**Breastfeeding and Defeasible Duties to Benefit**

**INTRODUCTION**

Lee and Furedi write that

*A process of cultural transmission seems to have turned provision of health information about the benefits of breastfeeding into hostility about formula use. This has a detrimental effect on relationships that are very important for new mothers, namely with health professionals and with other mothers.* [1]

Many new mothers face intense pressure surrounding infant feeding choices. Widespread, vocal disapproval of public breastfeeding is well documented and places heavy burdens, both practical and psychological, on women who decide to breastfeed. But women also face pressure when they *decide* *not* *to* breastfeed. This pressure tobreastfeed is the focus of our discussion. For many women experiencing motherhood for the first time, the message they receive is clear: mothers who do not breastfeed ought to have a darned good reason not to; bottle feeding by choice is a failure of maternal duty.

The pressure to breastfeed has demonstrated negative consequences for women who transgress, and knock-on serious risks for their neonates. Several studies report an association between decisions to formula feed and feelings of guilt, blame and failure.[2] New mothers on maternity wards report feeling pressured to breastfeed; and bottle feeding mothers report feeling neglected by ward staff.[3] One study found that over half of pregnant women (53%) received no information about safe and hygienic bottle feeding in the course of antenatal treatment.[1] Evidence indicates that mothers who bottle feed often conceal their feeding practices from midwives and other health practitioners,[1] to the detriment of thorough neonatal care support. Even if one thought that pressure to breastfeed increased rates of breastfeeding and that this led to a net health gain for mothers and babies in general, these negative consequences for formula feeding women and their neonates would give reason to search for alternative ways of improving breastfeeding rates. However, there is reason to think that pressure to breastfeed can also be counterproductive in terms of increasing breastfeeding rates. Lee and Furedi report that ‘Women can come to distrust professionals, and become sceptical about the value of professional knowledge and advice’.[1]

We argue that this pressure arises in part from two misconceptions about maternal duty. First, confusion about the scope of the maternal duty to benefit and second, conflation between moral reasons and duties. While mothers clearly have a general duty to benefit their offspring, we argue that this does not imply a duty (even a defeasible duty) to carry out each particular beneficent act. Mothers do not have a moral duty to carry out each and every act that would benefit their baby. Mothers do have moral reason to perform each beneficial action. However, not complying with a moral reason, unlike failure to comply with a duty, is not an accountable matter. Therefore, the act of holding mothers to account for individual beneficent act omissions, and the demand that individual omissions be justified, is unwarranted. The expectation that mothers who bottle feed should have a ‘darned good reason’ is morally unwarranted, in addition to being demonstrably harmful.

Recognising the difference between reasons and duties can allow us to discuss the benefits of breastfeeding and the importance of supporting mothers who wish to breastfeed without subjecting mothers who bottle feed to guilt, blame and failure.

**DEFEASIBLE DUTIES AND ACCOUNTABILITY**

On our understanding of ‘defeasible duty’, an agent who has a defeasible moral duty to perform an action is liable for moral censure if she fails to perform the action without being able to provide sufficient countervailing considerations. This does not just mean that adverse moral judgment will be correct if she fails to perform the action. Instead, failure to perform the action is an accountable matter: others are entitled to demand justification for failure to perform the action and if sufficient countervailing considerations are not available, blame and guilt is appropriate. Defeasible duties have these features in order to play an important role in moral practice, allowing us to hold others accountable for their behaviour [4]-[7]. Some people might use the term ‘defeasible duty’ in a way that is not connected with accountability. Our use of this term is not idiosyncratic and has been defended elsewhere [4]. But those who disagree with our use of the term should read ‘defeasible duty’ as a term of art in this paper, and remember that we are arguing that mothers are treated as if they have a defeasible duty to breastfeed which implies accountability – and that this treatment is unwarranted.

**MISCONCEIVING MATERNAL DUTY**

Discussion of maternal behaviour implicitly, and sometimes explicitly, assumes that mothers have a defeasible duty to perform any action that might benefit their child. Mothers are required to provide over-riding countervailing considerations to justify any given failure to benefit. This assumption arises from the fairly uncontroversial belief that mothers have a general beneficent duty towards their offspring. If one has a general beneficent duty towards some individual, so the thinking goes, and a given act will benefit that individual, then one has a (defeasible) duty to perform that act. If one fails to comply with a defeasible duty without good reason, then one is liable for moral censure. So, it seems, if there is an opportunity to benefit the baby and the mother declines to take it without good reason, the mother is liable for moral censure.

Scott, for example, argues in discussion of gestational moral duty that a would-be mother has a duty to do ‘all she can’ to benefit the foetus, but that ‘doing all she can will be doing all those things which she does not have serious reason to refuse to do’.[8] Scott discusses the hypothetical example of a pregnant woman refusing ‘for no reason’ to swallow a pill that would greatly enhance the welfare of the future child. She argues that the pregnant woman does have a duty to swallow the pill, because ‘swallowing the pill does not appear seriously to invoke her interests either in self-determination or bodily integrity’. In other words, the would-be mother has a duty to provide this benefit to her future child because she has no strong countervailing reason not to.

This assumption that mothers have a defeasible duty to perform any action that will benefit their child plays out in public discourse on breastfeeding as the claim that babies should be breastfed if possible—i.e. unless mum has strong countervailing reason not to. In the UK, at every visit to her midwife or antenatal clinic, a pregnant woman is bombarded with posters and leaflets reminding her that she must breastfeed to get her baby “off to the best start” [9]. Her midwife will ask her whether she intends to breastfeed. Should she reply that she does not intend to do so, she will be pressed to explain why not.

At the level of individual discourse, one need only look to social media outlets like Mumsnet to see this assumption in action. Many posts discuss low breastfeeding rates. Reliably, comments blaming the phenomenon on laziness, or selfishness etc on the part of bottle-feeding mothers are made. Bottle feeding mothers will then, just as reliably, respond by citing their pressing reasons for not breastfeeding, and insisting their child is nonetheless healthy. Some commenters will argue that breastfeeding choices are no one else’s business, but the underlying assumption remains intact: women who choose not to breastfeed, without extenuating circumstances, are liable to moral criticism.[10] On the whole, infant feeding is treated as an ‘accountable matter’.[11] Mothers are required to justify their infant feeding decisions and are subject to blame and guilt if they cannot do so.

Again, this is not to discount the testimony of mothers who experience pressure *not to* breastfeed. We agree that there is also this pressure. Recognizing the reason/duty distinction can help to support women who do wish to breastfeed without condemning those who do not. We say more about this below.

**BENEFICENT DUTY DOES NOT IMPLY DEFEASIBLE DUTY TO BREASTFEED**

The claim that a duty to benefit someone implies a defeasible duty to carry out a particular act that will benefit them—for example, that a duty to benefit one’s child implies a duty to breastfeed—trades on an ambiguity in the notion of a duty. As Hill notes:

*In saying “You have a duty to ...,” we may intend either to state a general principle or to declare that the person is required to do something on a particular occasion. Consider, for example, “It is your duty (here and now) to help that man” and “It is your duty to help others (sometimes).”* [12]

The claim that a mother has a defeasible duty to benefit her child fits the description of what Hill calls a ‘general principle’. Since general principles can often be fulfilled through multiple actions -- and it’s not possible to perform *every* action that fits the principle -- they allow moral agents latitude in how they go about fulfilling the principle. Put another way, general principles can generate *moral reasons* to perform certain actions without generating *moral duties* to do so: a general principle can make it the case that it would be morally good to perform a given action without making it the case that one *must* do so.

General moral principles can generate particular moral reasons without generating moral duties. For example, suppose that Sue has a duty to help others (general principle), and that furthermore, Sue has an opportunity to run in a charity race which would raise a significant amount of money that would greatly help those in need (particular beneficent act).[4] Sue would, in this case, have a moral reason to run in the charity race, since running would help others and she has a duty to help others. However, Sue would not have a *duty* to run in the charity race, since Sue’s duty to help others can be multiply realised. Running in the charity race would help others, but so would making a donation to Oxfam; so would helping her elderly neighbour repaint his window frames; and so on. Because a general principle can be adhered to in various ways, declining to take any one opportunity to realise it does not constitute a failure of duty. So long as other opportunities are taken up, one has realised one’s general duty. Since this is so, we can see that having a general duty to benefit gives us moral reasons to carry out any act that would benefit, but does not imply a duty to perform a particular beneficent act, and thus does not warrant moral criticism.[4]

What this means for breastfeeding, then, is that even if we accept that breastfeeding is beneficial, and furthermore accept that mothers have a general duty to benefit their children, it does not follow that mothers have a defeasible duty to breastfeed their babies.

**THE SCOPE OF THE DUTY TO BENEFIT**

We argued above that, like Sue who could run in the charity race or not, mothers have a general duty to benefit, but that this general duty does not imply a specific duty to breastfeed. But even if one accepts that Sue does not have a defeasible duty to run in the charity run because she has a general duty to help others, one might still think that mothers have a defeasible duty to breastfeed, since it’s commonly assumed that mothers don’t just have a duty to be of some benefit to their children, but rather, they have a duty to do ‘all they can’to benefit their children.[8]

According to this line of thinking, while Sue has a *sufficiency* duty to help others—she has, say, a duty to help others *some decent amount,* but does not have a duty to do every last thing she can to help others—mothers have a *maximal* duty to benefit their children: they have a duty to do everything they can to benefit their children. We reject this claim. Because opportunities to benefit one’s children are pervasive, and because there is a high level of uncertainty surrounding the risks and benefits to one’s child of many everyday activities, assigning a maximal duty to benefit their children constitutes an unacceptable moral burden on mothers, and is incompatible with self-ownership,[13] and thus incompatible with maternal wellbeing.

Mothers face almost infinite opportunities to benefit or harm their children. As their children grow, mothers are faced with a sea of conflicting advice about the risks and benefits of many every-day activities, from dummies (pacifiers) [14][15] and swaddling[16]to sun exposure[17][18] and peanut butter.[19][20] As such, even assessing whether a given choice poses a potential benefit to the child may require considerable research. Thus, in order for mothers to maximally benefit their children, a near-infinite amount of mothers’ time would need to be devoted not just to benefiting their children, but also to researching the possible benefits of the near-infinite number of choices they might make.

This combination of pervasiveness and uncertainty means that a maximal general duty to benefit one’s child would be intolerably burdensome. A mother would have to be prepared to defend and justify every decision she makes, and do so against a background of uncertainty. The mental and emotional energy required to perform this task would be huge. The mother’s very person would be reduced to an instrument of another’s wellbeing.[4]

On grounds of the equality of all persons, this maximal view of maternal duty should be rejected. Instead, we posit that mothers have a non-maximal duty to benefit their children, which might be well conceptualised as a sufficiency duty [21]. Mothers (and fathers, we might add), have a general duty to make it the case that their child’s existence is a good one, to the best of their ability.[21] This general, non-maximal duty to benefit their children means that mothers have moral reason to perform any action that would benefit their child; but do not thereby have a duty to do so.

It is clear that parents can have duties to perform some specific acts. For example, parents clearly have a defeasible duty to feed their children. It also seems plausible that parents in modern democracies have a defeasible duty to teach their children to read. Since the general duty to benefit is not plausibly understood as a maximal duty, it cannot be the case that all potentially beneficial acts are such that parents have a duty to perform them. So, while there are clearly some beneficent acts that parents have a duty to perform, it can’t simply follow from the fact that an act is beneficial that the mother has a duty to do it. The burden of proof is on those who want to argue that there is a duty to perform a given beneficial act to show why that particular act is required. The duty to feed your child is clear because not feeding your child is incompatible with your child having a good life—it may be incompatible with your child having a life at all. Although it is possible to have a good life without being able to read, it is plausible that the ability to engage in culture through reading is a core element of a typical good life in a modern democracy. In contrast, there is no evident consideration that shows why breastfeeding should be required. Barring such a consideration coming to light, this indicates that mothers don’t need that darned good reason not to breastfeed: there is (probably) moral reason to breastfeed, but there is not a duty to do so.

**BENEFITTING OR PROTECTING?**

One might worry that, rather than understanding breastfeeding as a benefit, we should understand it as a protection: like restraining your child in a child safety seat when you take them in a car. Understood as a protection, breastfeeding might seem to be duty bound. After all, a parent who does not restrain her child in a child seat when the child is in the car seems liable to moral criticism—indeed, is legally liable—even though there are many other opportunities to protect your child.

Even if breastfeeding is understood as a protection, rather than a benefit, a defeasible duty to breastfeed does not immediately follow. Like a maximal defeasible duty to benefit, a maximal defeasible duty to reduce risk of harm would be intolerably burdensome. Mothers cannot be required to justify every failure to reduce the risk of harm to their child, no matter how small the risk.

Our proposal explicitly requires revision of current beliefs about maternal duties. So it will be no surprise if our proposal does not match all the reader’s intuitions. However, again, we recognise that parents can have duties to perform specific protective actions. Further argument will be needed to show that there is a duty to perform a given protective action. There are two plausible reasons we might think that parents have a duty to use a car seat. First, we might think that each time a child rides in a car unrestrained, they are at significant risk of serious injury or death. Second, we might think that even if the risks to an individual child of riding in a car seat are minimal, the overall protection provided by a policy requiring parents to always use car seats may justify treating this as a duty, given that such a duty is relatively easy to fulfil and relatively non-intrusive. Such policies seem to involve society’s priorities determining which of many possible actions become defeasible duties: a defeasible duty to perform each action which led to similar reductions in risk would be intolerably burdensome. We’re happy to recognise that the public health benefits of improved breastfeeding rates would be significant [22], but the increased risk that an individual child will suffer serious harm (i.e. harm that is comparable to the harms in question when it comes to car-seat use) as a result of not being breastfed appears to be relatively low even based on the research that is cited to support breastfeeding. For example, Chen and Rogan argue that breastfeeding is associated with a reduction in risk of postnatal death and that “children who were ever breastfed had 0.79 (95% confidence interval [CI]: 0.67–0.93) times the risk of never breastfed children for dying in the postneonatal period.” [23] However, based on their conclusion (breastfeeding can prevent 720 postnatal deaths in the US per year) and and a birth rate in the USA of about 4 million per year [24], the absolute risk reduction for an individual child is about 720/4 million = 0.00018. that is 1.8 per ten-thousand. Moreover, breastfeeding involves the use of intimate areas of a woman’s body, is very time-consuming, and many women experience extreme pain and difficulty breastfeeding. Far from being easy to fulfil and non-intrusive, a defeasible duty to breastfeed would be a significant challenge to woman’s body-ownership.

We should note that there is controversy about exactly what the effects of breastfeeding are: someone might argue that breastfeeding provides such significant protection against such harm that mothers have a defeasible duty to breastfeed despite the challenge to women’s bodily ownership. This would require explicit argument. Responding to such a hypothetical argument is beyond the bounds of this paper. For the reasons given above, until such argument is given, the default assumption should be that mothers do not have a defeasible duty to breastfeed.

**PRACTICAL IMPLICATIONS**

Our core findings are (1) the benefits of breastfeeding do not support a moral duty to breastfeed nor moral criticism for those who decline; but (2) these benefits give moral reasons to breastfeed and reasons to provide support for women who wish to breastfeed.

At the individual level, the practical implications of (1) are fairly straightforward. Partners, friends, family members, health professionals, etc. are not entitled to ask women to *justify* their decision not to breastfeed. Moral criticism for a decision not to breastfeed is inappropriate, since a mother who chooses not to has not failed to fulfil either a moral duty to breastfeed, or her general duty to benefit her child. We argue further that moral pronouncements against bottle feeding, as are so often found in public discourse, are inappropriate. This does not rule out efforts by health professionals or others to promote breastfeeding. Our account implies that it should be possible to discuss the benefits of breastfeeding, to make sense of the efforts that some women make to breastfeed and even to celebrate breastfeeding, without condemning those who do not breastfeed. This is important, given that breastfeeding women are also subject to pressure and shame, particularly when it comes to breastfeeding in public. However, given the general tendency to treat women as if they have a duty to breastfeed, care must be taken in such discussion.

At the policy level, this account of maternal duty as regards infant feeding speaks in favour of policies that promote informed choice, and health and social support for whichever informed choice mother makes — a trend that is being increasingly recognized in policy (for example, the current draft National Childbirth Trust Baby Feeding Policy[25]).

Finding (2) implies that public health bodies do have reason to provide support to women who wish to breastfeed. Significant resources may be required to help women who wish to breastfeed to be able to do so, ranging from the provision of information to practical support, for example from a lactation consultant. We have strong reasons to devote resources to providing such support. However, given the social context, what might be intended as a simple offer of help may be understood as a moral judgement, again, care needs to be taken in how support is offered.

Since parents have a (defeasible, negative) right against barriers to the fulfilment of their general duty to benefit their children,[26] healthcare professionals and health bodies should provide information relevant to making an informed decision about infant feeding. Relevant information would include information about the health benefits of breastfeeding, as well as information regarding the benefits of each kind of feeding—breast, bottle and combination—more broadly construed, from the health sciences, as well as from psychology and sociology, covering evidence relevant to infant, maternal and familial wellbeing. Likewise, practitioners should be offering detailed information on the magnitude, rather than just the nature, of the purported outcome differences between breast and bottle feeding; and importantly: what does a difference of that magnitude mean in practical terms for life chances.

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