

Do mothers of extremely preterm babies have a duty to express breastmilk?

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Infant feeding decisions are decisions about how and what a baby is fed. Such decisions are highly emotionally charged. As Thomson et al summarise, "In the wider literature, guilt and blame is frequently cited in association with women's experiences of formula feeding, with discomfort, humiliation and fear appearing as descriptors of experiences of public breastfeeding".¹ I argue elsewhere that many problems surrounding infant feeding decisions result from a moralised context created by mistakes in our assumptions about maternal duties including the mistaken assumption that mothers have a defeasible moral duty to breastfeed.² I argue that mothers have a reason, but not a moral duty to breastfeed. Even those who are convinced by my argument in the case of full-term babies might find it harder to accept in the case of premature babies. It might seem that mothers do have a defeasible moral duty to breastfeed or, as is more likely to be appropriate in such cases, to express breastmilk. Here, I explain why preterm neonates present a tricky case for the right not to breastfeed. I show why, nonetheless, moral pressure for mothers to express breastmilk in the neonatal unit is neither permissible nor pragmatically advisable. I argue that instead we should address structural barriers to providing breastmilk and support donor milk initiatives.

1 | NO GENERAL DUTY TO BREASTFEED

As I have argued elsewhere,² much of the discourse surrounding infant feeding decisions assumes that if breastfeeding has health benefits for the baby, then mothers have a defeasible moral duty to breastfeed. To say someone has a moral duty to do something

is to say that they are morally required to do that thing, and appropriately subject to moral censure (blame, guilt) if they do not do it. Defeasible moral duties are duties that are not absolute, but can be outweighed, undermined or cancelled by sufficiently strong countervailing considerations. For example, as a lecturer, I have a defeasible moral duty to turn up to teach my lectures. However, this duty can be outweighed. If I break my foot on the way to the classroom, I am permitted to go to hospital to be treated rather than struggling in to teach through the pain.

Defeasible moral duties have other features. Most importantly, if I have a defeasible moral duty to do something and I do not do it, then other people (with sufficient standing) can ask me to justify this failure. So, if I do not turn up to the lecture, I can expect emails from my students asking me why. If I do not have a good enough reason, they are entitled to blame me and I should feel guilty. On my view, defeasible moral duties have these features because they allow defeasible duties to play an important role in our moral practice, that of holding ourselves and others to account.

The assumption of a general defeasible duty to breastfeed is a mistake. First, it depends on a general assumption that any potential benefit to the child generates a defeasible duty for the mother. This assumed maximal maternal duty to benefit has unacceptable duties for the mother's self-ownership and well-being. So this reasoning is part of a worrying general trend of over-inflating maternal duties. In addition, we need to be particularly careful about duties to breastfeed because breastfeeding is an ongoing, intimate relationship involving the use of deeply personal areas of a woman's body.

This is not to say that children have no moral rights related to breastfeeding. However, the right to breastfeed should be seen as a

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right held by the mother and child jointly against interference or lack of support from others. The recognition of the joint right is important because both mother and baby's rights are violated if third parties interfere with breastfeeding. The baby's rights are not violated by the mother if she decides not to breastfeed.

2 | TRICKY CASES FOR THE RIGHT NOT TO BREASTFEED

Cases involving preterm infants present a tricky case for my defence of the right not to breastfeed. This is partly because the difference that maternal breastmilk may make to health is much more significant in these cases. As Bertino et al³ summarise, "Feeding preterm infants HM decreases the rates of infection, necrotizing enterocolitis (NEC), and mortality, while improving neurocognitive and cardiovascular outcomes at the long-term".

There are other factors that speak in favour of a moral duty to provide breastmilk to a preterm baby. The demand to provide some breastmilk over a set period of time (eg expressing milk for the first weeks after birth in an extremely preterm infant) is very different from a general demand to breastfeed. It does not commit the mother to a long-term breastfeeding relationship. Moreover, moral duties to use one's body for others in extreme situations are less of a threat to self-ownership than moral duties to use one's body in the normal course of events. Many people would find it plausible that parents have a moral duty to donate a kidney if their child needs it. Because this duty only applies in an extreme situation, it does not undermine parental self-ownership.

However, there are factors that count against a defeasible moral duty to provide breastmilk even in such cases. Breastfeeding or pumping involves the use of deeply personal areas of a woman's body. Breasts have emotional and social meanings that other parts—even internal organs like kidneys—do not. A key part of bodily autonomy is a general presumption against defeasible duties to engage in intimate activity. In addition, the parents of preterm infants are already facing exceptionally difficult circumstances.⁴

3 | MORAL PRESSURE TO PROVIDE BREASTMILK

I have acknowledged that it is difficult to judge whether there is a defeasible moral duty for mothers to provide breastmilk for premature infants. Nonetheless, I think we can say that healthcare professionals should not apply moral pressure to mothers to convince them to provide breastmilk. First, even if there is such a defeasible moral duty (and I am not convinced of this), health professionals are not able to have sufficient evidence to judge that a given mother is overall morally required to provide breastmilk. Second, moral pressure to breastfeed is likely to be counterproductive. So moral pressure to

produce breastmilk in the neonatal unit is neither ethically permissible nor strategically advisable.

Health professionals are not in a position to judge that a given mother is overall morally required to provide breastmilk. This is because health professionals are not entitled to know everything they would need to know in order to judge whether her defeasible duty to breastfeed has been outweighed. They are not entitled to know the mother's personal history. She may have undisclosed history of sexual abuse or other trauma which means that she feels unable to provide breastmilk.

Being required to provide testimony of sexual abuse and other trauma to defend oneself against moral pressure to provide breastmilk is degrading. Indeed, for a health professional to demand that mothers disclose intimate personal history to justify a "failure" to provide breastmilk runs contrary to the relationship of mutual trust that we would hope for between parents and health professionals. This may well be counterproductive even in terms of increasing breastmilk provision and have further ramifications for the infant's well-being. Lee and Furedi report that pressure to breastfeed can lead women to "come to distrust professionals, and become sceptical about the value of professional knowledge and advice".⁵ Moreover, while feeding their babies with their own expressed milk can be potentially empowering for mothers, moral pressure can make even mothers who are expressing feel like "failures" for not producing enough milk.⁴

4 | ALTERNATIVES TO MORAL PRESSURE

Instead of applying moral pressure for mothers to provide breastmilk, health professionals should provide non-judgemental information and support to all parents. Structural barriers to providing breastmilk should also be identified and minimised. For example, producing breastmilk with a baby in hospital involves logistical challenges of trying to spend time with the baby, care for other children, sterilise pumping equipment and make sure you are eating and drinking properly to sustain lactation. Policies of providing pumping mothers with hospital food and help with sterilising can solve some of these logistical challenges, making it easier for mothers to provide breastmilk.

Increasing access to donor milk banks is another alternative to putting moral pressure on mothers to provide breastmilk. This not only allows access to human milk to infants whose mothers cannot or do not want to provide maternal milk, but has been linked to increased rates of breastfeeding on discharge.⁶

CONFLICT OF INTEREST

There are no conflicts of interest. In particular, I have not received funding from any bodies associated with the marketing or production of infant formula milk.

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REFERENCES

1. Thomson G, Ebisch-Burton K, Flacking R. Shame if you do, Shame if you don't: Women's experiences of infant feeding. *Matern Child Nutr.* 2014;11(1):33-46.
2. Woollard F, Porter L. Breastfeeding and defeasible duties to benefit. *J Med Ethics.* 2017;43(8):515-518.
3. Bertino E, Di Nicola P, Giuliani F, et al. Benefits of human milk in preterm infant feeding. *J Pediatr Neonat Individual Med.* 2012;1(1):19-24.
4. Gordon E. *First Breath: How Modern Medicine Saves the Most Fragile Lives.* London: Bluebird; 2019.
5. Lee E, Furedi F. Mothers' experience of, and attitudes to, using infant formula in the early months. *School of Social Policy, Sociology and Social Research, University of Kent;*2005:1-93.
6. Arslanoglu S, Moro G, Bellù R, et al. Presence of human milk bank is associated with elevated rate of exclusive breastfeeding in VLBW infants. *J Perinat Med.* 2012;41(2):129-131.



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