**Breastfeeding and Defeasible Duties to Benefit**

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**Draft paper.**

**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]](#endnote-1)*

 Many new mothers face intense pressure surrounding infant feeding choices. Widespread, vocal disapproval of public breastfeeding is well documented[[2]](#endnote-2) and places heavy burdens, both practical and psychological, on women who decide to breastfeed. But at the very same time, women also face pressure when they *decide* *not* *to* breastfeed. This pressure tobreastfeed is less frequently addressed in the literature, and it 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 quantifiable negative consequences for women who transgress, and for their neonates. Several studies report an association between decisions to formula feed and feelings of guilt, blame and failure.[[3]](#endnote-3) New mothers on maternity wards report feeling pressured to breastfeed; and bottle feeding mothers report feeling neglected by ward staff.[[4]](#endnote-4) 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.[[5]](#endnote-5) Evidence indicates that mothers who bottle feed often conceal their feeding practices from midwives and other health practitioners,[[6]](#endnote-6) to the detriment of thorough neonatal care support. Lee and Furedi report that ‘Women can come to distrust professionals, and become sceptical about the value of professional knowledge and advice’. This means that the pressure to breastfeed can also be counterproductive in terms of increasing breastfeeding rates.

 We argue that this pressure to breastfeed 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 any 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 quantifiably 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.

**MISCONCEIVING MATERNAL DUTY**

Discussion of maternal behaviour implicitly, and sometimes explicitly, assumes that 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 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. A moral 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.[[7]](#endnote-7)[[8]](#endnote-8)[[9]](#endnote-9)[[10]](#endnote-10) So, if there is an opportunity to benefit the baby — so the thinking goes — 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’.[[11]](#endnote-11) To illustrate, Scott discusses the hypothetical example of a woman refusing to swallow a pill that would greatly enhance foetal welfare and that of the future child, and doing so ‘for no reason’. 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, for example, the NHS ‘Start4Life: Off to the Best Start’ leaflet advises mothers that ‘What happens in your baby’s first years has a big effect on how healthy he or she will be in the future. Mum’s milk gives your baby all the nutrients he or she needs for around the first 6 months of life…’[[12]](#endnote-12) It goes on to list the benefits of breastfeeding, whilst adding simply that ‘infant formula is made from cows’ milk and other ingredients. It doesn’t contain the ingredients that help protect your baby from infection and disease.’ These statements are followed by twelve pages of advice on breastfeeding, with a text box in the margin that reads ‘try not to give your baby other food or drink’. The directive is clear: give your baby only breastmilk, unless you have some good reason not to.

 At the level of individual discourse, one need only look to social media outlets like Mumsnet to see this assumption in action, in a fairly formulaic way. One need not look far to find posts wherein low uptake of breastfeeding is discussed. 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 (usually health 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 to ‘excuse’ this choice, are liable to moral criticism.[[13]](#endnote-13) On the whole, infant feeding is treated as an ‘accountable matter’.[[14]](#endnote-14) 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).” [[15]](#endnote-15)*

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.

 This distinction between moral reasons and moral duties has analogs in our every-day practical (non-moral) reasoning. Suppose, for example, that I want to make jam. In order to make jam I need sugar, pectin, and some sort of fruit. While sugar, pectin, and some sort of fruit are rationally obligatory—I can’t fail to procure sugar, pectin, and fruit and still strive to make jam, rationally speaking—any particular fruit is such that, since I want to make jam I have a reason, but not a rational duty, to acquire it. My aim to make jam gives me a reason to buy cherries, for example; but equally, I could buy apricots. Since I could just as well use apricots, it’s not a rational failure if I don’t buy cherries. I can carry on making jam, in a rational way, with or without acquiring cherries. So, I have a reason, but not a rational obligation to buy cherries, given my intention to make jam.

 As for rationality, so for morality: 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).[[16]](#endnote-16) 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.[[17]](#endnote-17)

 What this means for breastfeeding, then, is that even if we accept that breastfeeding is beneficial (even “best”), 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. Because of this, it is not the case that mothers are liable to moral criticism if they decline to breastfeed without strong countervailing reasons against doing so.

**THE SCOPE OF THE DUTY TO BENEFIT**

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.[[18]](#endnote-18)

 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,[[19]](#endnote-19) and thus incompatible with maternal wellbeing.

 Mothers face almost infinite opportunities to benefit or harm their children. In the case of breastfeeding in particular, even if mother should choose to benefit her child by breastfeeding, she has then the decision of what she should ingest herself, such that what baby ingests is most beneficial; what way to hold baby while breastfeeding such that baby is most comfortable, what environment to breastfeed in, at what age to wean, and on and on. 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[[20]](#endnote-20)[[21]](#endnote-21) and swaddling[[22]](#endnote-22) to sun exposure[[23]](#endnote-23)[[24]](#endnote-24) and peanut butter[[25]](#endnote-25)[[26]](#endnote-26). As such, even assessing whether a given choice poses a potential benefit to the child may require considerable research. This means that in order for mothers to maximally benefit their children, a near-infinite amount of mothers’ time would need to be devoted not just to benefitting 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.

 On grounds of the equality of all persons, this maximal view of maternal duty should be rejected. Instead, we posit that mothers have a *sufficiency* duty to benefit their children. 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[[27]](#endnote-27). This general *sufficiency* duty to benefit their children means that mothers have moral reason to perform any action that would benefit their child; but having a moral reason to perform any given beneficent act does not generate a duty to do so. Because there is no duty to perform a given act, mothers are not liable to moral criticism should they decline to perform the act without strong countervailing reasons against so acting. In the case of breastfeeding, this means that mothers don’t need that darned good reason: there is (probably) moral reason to breastfeed, but there isn’t a duty to do so.

**PRACTICAL IMPLICATIONS**

The practical implications of this account flow directly from the core findings that (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 discriminatory and inappropriate, and should be seen for what they often are: bullying behaviour. 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*[[28]](#endnote-28)*).

 Finding (2) implies that public health bodies do have reason to provide support to women who wish to breastfeed. However, breastfeeding support must not occur at the expense of those who decide not to breastfeed or their neonates.

 Since parents have a (defeasible, negative) right against barriers to the fulfilment of their general duty to benefit their children,[[29]](#endnote-29) healthcare professionals and health bodies should provide information relevant to making an informed decision about infant feeding, without bias or paternalism. Relevant information would include both information about the health benefits of breastfeeding, as well as information regarding the benefits of each kind of feeding—both breast and bottle—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. For example, how many IQ points make up the difference between average outcomes of the two approaches, and importantly: what does a difference of that magnitude mean in practical terms for life chances.

This information should be made widely available to the public, and not just to new parents, so that feeding issues are well understood throughout society. Given the tendency to mistakenly assume that breastfeeding benefits imply a duty to breastfeed, and the ways in which this can be harmful for those who do not breastfeed and their neonates, extreme care needs to be taken in how this information is conveyed.

 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 judgment, again, care needs to be taken in how support is offered.

Access to infant-feeding support should be available to all parents, whatever method they are using, including bottle feeding. Information given to new parents about bottle feeding should be as thorough and up-to-date as information given on breastfeeding. Where research is lacking on issues like bottle sanitation, water quality, and comparative healthfulness of different infant feeding formulas, this research ought to be pursued and disseminated.

 Additionally, both methods of infant nourishment ought to be facilitated within communities, and at policy level. This means that breastfeeding ought to be warmly welcomed and facilitated in public spaces; but also that appropriate, hygienic bottle making facilities in public and private centres ought to be encouraged. Where public bodies seek to influence attitudes to infant feeding, a friendly, encouraging attitude to both styles of nourishment ought to be cultivated amongst practitioners.

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