**Parental Obligation and** **Compelled Caesarean Section: careful analogies and reliable reasoning about individual cases**[[1]](#footnote-1)

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Whether it is morally permissible to compel women to undergo a caesarean section is a topic of longstanding ethical debate. (1,2) Despite plenty of arguments against the moral permissibility of a forced caesarean section[1–7] the question keeps cropping up both in the ethical literature[8,9] as well as in legal, political and public debate[10,11] . This paper seeks to scrutinise a particular moralargument in favour of compulsion: the appeal to parental obligation. We present what we take to be a distillation of the basic form of the standard‘parental obligation’ argument on offer for the moral permissibility of compelling a C-section. We then argue that, in the absence of an exhaustive theory of parental obligation, the question of whether a labouring woman is morally obliged to undergo emergency surgery – and especially the further question of whether it is morally permissible for third parties to compel this – cannot be answered via ready-made theory. As such, we propose that the most viable option for settling both questions is by analogy. We follow earlier writers in presenting an analogous case – that of fathers being compelled to undergo non-consensual invasive surgery to save their children – but expand the analogy by considering objections that appeal to the ownership of the fetus. We offer two lines of response: (1) the parthood view of pregnancy and (2) chimaera dad. We argue that it is clear in the analogous case that the moral permissibility of compulsion cannot be justified. We also offer this analogy as a useful tool for assessing whether mothers have a moral duty to undergo caesarean sections, both in general *and* in particular cases, even if such a duty is insufficient to warrant compulsion.

We limit our discussion to cases where (1) the pregnant woman has capacity[[2]](#footnote-2), and (2) the caesarean section is proposed primarily in the interests of the fetus/unborn child. We recognise that in such cases the caesarean section is often deemed also to be in – or at least not against – the interests of the mother, either because she has a direct emotional interest and investment in the fetus’ survival, and/or, less often, because that which is deemed a threat to the fetus – such as the risk of uterine rupture or preeclampsia – is also deemed a risk to her.[[3]](#footnote-3) Our analysis will engage the first issue, but we deem the second irrelevant, at least for the question of compulsion. Even setting aside the fact there is genuine and profound disagreement on what is and is not in the woman’s interest in these cases, and how that is to be determined[12], it is well established in both medical ethics and law that patients with capacity can refuse treatment, even if doing so is against their interests (or even life). We do not compel the removal of cancerous tumours or the giving of blood-transfusions to refusing Jehovah’s witnesses, either of which removes a threat far more serious and likely than that which childbirth absent a caesarean poses for the mother in all but the rarest of cases. Short of a defence of unfettered paternalism not seen anywhere else in medicine, any case is to be made in favour of forced caesarean section must be a case that rests on the interests of the fetus/future child alone.

*The Standard Argument*

We take two arguments for the moral impermissibility of C-section refusal in case of fetal distress as representative of the arguments on offer for this view – those of Malek[13] and Savulescu.[8] Though these two arguments differ in many respects, we submit that they have the same basic structure, and rely on the same key move: pregnant women have parental obligation, and this obligation tips the balance between their autonomy rights and their benevolent duties towards the fetus.

Various of the assumptions contained in these arguments – that the fetus is morally salient either in itself or because it is a future person;[14] that the fetus is metaphysically distinct from the pregnant woman;[15] that moral agents have easy rescue duties towards one another;[16] that all pregnant women are future mothers;[17] etc. – are substantive in their own right. We remain agnostic on them; we simply accept them for the sake of argument. We thus seek to show that the standard argument for the moral permissibility of enforced C-section is unsuccessful even on its own terms.

*Savulescu on Millian Parental Sacrifice, Deeply Held Values & Grievous Bodily Harm*

According to Savulescu,[8] the state is justified in compelling emergency medical intervention like C-section in childbirth because the state is justified, on ethical grounds, in demanding some sacrifices of its citizens. Compelling what he calls ‘easy rescue’ is justified, he argues, on broadly Millian liberal grounds: if ‘the harm to A [rescuer] of I [intervention] is below some acceptable threshold, and the harm to B [rescuee] of not-I is great, […and] A has a duty or obligation to B’, then the state may compel A to I for the sake of B. He gives the example of compelling a patient to donate one drop of blood for the sake of another patient who will otherwise die. He quotes Mill – ‘every one who receives the protection of society owes a return for the benefit’ – and asks, w*hat smaller return could be asked than a drop of blood to save a life?*

But of course, a pin-prick seems a harm of a different sort to that of non-consensual abdominal surgery. Savulescu recognises this. He characterises the latter harm as, variously, ‘the psychological harm of being forced to undergo surgery against one’s *values*’ (emphasis added); ‘having one’s deeply held values violated’; ‘like a kind of rape or torture’ (this characterisation he attributes to Jean Robinson); and ‘having one’s values offended’. It is noteworthy that only in the Robinson characterisation do we approach something like what non-consensual invasive abdominal surgery actually always is: grievous bodily harm; an unambiguous, even if justified, violation of bodily integrity. That said, Savulescu recognises that some further justification is needed in the case of enforced C-section than in the case of enforced pin-prick. Mill’s owing society a return for the benefit won’t justify this level of harm to A, since if it did, the state would be justified in forcing all manner of person to disown all manner of deeply held values, as well as rights to bodily integrity, sustain grievous bodily harm, and so forth, as and when it is advantageous for those – even those total strangers – who might be harmed by a failure to do so. This clearly would not gel with Millian liberalism in the way that ‘easy rescue’ duties seem to do.

However, Savulescu points out that Mill recognised that parents have particular duties towards their children (present or future, apparently) and that this duty extends beyond simple easy rescue:

...as Mill recognized, parental duties extend beyond parents refraining from acting in harmful ways; they require parents actually making sacrifices for the sake of their children.

Because the pregnant woman is a future mother, Savulescu argues, she has rescue duties towards the fetus that extend beyond her general duty of easy rescue: they extend even to violation of her deeply held values (or right to bodily integrity) when significant harm to the future child is at stake. The Millian liberal state, therefore, is morally justified in compelling such sacrifice, according to Savulescu.

*Malek: Parental Obligation Goes Beyond Mere Rescue*

Malek similarly appeals to parental obligation in arguing that, unlike a mere bystander, the pregnant woman has a duty to make significant sacrifice in the face of potential harm to the fetus.[13] Malek argues that ‘pregnant women and parents [have] analogous obligations to their children and fetuses’, since parental obligation is causally grounded. She argues that

It is plausible to hold that an individual chooses to take on parental obligations when she voluntarily creates and maintains a vulnerable life. This action generates duties to protect that life from harm. The key features of this account are (1) the voluntary action of the individual, (2) the vulnerability of a life to harm, and (3) the causal relationship between the two.

Malek sidesteps a direct answer to the question ‘are pregnant women mothers?’, but argues that since (1)-(3) explain parental obligation, pregnant women must have *analogous* obligation because (1)-(3) are present in their case, too. Because of this, she argues, pregnant women have duties towards their vulnerable fetuses that go beyond easy rescue. Since they are responsible for the threat the fetus is under, they have a duty to avert it.

Malek acknowledges that the physicality of pregnancy is such that averting threats in the case of the fetus carries different costs to the pregnant woman than does averting threats to a child. Importantly, children do not usually need their parents to undergo invasive surgery in order to be saved from harm themselves. However, she argues that:

...rather than seeing the necessary impact on a pregnant woman as disrupting the parent–child/maternal–fetal analogy, it would be better conceptualized as a complicating factor, additional consideration, or possible side constraint.

*Fixing Parental Obligation*

The standard argument – and both Malek’s and Savulescu’s in particular – rely on the assumption that pregnant women have parental obligations (or something analogous to parental obligations) towards their fetus or future child. We note, in the first instance and in order to set the issue to one side, that not all pregnant women are future mothers, either in the sense required by Malek, or in general. Not all women became pregnant or continued pregnancy voluntarily; some women gestate with the intention that someone else will parent the child - surrogates and women who intend giving the baby up for adoption are the two most obvious examples of this; and only some accounts of parental obligation will have it that parental obligation tracks biology, rather than, say, social family or intention. It is not clear, then, that all pregnant women will one day have parental obligations. Further, even for those pregnant women who will one day have parental obligations, it’s a substantive claim that they *already* have parental obligations in virtue of this future.

All of that said, in order for this parental obligation argumentative move to work either to establish a moral obligation to undergo surgery, or (and in addition) to establish that such surgery can morally permissibly be compelled on such grounds, it needs to be established not just that pregnant women have parental – or analogous – obligations, but also that such parental obligations extend *significantly* beyond mere ‘easy rescue’; it needs to be established that they demand sacrifice of deeply held values – and of rights to bodily integrity – from parents in the face of threatened harm to the future child and thus to the fetus – and moreover that these sacrifices can morally permissibly be imposed if not undertaken voluntarily. However, literature from the field of parental ethics cannot establish this.

To date a reasonable amount of ink has been spilt by philosophers and other ethicists towards the cause of articulating theories of parenthood: towards spelling out how and why one comes to acquire parental obligation. As Savulescu notes, Mill gestured towards a causal theory of parenthood much like Malek’s. Bestowing life on a child, Mill wrote, ‘unless the being on whom it is to be bestowed will have at least the ordinary chance of a desirable existence, is a crime against that being’.[18] And of course, Mill also famously wrote that, while drinking to excess is a merely self-regarding harm (and thus out of the bounds of liberal theory), drinking to excess when one has a family to support, and thereby neglecting that support, ‘becomes amenable

to moral disapprobation’.[18] Kant’s take on parenthood was broadly the same,[19] and so on. Some contemporary theorists – including Malek – articulate contemporary versions of this causal account;[20–22] others offer consent-based views of parenthood;[23] and still others give purely biological accounts of parental obligation.[24,25] Only causal and biological accounts of parenthood would support the standard argument we’ve presented above. However, whichever sort of account is the right one, the problem is that none of them tells us whether mothers (women) are obliged to consent to invasive medical treatment for the sake of their children (fetuses or future children), let alone whether they can be compelled to undergo the surgery if they fail to meet that purported obligation: put simply, no one has got that far yet. The bare claim that the pregnant woman has parental obligation, on its own, does not show that she has an obligation to undergo C-section, let alone that the purported obligation can be enforced; and parental ethical theory cannot help us here.

*What do parental obligations demand?*

So, how do we establish what parental obligations demand, with regard to surgical childbirth intervention? According to Savulescu, again, intervention in the actions of A for the sake of B is ethically justified if

1. the harm to A of I is below some acceptable threshold, and
2. the harm to B of not-I is great; and
3. A has a duty or obligation to B.

Savulescu suggests that intervention that overrides the will of a labouring woman and forces upon her non-consensual surgical intervention for the sake of avoiding risk of serious harm to the future child is justified because conditions (1)-(3) are met. Presumably this is because the pregnant woman’s parental duties (3) are such that the harm to her (1) is below the acceptable threshold. So, the labouring woman’s obligation to her future child qua future parent is, according to Savulescu, such that invasive abdominal surgery is within the bounds of what she is *obliged* to endure for the sake of her future child. And, secondly, so strong is her obligation qua future parent that it is even within the bounds of what third parties are morally justified in compelling her to do if she refuses to discharge this obligation.

Savulescu runs through various options for how to conceptualise the ‘acceptable threshold’ in (1), and we have omitted discussion of this issue for brevity. However, it is interesting to note that Savulescu rejects what he calls ‘The Maximising View’ of what sacrifice is required of moral agents in general on grounds that it ‘would justify the state removing one of A’s kidneys if that kidney would save B’s life’: this, he says, ‘gives too little weight to liberty’.[8]

Following Purdy,[2] Bordo,[3] and Kolder, Gallagher and Parsons,[26] we therefore propose the following: parental obligation (3) morally justifies third parties in compelling non-consensual abdominal surgery (c-section) on pregnant woman A (1) for the sake of future child/fetus B (2) *only if* parental obligation (3) would likewise morally justify third parties in compelling father A to undergo non-consensual abdominal surgery (1) to avoid great harm to his child B (2). In order to make the analogy vivid, one might imagine that the child needs the father’s kidney; or a lobe of his (regenerative) liver. In other words, parental obligation only explains third parties being morally justified in imposing surgery without consent in the case of the pregnant woman if it also explains imposing surgery without consent in the case of dad and his kidney or liver lobe (assuming a similar risk profile for father and child).

*The Question of Compulsion*

We only have our intuitions to consult here, and we invite every reader to consult their own. But our intuitions tell us that parental obligation does not justify non-consensual invasive surgery on dad for the sake of the child. In support of that we note that most Western legal systems firmly reflect this intuition. In England and Wales, organ removal on living patients without consent is criminalised, no exceptions, via the Human Tissues Act 2004 s5.[[4]](#footnote-4). Likewise, the European Convention on Human Rights and Biomedicine, to which 35 European states (but not the UK) are currently signatory, makes clear in Article 5 that

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.

It is noteworthy that neither the Convention nor the Human Tissues Act 2004 specifies an exemption to Art 5 on grounds of familial obligation. More than this: it is recognised in the donation ethics literature that informs such legislation and treaty provision that family-member (especially parental) consent to live donation deserves heightened scrutiny, precisely because the care relationships that drive family members to donate might be understood as coercive in a way that calls their consent, and thus the permissibility of the medical procedure, into question.[27–29]

In the American case of *McFall v* Shimp,[30]the court considered an order to compel Shimp to undergo a bone marrow extraction to save the life of his relative. In denying the request, Flaherty made clear that Shimp’s decision to refuse the donation was, in the court’s view, ‘morally indefensible’ but went on to write that

For a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for *another* member, is revolting to our hard-wrought concepts of jurisprudence.

Shimp was not the plaintiff’s father, so a judicial view on the limits of parental obligation cannot be gleaned from the case. On the other hand, the order was sought in *McFall* because Shimp was the only available suitable donor – McFall would die without it – and in this sense *McFall* is neatly analogous to the non-consensual C-section case, where the pregnant woman cannot simply find someone else to be cut open to save the future child. Additionally, given the strength of wording in the judgment, it seems unlikely that it would have made any difference had Shimp been McFall’s father.

It is of course quite right that what the law allows is not decisive on moral questions. Precisely what one would hope to discover in an inquiry such as this is what we *ought* to do or allow, to which considerations one may then appeal in making, shaping or criticising the law. The output of that enquiry is all the more racy and exciting if what we ought to do or allow is different to what the law prescribes. However, in the absence of firm theoretical/argumentative reason to doubt the moral veridicality of the preponderance of Western law, the fact that patient consent is so uniformly insisted on in law (as well as in medical ethics) should carry some intuitive weight.

Ultimately, however, there is a moral question here that cannot be settled by consulting any existing law; the best we can do is generate reliable moral judgment, which is why we propose consulting our analogy. If parental obligation implies a duty on the part of the parent to make considerable sacrifices for the sake of the child – and we think it does – *and* if that duty is weighty enough to warrant third parties in compelling the parent to discharge that duty, then that duty must be equally strong across parents, and not vary in strength according to sex. It follows, then, that if third parties are not morally justified in strapping dad down and cutting him open to prevent (risk of) harm to the child, then third parties are not morally justified in compelling a labouring woman to submit to non-consensual C-section to do the same.

*The Question of Obligation*

It seems clear to us that parental obligation does not morally justify compelled organ removal: Savulescu is right that this would give too little weight to liberty. But there is a second question: does a parent have a *moral* obligation to donate their kidney or liver lobe to their child if said child will otherwise die or be profoundly disadvantaged, even if that moral duty is not so weighty that it is morally permissible for third parties to enforce? Questions about parental duty and the moral permissibility of compulsion are often confused; we emphasise that there remains a huge gulf between the moral intuition that a parent *should* donate their organ or undergo c-section, and the conviction that this morally justifies third parties in strapping them down and taking it by force. Note that *McFall v Shimp*[30]made just this contrast: the court considered Shimp’s decision to refuse the donation decision ‘morally indefensible’, yet still refused to compel him to act morally. A similar contrast is made in *St George’s Healthcare NHS Trust v S*: a person ‘is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear *morally repugnant*.’[31][[5]](#footnote-5)A positive answer to the question about moral duty does not directly translate to an answer about the moral justification for compulsion.

But it is nonetheless a good question in its own right, so: does the parent have such a duty? What sacrifice does parental obligation demand? As in the case of compulsion, this question cannot be answered by ready-made ethical theory. In this case, too, we have not got that far; and merely noting that someone has parental obligation does not determine the details of what and how much they are obliged to do, as little as it determines what it is morally permissible to compel them to do. Our analogy is therefore not just as a useful tool for accessing reliable moral intuitions and arguments about the moral permissibility of compulsion, but also about parental moral duty.

Once again we can only invite the reader to consult their own intuitions, but for what it’s worth, here are our own: we definitely think there are some cases in which parents are morally obliged to undergo surgical intervention for the benefit of their children. There may even be a general parental obligation to undergo such intervention, if a certain threshold quantity of expected benefit/harm-avoidance is met. That said, it is worth remembering the present reality, here, which is that, worldwide, the overwhelming majority of pregnant women readily and regularly consent to caesarean sections and various other invasions of their bodily integrity, as well as (risks of) grievous bodily harm, during childbirth, where this is deemed to result in even only a small chance of benefit to their future children. If there is general moral obligation here, it is almost certainly widely met – and probably regularly exceeded.

But we also think there are, or at least can be, cases where a general obligation, if there is one, does not apply or is defeated. These are cases where the relevant likelihoods, individual beliefs, values and reasons are such that parents are not under an obligation to submit to surgery – whether this is a c-section or kidney donation. Whether any particular case of proposed caesarean section is one in which there is or isn’t a moral obligation, is therefore not one that could be settled in a unified matter. Once again the reality matters: caesarean section refusals are incredibly rare, and in those rare cases women nearly always have at least some particular reason for their refusal. Even if a general obligation to undergo caesarean section exists, noone could therefore move, on those grounds, to a pronouncement on such individual cases, *without* carefully considering these reasons that might act as defeaters (as well as other relevant individual particulars, including potential maternal health reasons in favour of a caesarean); we recommend then considering an accordingly appropriately modified version of our proposed analogy.

*Benefits of the Analogy*

The analogy is suitable because it captures important elements of the analysis beyond the presence of parental obligation alone. First it captures parental emotional investment in both cases: the fact that the C-section/kidney donation may be deemed in the parent’s interest because of the grief and – perhaps guilt – the parent is likely to feel in case of a still-birth/death resulting from their non-consent/donation.[[6]](#footnote-6) Second, it captures that the rescue in both cases is uniquely one that requires elaborate medical intervention on the own body. This is relevantly different from rescues that (merely) require time, labour or other efforts – or even physical risks. Rescues that require surgical intervention on the body involve bodily integrity and intimate values in a way that even if we had a general analysis of parental duties and the burdens that legitimately imposes in terms of time, effort, financial cost, physical risk, etc. – such an analysis would still fall short of settling the morality of compelled caesarean section. Third, the analogy can easily be adjusted to capture different absolute and relative risk/benefit ratios and individual reasons that play a role in individual forced caesarean section cases; we could, for example, imagine a kidney-stingy dad whose reasons for refusal involve a phobia of needles; a substantiated deviant opinion on the likelihood of success; religious objections; or concerns about their ability to care for other current and future children. Fourth, the analogy can capture concerns about capacity; insofar as disagreeing with medical advice in general, or specifically medical advice in the best interests of one’s child, casts automatic suspicions about capacity, this applies to both fathers and mothers.

At the same time the analogy is necessary because we cannot reliably discuss the question of parental obligation based on pregnancy cases alone. There is a real and documented risk that pregnant people, either as women, or as pregnant humans, are treated in ways radically unlike other people, in that they are denied the respect, dignity and and freedoms normally accorded to adults with capacity.[2,3,32] Whether or not that analysis is right, just to guard against the possibility of that risk we need an analogy that involves rescue-by-surgical intervention on a body that is male and not pregnant. Our analogy does just that.

*Limits of the Analogy – and a response.*

One might object that there is a salient disanalogy between the case of the pregnant woman undergoing C-section and the dad undergoing organ removal, in that unlike the case of the pregnant woman, in the dad’s case an organ is being removed. This, one might think, matters to what kind of liberty is at stake, since dad is not just being assaulted, but is also losing possession of his tissue. Of course, an organ is also being removed in the case of C-section: lots of organs, in fact. But one might think the cases are different for either of two reasons. First, the organs that are being removed in the case of the caesarean are not being used by the woman and/or are not needed by the woman; or second, they do not belong to the woman.

We submit that neither of these facts takes away from the analogical force of the example. First, up until the point that the fetus and placenta are removed in C-section, the woman’s body *is* using those organs: it is circulating blood through the placenta. Circulating blood through a placenta is not necessary for the good functioning of the woman’s body – setting aside reproductive function, for which it is essential – so she does not strictly need these organs; but likewise, neither second kidneys nor every part of an unresected liver are necessary in order for dad’s body to function.

The second reason – that the pregnant woman lacks proprietary rights over the organs being removed; that they’re not *hers,* they’re baby’s – will seem more compelling to many. Kidney-stingy dad, one might think, has a right to his organs because they’re *his*; because (something like) bodily ownership is just basic, and so taking tissue from a person against his will goes a step beyond grievous bodily harm, and is therefore a deeper infringement of one’s liberty. Of course if one accepts the parthood view of pregnancy, which argues that the fetus is part of the mother’s body,(15) then the response is straightforward: the cases are analogous. If one does not accept the parthood view, then we still suggest that either ownership is not relevant after all, or if it is, it describes the situation of the pregnant woman as well.

Baird *et al* recount the case of a father who initially was deemed not to be the genetic father of his child.[33] Upon further investigation, it was found that the father exhibited chimerism, thought to be caused by his body’s absorption of a fraternal twin in utero; thus his sperm was genetically fraternal to most of the rest of his body and he was (mostly, if you like), ‘his own child’s genetic uncle’*.*

Let’s call this chimera father ‘dad C’, and his child ‘child D’, and for the sake of argument let’s suppose that dad C has both sperm and one kidney that are derived from the absorbed twin and therefore genetically fraternal to the rest of his body. Would Millian liberalism countenance treating dad C differently from ordinary kidney-stingey ‘dad A’, on the grounds that C has *no,* *less* or *more dubious* of an ownership claim over his kidney than A? That is to say, would we countenance that compulsion is morally permissible in C, but not A, on the grounds that A clearly owns his kidney, but that C’s chimaeric kidney could be said, in some sense, not to be ‘his’, but his twin’s? Does this make a difference to C’s liberty rights, *vis-a-vis* non-consensual abdominal surgery? After all, if his kidney is in some sense not – or only questionably – his, then the only harm C suffers is assault occasioning grievous bodily harm (or, in Savulescu’s terms ‘having one’s deeply held values violated’) – but no tissue theft, as such.[[7]](#footnote-7)

We think it is clear that the genetic identity or zygotic origin of his tissue or organ does not make a difference either to the harm dad suffers or to the applicability of his liberty-rights, but there are two different explanations one might give for this non-difference. First, we might say that the reason for the non-difference (that is, the reason that dad A has a right against coercive surgery if and only if dad C does) is that *cutting him open* is what matters. While removing organs might be an additional wrong, both dads have a sufficient right against being cut open, even if nothing is taken, to outweigh any purported parental duties to rescue their child. Notice in this case that if the dads have such a right against being forcibly cut open, then so does the pregnant woman.

Alternately, it might be the case that dad A has a right against coercive surgery iff dad C does because regardless of their genetic identity or zygotic origin, both of dad C’s kidneys belong to him. Gene sequences or zygotic origin, we might think, just aren’t decisive to tissue ownership. The kidney is in his body, it grew there, it functions there, so it is his. But the end-point of this line of thinking is surely obvious: the placenta and fetus are in the pregnant woman’s body, they grew there, placenta and fetus are functioning there, so removing them from the pregnant woman is an unacceptable infringement of her liberty if removal of the chimeric kidney from dad C is an unacceptable infringement of his.

The analogy we offer is apt and insightful for reliably testing our intuitions regarding the ‘parental obligation’ argument in favour of compelled caesarean section. Whichever way you slice it, non-consensual abdominal surgery just isn’t morally permissible. While it may be the case that both pregnant woman and dad *ought to* make the relevant sacrifice to save the child/fetus, in certain cases, which is a further question our analogy is apt and insightful for answering, the move from parental obligation to morally permissible medicalised assault occasioning grievous bodily harm just does not work.

*Summary*

The standard argument for the moral permissibility of compelled caesarean section by appeal to parental obligation does not work. Even setting aside the very real issue over whether pregnant women are parents – or have obligation in virtue of being future parents; or have obligation towards future children – the claim that parents, and hence pregnant women, are obliged to sacrifice their rights over their own bodies, and the further claim that it is therefore morally justified to subject them to non-consensual abdominal surgery – to grievous bodily harm – because they have parental obligation is dubious in the absence of a theoretically sound account of the contours and limits of parental obligation.

In this absence, reasoning about the extent of the labouring woman’s obligation, and the moral permissibility of enforcing that obligation, must instead proceed by analogy: we have considered whether fathers are morally obliged, and, further, whether they can be morally permissibly compelled, to undergo a similar infringement of their bodies under similar risk/benefit profiles. Even if the moral obligation exists in the case of fathers in some cases, it is evident that it is not morally permissible to enforce this obligation – nor would anyone enforce that obligation. The argument that pregnant women can be justly subjected to non-consensual abdominal surgery because they have parental obligations is at best without support, and at worst untenable, given the implausibility of treating fathers in an analogous way in relevantly similar scenarios.

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2. An anonymous reviewer notes that in all UK cases of court-ordered caesarean in the UK, the pregnant woman was deemed to lack capacity (at least in first instance), and moreover that the very nature of capacity is such that when a pregnant woman disagrees with medical advice that a caesarean is clinically indicated, her capacity becomes suspect.

   We grant that a relevant and important discussion can be had about whether and when patients have capacity, and how that is to be determined – as well as about the further question whether and under what assumptions, in such cases where capacity is deemed lacking, a caesarean that is deemed in the interests of the *fetus* (as per our second assumption), could legitimately be performed in the supposed best interests of the *mother* (or on some other ground). These are important, complex and interesting issues, but (and partially therefore) beyond the scope of this paper; the argument and cases we engage (see footnotes 4 & 5) do not rest on a presumed lack of capacity.

   We do wish, however, to note our disagreement with the second statement. First, women can (and do) refuse caesareans for a whole variety of reasons, only one of which is a disagreement over the medical judgment of clinical indication; second the nature of capacity is *not* such in that merely refusing to comply with or disagreeing with medical advice automatically makes ones capacity suspect – or at least it is not in patients in general. The thought that in a pregnant woman this would be any different is widespread, deeply problematic, and as such has been justly exposed and criticized. (See e.g. Villarmea, S. & Kelly, B. (2020) Barriers to establishing shared decision-making in childbirth: unveiling epistemic stereotypes about women in labour. *Journal of Evaluation in Clinical Practice,* <https://doi.org/10.1111/jep.13375>; see also “Gone are the days in which it was thought that, on becoming pregnant, a woman lost [..] her capacity” Montgomery v Lanarkshire Health Board [2015] SC 11 [2015] 1 AC 1430.) Finally, even if such disagreement would legitimately cast a suspicion, then it does not follow that the suspicion bears out. The presumption that patients, in general, have, rather than lack, capacity should apply in obstetrics as it does in any other area in medicine where patients exercise their rights.

   We thank the anonymous reviewer for pressing us on this. [↑](#footnote-ref-2)
3. We thank the editor and an anonymous reviewer of this journal for pressing us on this. [↑](#footnote-ref-3)
4. The situation is different post-mortem, where the Organ Donation (Deemed Consent) Act 2019 now allows for the removal of organs in those who have failed to make their wishes clear. (A documented refusal is still respected). This is less relevant to our argument because the questions we address about the moral obligation to undergo, and the moral permissibility of compelling, C-section are restricted to patients who have capacity and are, therefore, alive. Nonetheless one could also, and analogously to post-mortem organ donation, ask such questions about the obligation to undergo, and the moral permissibility of compelling, peri-mortem caesarean sections (where the life of the mother is not deemed salvageable, but the baby’s is). And, in such questions, one could consider both cases where her opinions are unknown, and cases where there is documented advance refusal. Here, too, the relevant comparison case would be dead or dying kidney-dad in the same circumstances. (We thank an anonymous reviewer for asking about the peri-/post-mortem case). [↑](#footnote-ref-4)
5. .*My emphasis.* We thank an anonymous reviewer for alerting us to this. [↑](#footnote-ref-5)
6. We thank an anonymous reviewer of this journal for pressing us on this. [↑](#footnote-ref-6)
7. Note that we do *not* take the view that C has less parental obligation than A (for example on the back of a genetic view of parenthood); we think that all else being equal C has as much parental obligation as A. Indeed we think the same intuitions apply if both A and C had adopted, rather than sired, children. One could also consider the (technologically farfetched) scenario where dad is asked to donate a lobe of a liver that he himself had acquired by donation. We thank an anonymous reviewer of this journal for asking us to clarify this. [↑](#footnote-ref-7)