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Forced cesareans: applying ordinary standards to an extraordinary case

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Abstract

Is it morally justifiable to force non-consenting pregnant women to submit to cesarean surgery to save their fetus in distress? Even though proponents and opponents largely agree on the interests at stake, such as the health and life of the fetus and the respect for bodily integrity and autonomy of pregnant women, they disagree on which moral weight to attach to these interests. This is why disagreements about the justifiability of forced cesareans tend to be pervasive and intractable. To sidestep this deadlock, we will focus on conditions that give rise to the 'cesarean dilemma' in the first place, namely the conflict between inherent norms and values medical professionals are committed to by virtue of being a medical professional. Using the reflective equilibrium, we will test the opponents' and proponents' considered judgments about forced cesareans against the norms and values they –as medical professionals– are committed to and determine whether they are coherent. Subsequently we will identify the proponents' incoherencies between the considered judgments and norms and values they are committed to and conclude that as long as these incoherencies are in place, forced cesareans are morally impermissible.

Introduction

A is brought into the delivery suites. She is 36 weeks pregnant and is diagnosed with an umbilical cord prolapse. Immediate cesarean section is indicated to save the fetus. Two years ago A was treated for an appendicitis. Her wound got infected and she developed a sepsis. This unfortunate ordeal left A terrified of surgery – especially abdominal surgery. Scared but coherent, she refuses to consent to the cesarean section. After an hour of persistent but fruitless pleas of the doctors, the fetus dies.

Should the doctor in the case of A have forced A to submit to cesarean surgery?⁴ Disagreements about the justifiability of forced cesareans are pervasive and intractable. Although opponents and proponents of forced cesareans agree about the interests at stake, they disagree about the moral (and legal) ‘weight’ that should be given to these interests. Proponents typically acknowledge that women have a right to bodily integrity and autonomy. They claim however, that these rights aren’t absolute and the life and health of the fetus should, in dire circumstances, outweigh the right to refuse surgery. (1, 2) Opponents on the other hand acknowledge that the fetus has interests. They claim however, that even though the rights to bodily integrity and autonomy (from here on right to autonomy) aren’t absolute, they do protect women against forced surgery.(3) As medical ethics and law stand now, no one can be forced to submit to surgery to save someone else’s life. Forcing women to submit to surgery would therefore be an unjustified demand, irreconcilable with the moral and legal standards in the medical domain. Because of these different perspectives on the justification of forced cesareans proponents and opponents are unlikely to reach consensus on an issue that, because of the possible tragic consequences for mother and child, demands it.

We will sidestep this deadlock by focusing on the conditions that give rise to the cesarean dilemma. The cesarean dilemma is precisely –a dilemma– because of the conflict of ethical principles professionals working in the medical domain are committed to. Without this commitment to principles such as ‘beneficence’ and ‘respect for autonomy’ the cesarean dilemma would in fact not arise. Therefore, we will test the coherence of the ethical principles medical professionals are committed to and the considered judgments they hold. This is the adage of Rawls’s reflective equilibrium (RE).(4) To present the ethical principles professionals are typically committed to in a systematic way, we will use the widely accepted principles of biomedical research of Beauchamp and Childress.(5)

4 In the Netherlands for example, the Dutch group ‘Actio Caesarea’, consisting of doctors and (former) judges, argues for the possibility to force women, via a court order, to submit to cesarean surgery in cases of medically indicated fetal distress (1).

The use of the RE is appealing because the justifiability of the positions at stake is judged by referring to the principles and considered judgments the opponents and proponents *themselves* are committed to. The RE is thus an instrument that can be of help as it requires the arguments of proponents and opponents to be, at the very least, coherent.

We will conclude that as long as a pregnant woman is competent to consent, proponents face a serious challenge to argue in favor of forced cesareans while at the same time remaining faithful, as professionals, to their own body of considered judgments and ethical principles.

We will start by giving an overview of the arguments typically put forward by proponents and opponents of forced cesareans. Because seemingly the respect for the pregnant woman's *rights* is seemingly in conflict with the duty to bring forth the best *consequences* for the fetus, we will, for the sake of clarity, present the arguments in terms of (i) deontological arguments in favor and against, and (ii) consequentialist arguments in favor and against forced cesareans.

Opponents

Based on most legal and moral literature on the topic, it is surprising that the justifiability of forced cesareans is a matter of controversy. With few exceptions, the literature suggests that a pregnant woman's *right* to autonomy trumps the doctor's *duty* to promote the interests of the fetus and pregnant woman.⁽⁶⁻¹¹⁾ This defense of the pregnant woman's right to refuse surgery typically takes two forms.

First is what we call the *deontological defense*. This line of defense exhibits in a number of ways the importance of respecting a competent patient's right to autonomy, that is, the right to have control over what happens to their body (e.g. in the medical setting) – whatever the consequences of this right may be⁵. One way this right is justified for instance, is by arguing that the right to autonomy is meant to protect the 'intrinsic value' or 'human dignity' of patients. This right to protection brings forth the claim to self-governance and privacy that patients have on medical professionals. This entails that in situations of medical decision-making, a (competent) patient cannot be forced to undergo treatment without her consent even if the consequences are detrimental to herself or a third party. Hence, a pregnant woman may not be 'victimized' through

5 This is not to say that there exist no consequentialist or utilitarian defenses of the right to autonomy.

surgery without consent for the sake of her own or someone else's good. This right is enshrined in the doctor's duty to obtain informed consent.⁽¹²⁾ As it is now, the respect for the patient's autonomy and the duty to obtain informed consent are of paramount importance in the medical domain. A legal example that demonstrates the importance of respect for autonomy is the ruling of the Court of Appeal in the UK in the case of *S v St George's NHS Trust*. The court made it unequivocally clear that a pregnant woman is allowed to refuse medical treatment (cesarean surgery) even if this would likely harm her own health or the health of her unborn "unless she is clearly and properly not sound of mind".⁽¹³⁾ The ethical argument underpinning this court order thus is that a pregnant woman's right to autonomy cannot be traded off in pursuance of the best possible consequences for the fetus.

The corollary of this deontological reasoning is a critique of the use of 'greedy' consequentialist reasoning. For example, in her refutation of consequentialism Rhoden writes "If decisions are made for a woman in a way that suggests that it does not matter very much *who she is*, then she has, in a very real sense, been wronged. Of course, courts in these cases do not override women's choices lightly. They are faced with extraordinarily hard decisions in which the threat to the infant must be neither denied nor minimized. But, if the way to avert this threat is to coerce the woman and violate her rights, then the court, *in pursuing the best consequences*, inevitably treats the woman merely as a means to the goal of preserving the infant's health."⁽¹⁰⁾

Second is what we may call the *consequentialist defense*. This line of defense accepts the assertion that the interests of the mother and the fetus ought to be balanced against one another. When *all* possible consequences are taken into account however, the balance would arguably not tip in favor of the use of force. Here is a list of adverse consequences.

(i) If the option to force women to submit to surgery is accepted, it invites –in addition to the use of force– the use of coercion. Consider the case of Lisa Epsteen who received an email from the chairman of an obstetrics and gynecology department in the U.S. in which he stated: "I would hate to move to the most extreme option, which is having law enforcement pick you up at your home and bring you in, but you are leaving the providers [of the hospital] no choice."⁽¹⁴⁾ The chairman was deeply concerned that Epsteen's refusal to come in for surgery would result in her fetus dying or incurring serious brain damage. His rationale for the email is understandable. However, even if forced cesareans are justified, the coercive offer to bring Epsteen in and potentially force her to undergo surgery requires additional justification.

(ii) The actual enforcement of forced cesareans may lead to humiliating situations. For example, in Chicago a Nigerian woman was hospitalized for the final months of her pregnancy and was advised to have a cesarean section. When she did not agree she was placed by force in leather wrist and ankle cuffs. She reportedly screamed for help and bit through her intravenous tubing in an attempt to get free.(15, 16)

(iii) With the possibility of forced cesareans looming, women, especially those with an obstetric history, may become less likely or even reluctant to seek needed obstetric care.(17)

(iv) The possibility of force is also detrimental to the patient-doctor relation in which it is of crucial importance that a patient feels safe.

(iv) Concerns have also been expressed about the lack of due process for women who would be forced to undergo cesarean surgery. In these cases there is typically an "absence of notice, an absence of adequate legal representation for the pregnant woman and no explicit standard of proof to judge the necessity of a cesarean."(18)

We haven't presented an exhaustive list of adverse consequences of forced cesareans. But these examples should suffice to show that even if a consequentialist line of reasoning is accepted, it remains questionable whether the overall benefits of the use of force do outweigh the burdens for (pregnant) women. We will now present the arguments put forward by the proponents of forced cesareans.

Proponents

Compelling as they may be, the arguments put forward can be disconnected from the 'sense of urgency' felt by doctors who face this dilemma. Research conducted by Samuels et al. found that 51% of the questioned 229 obstetricians and 126 health lawyers were highly likely to support the use of a court ordered cesarean section to protect and promote the health of the fetus.(19) These doctors and lawyers (seem to) hold the view that saving the fetus in distress is a good reason to bypass informed consent. When a child may suffer life-long misery or even die because a mother refuses surgery, feelings of helplessness and despair do arise. With these stakes it is no wonder that some doctors will do all they can to save the fetus, if not by persuasion then by force. Again, we may divide the arguments into a deontological and a consequentialist defense.

First, *the consequentialist defense* is straightforward. Severe harm or death may be prevented at the cost of what is considered to be intrusive but relatively safe and routine

surgery. Therefore, in cases of a medically indicated cesarean, the use of force is justified.

Second, is the *deontological defense*. Once a human life begins it matters how that life goes. This creates a conditional duty⁶ to act in such a way that the interests of the (un)born are promoted. Pregnant women have this duty towards their (un)born. This duty includes making some acceptable sacrifices, such as consenting to cesarean surgery, if that would save the life of her (un)born. Chervenak et al. present a similar argument. (1, 20). They argue that if (i) cesarean surgery is medically indicated and the indication is based on (ii) well-founded obstetrical judgment, which should be (iii) replicable by a well-informed competent clinician, a doctor should not be guided only by a mother's refusal but also by his own duty of beneficence. Respecting the refusal of a mother to undergo a medically indicated surgery would be, according to Chervenak et al., "a form of indefensible imprudence."⁽¹⁾

In short, the justification of forced cesarean sections builds on the beneficence based maternal and professional conditional duties that follow from maternal duty, prudence and well-founded medical judgment. In sum, both opponents and proponents of forced cesareans present reasonable arguments that support their position. The result is a moral deadlock. We will now introduce the RE and explain why and how this method can help to establish whether forced cesareans are justifiable.

The RE

In short, the RE is a method that allows us to align, as well as possible, our most confident moral judgments or intuitions (considered judgments), with the ethical principles we are committed to.⁽²¹⁾ This method does not treat considered judgments as unassailable truths nor ethical principles as self-evident axioms. Rather it takes considered judgments as starting points. In order to affirm these considered judgments, they must be coherent with other considered judgments and ethical principles one is committed to. When coherence is achieved, the RE has been reached and there are good reasons to be confident about the soundness of the judgment at hand.

The RE works 'up and down'. Ethical principles are specified in terms of considered judgments. For example, the principle of 'respect for autonomy' is specified as the considered judgment that *it is wrong to perform surgery on A against her will*. Considered

⁶ A duty resulting from certain relations we have with one another

judgments on the other hand are subsumed under ethical principles. For example, the considered judgment that doctor should save the baby is subsumed under the principle of beneficence. The more one is successful to specify and subsume, the more reason one has to be confident about the judgment at hand.

We emphasize the importance of taking the viewpoint of the professional as they are committed to professional norms and values. Surely a doctor strives to promote the health and well-being of his patients while treating them with due respect –and if he doesn't, he should! We are therefore aiming to find a *narrow* reflective equilibrium in which we take the professional norms and values, which we base on the biomedical principles of Beauchamp and Childress, to be (at least for now) unproblematic. We do so because, the cesarean dilemma does, *prima facie*, not challenge the whole body of norms and values of the medical domain. Quite the contrary, the cesarean dilemma appears precisely as a dilemma because two cornerstone principles, which are -the duty of beneficence- and -the duty to respect autonomy-, are in conflict. If, say, the duty to respect autonomy wasn't a cornerstone principle, the cesarean dilemma would arguably not arise. The benevolent paternalistic doctor would simply decide what is best for the mother and her fetus. We will now assess the coherence of the considered judgments and ethical principles pertaining to the cesarean dilemma.

The equilibrium at work: the case of A revisited

We begin by formulating a hypothetical equilibrium (HE) which after scrutiny will or will not pass the test of the reflective equilibrium. (HE) *Doctors should have the possibility to force a competent pregnant woman to submit to surgery if according to the best of their professional judgment this would save the life or greatly benefit the health of the fetus without exposing the woman to disproportionate risks.*

Textbox 1

A is brought into the delivery suites. She is 36 weeks pregnant and is diagnosed with an umbilical cord prolapse. Immediate cesarean section is indicated to save the fetus. Two years ago A was treated for an appendicitis. The wound resulting from the appendectomy got infected and she developed a sepsis. This unfortunate ordeal left A terrified of surgery –especially abdominal surgery. Scared but coherent, she refuses to consent to the indicated cesarean section. After an hour of persistent but fruitless pleas of the doctors, the fetus dies.

Let's go back to the situation in which A (textbox 1) is brought into the delivery suites and she adamantly refuses the indicated cesarean.

We start with considered judgment (CJ1) (table 1) *the doctor should force A to submit to surgery*. For (CJ1) to be accepted it should be in equilibrium with other considered judgments as well as the medical ethical principles.

We add (CJ2) *Given that X is a doctor he should try to save the life of the fetus in distress*. As a doctor it is reasonable to hold these two considered judgments because a doctor wants to do good; (P1) *the principle of beneficence*. In RE terms: (P1) is specified by (CJ1,2) and (CJ1,2) are subsumed under (P1).

For a doctor who holds (CJ1,2) to act *fair* (P2) he should force all women in A-like circumstances to submit to surgery because the doctor should treat all equal medical cases equally. Whether that is the case depends of course on what qualifies as an A-like case. A-like cases can be thought to comprise all cases in which competent women refuse a medically indicated cesarean.

Table 1

Hypothetical Equilibrium
(HE) Doctors should have the possibility to force a competent pregnant woman to submit to surgery if according to the best of their professional judgment this would save the life or greatly benefit the health of the fetus without exposing the woman to disproportionate risk
Considered judgments
(CJ1) the doctor should force A to submit to surgery.
(CJ2) Given that X is a doctor he should try to save the life of the A's fetus in distress
(CJ3) forcing A to submit to surgery is justified because the benefit for the fetus outweighs the harm to A.
(CJ4) Forcing A to submit to surgery to benefit the fetus is justified if persuasion fails
(CJ5) Because A's refusal is based on fear, it isn't a reflection of what she really wants; without fear she would consent
Principles based on the principles of biomedical research by Beauchamp and Childress
(P1) the principle of beneficence
(P2) the principle of fairness
(P3) the principle of proportionality
(P4) the principle of subsidiarity
(P5) the principle of respect for autonomy

A-like cases can however also be thought to comprise all cases in which one person has a conditional duty towards another person, like mother and fetus but also father and son, and the prior is in a unique position to save the latter by way of surgery. Consider for example the case in which a father could save his son by donating his kidney which

would come at a risk comparable to a mother having cesarean surgery to save the life of her fetus. If a mother is forced to save the life of her fetus but a father is not forced to save the life of his son, then equal cases are *not* treated equally.⁷ (CJ1,2) are not coherent with (P2).

The scenario in which a father is in the unique position to save his son but chooses not to do so has, as far as we know, not been recorded. The case that comes closest to this scenario is the case of *McFall v Shimp*.^(22, 23) McFall was dying and Shimp, his cousin, was the only person known to have compatible bone marrow. Shimp refused to donate, so McFall attempted to force Shimp to comply on the grounds that his life depended upon the transplantation. The court decided that Shimp could not be compelled to donate. McFall died⁸.

From a moral viewpoint, what matters is that moral fiduciaries can be in a unique position to save those under their moral protection. This can be a mother saving her fetus but also a father saving his son (and why stop there and not include McFall?). To single out women as the only targets of force is, from a moral viewpoint, arbitrary. Therefore, we argue that A-like cases should be expanded to all moral fiduciaries who are in the unique position to save those under their protection at a reasonable cost, such as submitting to relatively safe surgery. Consequently, we should either permit force in *all* or in *no* A-like cases. In RE terms: (CJ1,2) are not coherent with (P2) if we only use force against pregnant women.

We will now scrutinize the principle of beneficence (P1). It is understandable that doctors want to use force to save the fetus (CJ1,2) as they have a duty of beneficence (P1). But what is understandable is not necessary justifiable. Especially in the medical domain, the demands of beneficence is not without limits. The case of Angela Carder is a clear example of the danger of the ‘overdemandingness’ of beneficence.

Carder, who was pregnant, was a bone cancer patient. She became critically ill and the condition of the fetus seemed to deteriorate to such an extent that Angela’s family was asked for permission to perform a caesarean section.⁽²⁴⁾ Because the caesarean might further shorten Carder’s life and it would lead to more discomfort in her already precarious situation the family, in accordance with Carder’s own desire, decided against

7 *In this paper we only discuss to the justifiability of forced cesareans. We are however, aware that there is a broad discussion about the justifiability of liberty-restricting measures in cases where maternal behavior may possibly harm children(-to-be).*

8 *It is worth noting that in common law there is a distinction between parents and all others in regard to a duty to rescue.*

surgery. The hospital attorney however felt that the interests of the fetus deserved more consideration. “Balancing Angela Carder’s life expectancy as a cancer-ridden patient against that of the fetus, the court ordered the cesarean.”(25) the surgery was performed, sadly followed in short order by the child’s death and that of its mother.(26) Three years later an appellate court overturned the lower court ruling in order to prevent a precedent.(24) The ruling stated clearly that considerations such as a mother’s prognosis and likelihood of success should not make a difference when protecting a woman’s right to be the decision maker.

To prevent such dramatic situations, the demands of beneficence are regulated by (P3) *proportionality* and (P4) *subsidiarity*. The burdens of cesarean surgery have to be acceptable relative to the benefits for the fetus (P3) and the benefits for the fetus must be achieved using the least intrusive methods (P4). (P3,4) are the ‘checks and balances’ for (P1).

Going back to the case of A we can now add two more considered judgments: (CJ3) *forcing A to submit to surgery is justified because the benefit for the fetus outweighs the harm to A.* (CJ4) *Forcing A to submit to surgery to benefit the fetus is justified if persuasion fails.* We’d like to mention that to our mind persuasion as mentioned in (CJ4) is morally permissible and for the sake of the fetus it is even required. Let us now scrutinize (CJ3,4).

How coherent are (CJ3,4) with (P3,4)? Do the demands of proportionality and subsidiarity allow for the use of force when the use of force brings about benefits for the fetus that outweigh the burdens for the mother? To be clear we are not aiming at finding the conditions in which the benefits for the fetus outweigh the burdens for the mother. Even if it is possible to identify such conditions, *by themselves* these conditions do not justify the use of force as such. For the sake of argument, we will assume that the exchange of benefits and burdens is reasonable and ask whether this is sufficient to justify force.

The use of force in the medical domain is rare. Its use for the benefit of others even rarer. This is not because the options to help each other are limited. Individuals may undergo surgery, donate organs, donate blood or participate in medical research; all for the sake of others. The use of force is limited because it, *prima facie*, violates (P5) *the principle of respect for a patient’s autonomy*. Yet, one example of the justified use of force for the benefit of others is the use of force when quarantining contagious individuals to prevent serious communal harm.(27) In dire circumstances, quarantine can be the only available measures to stop an outbreak of diseases such as SARS and Ebola. The restriction of movement during the estimated period of communicability is therefore

thought to be a proportionate and subsidiary use of force (P3,4). Let us now compare the risks and burdens pertaining to quarantines and forced cesareans. To be sure we are aware that the (possible) voluntariness of pregnancy and involuntariness of having a contagious disease limit the comparison. However, we may still discuss, in a meaningful way, the burdens and benefits of both interventions.

Without doing injustice to the considerable praiseworthiness of rescuing the potentially lost life of a viable fetus, the prevention of an epidemic (including the potential death of a great many viable fetuses) counts as a 'greater' benefit'. More lives can be saved. The burdens on the other hand are arguably bigger for those who are forced to *submit to surgery* than those whose *movement is restricted* by force. Consider that "in response to concerns about informed consent, HHS/CDC has added regulatory language requiring that the Director advise the individual that if a medical examination is required as part of a Federal order that the examination will be conducted by an authorized and licensed health worker *with prior informed consent*. [emphasis added]"(27) The HHS/CDC rightfully assumes that medical examination without informed consent is a greater intrusion on one's rights than the restriction of movement. In sum, the benefits of quarantine are bigger and the burdens are smaller. Therefore, as we do not force medical examination to save many people from an epidemic, *a fortiori* we shouldn't force surgery on a pregnant woman to save the life of a fetus.

Whether (CJ4) is subsidiary (P4) is more open to debate. One may claim that professionals cannot rely on persuasion as the least intrusive option. A pregnant woman can still refuse. On the other hand, in the overwhelming majority of cases information and persuasion are sufficient to convince women to undergo cesarean surgery. We will now address (P5) *respect for autonomy*.

Is respect for autonomy (P5) reconcilable with the use force in the medical domain? Obviously not; except for two situations. First, when medical disaster can be prevented as we have described in the quarantine case. The use of force is, however, even in that extraordinary situation limited to the restriction of movement. Second, it is permitted when a patient (temporarily) lacks the capacity to make a medical decision. In such a case, medical treatment can be enforced for the good of that patient. A legal example that demonstrates the importance of the capacity to make a decision about cesarean surgery is the case of Ms. A. Pacchieri an Italian 35 year old woman who traveled to the UK.(28) Pacchieri who suffered from bipolar disorder had a panic attack and was subsequently detained. At 39 weeks of gestation an application was made to the Court of Protection to perform a cesarean section as this was thought to be in the best interest of Pacchieri. The judge made a declaration that Pacchieri lacked capacity in relation

to this decision and that it was in her best interests for her baby to be delivered by caesarean section, with the use of reasonable restraint in order to achieve that operation safely and successfully.(29)

Given the importance of capacity we add (CJ5) *Because A's refusal is based on fear, it isn't a reflection of what she really wants; without fear she would consent.* If (CJ5) is true, then (P5) offers insufficient reason to not force A to submit to surgery. A is scared and will regret her refusal and thus there is reason to force her to submit to surgery.

If (CJ5) is not true and A's refusal is a reflection of what she really wants, then there is good reason to adhere to (P5) and not allow force. And herein lies the problem. In acute situations such as a cesarean dilemma, it is particularly hard to establish a pregnant woman's decision-making capacity.(30) Moreover, decision-making capacity comes in varying degrees. The additional *normative* question is; which level of decision-making capacity (scalar) is sufficient to establish competence (binary)? (31)

A's decision is obviously affected by her fear for abdominal surgery. Yet fear alone should, in our view, never be the threshold for incompetence. Emotions such as fear, anxiety, anger and despair are part and parcel of the medical domain. Such a threshold would render many patients who are capable of balancing emotion with reason, incompetent. However, it isn't easy to imagine situations in which the refusal of a medically indicated cesarean surgery is based on understandable and appreciable reasons. And these reasons for refusal are important to deflect the sentiment that in the medical domain, we allow for actual life to capitulate to abstract principle. It is at this point, that the 'art of establishing decision-making capacity' plays a crucial role and that our case study of A reaches its limits. We can, of course, construct A's case in such a way that she turns out to be competent –or not. But that does not help to establish the justifiability of forced cesareans.

Conclusion

From here, we turn back to the RE and draw two conclusions. First, we have shown that coherence is lacking between considered judgments (CJ1-5) and principles (P1-5). This suggests that the HE does not pass the test of the RE and should therefore be rejected.

Second, although we reject the HE this is not based on a blind adherence to the principle of respect of autonomy (P5). To understand the adherence to a patient's wish when anxiety and fear may have marred her decision-making capacity as 'respect'

for autonomy is, in our view, questionable and such adherence can, especially in a litigious culture, be a ‘moral bailout’. The overwhelming majority of cases show that refusal is an atypical response when cesarean surgery is required to save the fetus. This understandably raises questions about the woman’s decision-making capacity. In this dilemma, nothing would be more regrettable than not changing the mind of a mind open to change. Still, the moral norms and standards of the medical domain, in which the use of force to benefit others is close to unthinkable, should also apply to pregnant women and their doctors. The fact that this is an extraordinary dilemma offers on its own no reason to judge it according to extraordinary moral standards.

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