especially important during labor and delivery given that pregnant women are potentially more vulnerable to force or coercion when making treatment decisions than other patients.[21]

These considerations also call for specific legal protections for obstetric autonomy, similar to the more general legal protections for medical autonomy that protect the rights of non-pregnant patients. [22] For example, the aforementioned legislation in Venezuela penalizes medical personnel who commit 'obstetric violence' which includes not only non-consensual medical interventions and acceleration techniques but also forcing women to labor in their chosen birth position, ineffective attention to changes in the course of labor, and interfering with the early attachment between a mother and child without medical cause. The penalties include fines, public censure, and disciplinary action by professional associations.

This kind of legislation may seem superfluous since legal protections for informed consent ought to protect women's rights to obstetric autonomy without additional legal penalties for obstetric violence. Yet today women's wishes during childbirth are consistently ignored and women are silenced even when they are capable of expressing an informed choice. In this context, a legal presumption in favor of obstetric autonomy and special protections for women's rights are warranted because current obstetric practice consistently disregards informed consent requirements. Institutional tolerance for obstetric violence fits within a historical pattern of law enforcement that has ignored women's autonomy on the grounds that their roles as wives and mothers required women to cede control of their bodies. Marital rape, which was legal in some US states until the 1990s, was tolerated on the grounds that wives were obligated to have sex with their husbands (Bennice and Resick 2003). Marital rape exceptions were particularly unjust because they legitimized sexist attitudes that valued a woman's role in the family over her standing as an autonomous person. Legal rules should not disproportionately limit the rights of women who occupy gendered roles in their families. Though a child's

[21] A similar issue was raised in a recent article about heroin users (Henden 2012). There the author argued that these systematic social vulnerabilities undermined the possibility of consent. In direct contrast to this thesis, I am suggesting that these vulnerabilities make the imperative to respect patients' choices all the more urgent.

[22] For example, Article 2 of the German constitution states that every person has an inviolable right to life and physical integrity and Article 6 states that "every mother shall be entitled to the protection and care of the community." Together, these provisions should be interpreted as legal protections for obstetric autonomy.

medical needs are clearly more morally significant than a husband's preference to have sex, balancing tests also objectify women by prioritizing their role as mothers over their standing as autonomous patients.

Legislative protections for obstetric autonomy would have legal implications beyond balancing tests. For example, obstetric autonomy would invalidate anti-home-birthing legislation because legal requirements that women attempt to deliver in a medical setting or with medical assistance would significantly limit women's medical and bodily autonomy, freedom of movement, and privacy rights.[23] Just as respect for obstetric autonomy would require that health workers respect women's rights to refuse specific medical interventions, obstetric autonomy would also protect the right to refuse medicalized childbirth more generally. Nevertheless, a presumption in favor of obstetric autonomy may deter home-birthing, even though it calls for legal protections for the practice. As in the case of informed consent, strong protections for patients' rights would potentially encourage women to seek medical treatment during labor. Today some women avoid hospitals during labor because they are afraid they will be pressured or forced to accept unnecessary interventions. If women felt confident that health workers would respect their rights as patients, they might be less likely to avoid hospitals during labor. In this way, protections for obstetric autonomy could deter risky home births without forcing women to labor in hospitals. Even those who would defend a balancing test may therefore have pragmatic reasons to favor a presumption of obstetric autonomy instead, because obstetric autonomy could promote safer deliveries on balance.

Currently hospitals are entitled to refuse to assist women who choose to vaginally deliver twins, breach babies, or preterm infants. These policies are motivated by concerns about liability or health workers' conscientious commitments to protecting an infant's life by encouraging safer delivery choices. Medical personnel do have rights to refuse to perform procedures that they deem unacceptably risky or procedures that violate their conscience. Hospitals must balance providers' rights against women's obstetric autonomy. But even if providers have rights to refuse to provide treatment, they are not entitled to forcibly perform medical procedures without consent. Therefore, if a woman comes to a hospital with the intention of delivering twins or a breech baby vaginally, providers should not interfere with that choice. Since obstetric autonomy requires that medical personnel at least tolerate risky vaginal deliveries, substantial liability reforms may also be required to acknowledge that health workers are not morally responsible for adverse outcomes that directly result from their patients' choices.[24]

7 Conclusion

To review, I have argued that pregnant women and women in labor are capable of giving informed consent. Physicians who treat pregnant women are bound by the doctrine of

[23] The foregoing analysis does not establish any specific rights for providers. A presumption of medical autonomy does not prohibit policy makers from prohibiting midwives from facilitating morally and medically risky home deliveries. In principle, legislation that bans midwifery outside of hospitals is not impermissible from the standpoint of obstetric autonomy, though there may be other considerations in favor or against regulating obstetric professions that I have not considered.

[24] For example, Richard Epstein's proposal for medical malpractice reform to a strict contract model, wherein patients can contractually waive their right to sue for damages in exchange for risky medical treatments (Epstein 2006).

informed consent to respect patients' treatment decisions. Pregnancy and childbirth are morally risky and some treatment decisions might be morally wrong if they endanger the life of an unborn child. However, the reasons that justify a presumption of medical autonomy are so strong that they also justify institutional and legal protections for medically and morally risky treatment decisions.

More generally, this analysis yields a surprising normative conclusion about the limits of public policy. In most cases, it is uncontroversial that policy makers can permissibly limit personal choice when those choices harm others. Anti-paternalism is more controversial, though many ethicists accept that hard paternalism is sometimes permissible. Yet, in the childbirth case, a presumption of medical autonomy protects not only self-harming treatment decisions but decisions that threaten to harm others as well. These institutional conclusions have broader implications for public policy. A common strategy in public health ethics is to claim that a particular self-harming behavior has negative externalities, thus rendering a seemingly paternalistic policy permissible as a means to mitigate harm. For example, smoking bans are often justified not on behalf of smokers but to protect restaurant workers' right to a smoke-free workplace.[25] I have argued that this strategy cannot be deployed in such a straightforward way. In some cases the reasons against paternalism are so strong that they also justify rights to do wrong.

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[25] This is true in Germany, for example. The German constitution protects rights to personal integrity and development, so smoking bans must be justified for the sake of employees' rights rather than for paternalistic reasons.

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