

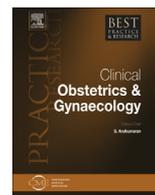


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### Ethical issues in cesarean delivery



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Cesarean delivery is the most common and important surgical intervention in obstetric practice. Ethics provides essential guidance to obstetricians for offering, recommending, recommending against, and performing cesarean delivery. This chapter provides an ethical framework based on the professional responsibility model of obstetric ethics. This framework is then used to address two especially ethically challenging clinical topics in cesarean delivery: patient-choice cesarean delivery and trial of labor after cesarean delivery. This chapter emphasizes a preventive ethics approach, designed to prevent ethical conflict in clinical practice. To achieve this goal, a preventive ethics approach uses the informed consent process to offer cesarean delivery as a medically reasonable alternative to vaginal delivery, to recommend cesarean delivery, and to recommend against cesarean delivery. The limited role of shared decision making is also described. The professional responsibility model of obstetric ethics guides this multi-faceted preventive ethics approach.

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#### Introduction

Ethics provides essential guidance to obstetricians for offering, recommending, recommending against, and performing cesarean delivery, which is the most common and important intervention in obstetric practice. Drawing on our previous work, we present the professional responsibility model of obstetric ethics [1,2]. We will deploy this model to address two especially ethically challenging clinical topics in cesarean delivery: patient-choice cesarean delivery [3,4] and trial of labor after cesarean delivery [5].

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A distinctive of this chapter will be its emphasis on a preventive ethics approach [2,6]. Preventive ethics, a concept pioneered by the authors [7], is designed to prevent ethical conflict in clinical practice. To achieve this goal, a preventive ethics approach uses the informed consent process to offer cesarean delivery as a medically reasonable alternative to vaginal delivery, to recommend cesarean delivery when it is justified to do so, to recommend against cesarean delivery when it is justified to do so, and to engage in shared decision making when it is justified to do so [8]. The professional responsibility model of obstetric ethics guides this multi-faceted preventive ethics approach.

### **Professional responsibility model of obstetric ethics**

In our chapter on “Ethical Dimensions of the Fetus as a Patient,” we have defined ethics and medical ethics, the ethical principles of beneficence and respect for autonomy, and the ethical concept of the fetus as a patient. The professional responsibility model of obstetric ethics incorporates these concepts and principles [1,2]. This model provides an antidote to the rights-based reductionism that characterizes much of the literature on perinatal ethics [1,2,8]. This oversimplification in the context of cesarean delivery occurs when the only or overriding ethical consideration is the unlimited rights of the pregnant woman [1,2,8]. This is woman’s-rights-based reductionism in obstetric ethics, which the professional responsibility model rejects [1,2,8].

We do not deny that appeal to the pregnant woman’s unlimited rights has an initial appeal, largely because of its simplicity: a pregnant woman has the unconditional right to control what happens to her body. This initial simplicity, however, does not withstand close scrutiny. Asserting the pregnant woman’s unlimited rights is not just simple but simplistic, because it ignores professional integrity, which can set justified limits on the preferences of pregnant women [1,2,8]. For example, a distraught woman who is thirty-four weeks pregnant reports that her husband has deserted her and insists on induced abortion immediately. The professional responsibility model creates an ethical obligation of her obstetrician not to implement her request because feticide is ruled out by the obstetrician’s beneficence-based obligation to protect the life of this fetal patient. The obstetrician should therefore recommend against feticide and explain that no conscientious obstetrician should implement her request. There are many such circumstances in which a pregnant woman’s request for an induced abortion should not be implemented unquestioningly.

The woman’s-rights-based reductionism approach has been advocated in the obstetric ethics literature. This approach asserts an unconditional right of the pregnant woman to control her body in all aspects of the management of pregnancy, including the performance of cesarean delivery: “... the moral and legal primacy of the competent, informed pregnant woman in decision making is overwhelming” [9]. Another expression of this approach seems to be non-reductionist, but only at first. Its authors state that patient safety as a “first-order issue” [10] and support what they call “restrictive guidelines” based on protecting the life and health of pregnant women [10]. This seemingly more nuanced approach, however, is then abandoned in favor of the woman’s-rights-based reductionist model when the authors go on to assert: “Crucially, even when restrictive guidelines are warranted the rights of pregnant women to bodily integrity must be maintained” [10]. Some express this approach explicitly, e.g., that “women have fully endowed rights that do not diminish with conception, nor progressively degrade as pregnancy advances to viability and birth” [11]. The woman’s-rights reductionism approach has been used to claim the right of pregnant women to have a clinically non-indicated cesarean delivery [12,13]. Another example is the assertion of the pregnant woman’s autonomy as an “unrestricted negative right,” i.e., an unconditional right to non-interference with refusal of cesarean delivery: “autonomy is an inter-relational right – ultimately there is no circumstance in which someone should be brought to an operating room against their will” [14].

Womens-rights-based reductionism in obstetric ethics undermines the professional nature of the relationship of an obstetrician to his or her patients [8]. The professional obligations of the obstetrician originate in the ethical concept of medicine as a profession. This concept was introduced into the history of medicine by Drs. John Gregory (1724–1773) of Scotland and Thomas Percival (1740–1804) of England. This concept is based on three commitments of physicians: (1) becoming and remaining scientifically and clinically competent; (2) protecting and promoting the health-related and other interests of the patient as the physician’s primary concern and motivation; and (3) preserving and strengthening

medicine as what Percival called a “public trust,” a social institution that exists primarily for the benefit of society not its members (in contrast to the concept of medicine as a merchant guild) [15].

In the professional responsibility model obstetricians have beneficence-based an autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient [1,2,6,16]. Beneficence-based obligations are a direct function of evidence-based clinical judgment about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms for patients. The pregnant woman's autonomy is empowered by offering or recommending medically reasonable alternatives, i.e., clinical management that is technically possible and supported in beneficence-based clinical judgment. That a form of clinical management is technically possible does not, by itself, make that form of clinical management medically reasonable. As a beneficence-based concept, medical reasonableness is not based on the preferences of the pregnant woman, especially when they are poorly informed or uninformed.

The contrast of the professional responsibility model with women's rights-based reductionism is stark. Women's rights-based reductionism is a failure, because it requires the obstetrician without question or objection to implement birth plans that unconditionally exclude cesarean delivery or the unconditional right to planned home birth. Women's rights-based reductionism eliminates the obstetrician's beneficence-based obligations to the pregnant patient and therefore reduces the obstetrician to a mere technician or even automaton. This reductionist approach also has absurd implications, e.g., ruling out, as potential paternalism, strongly and repeatedly recommending that pregnant women who abuse tobacco and alcohol seek help and be supported in doing so. Respect for the pregnant woman's rights allows simply accepting such clinically choices by patients because they have made autonomous choices. Once such choices have been made, that they are clinically unnecessarily risky is of no concern on the reductionist approach. This is abandonment from the perspective of professional responsibility for patients. Women's rights-based reductionism, despite its initial simplicity and powerful appeal for many, is unacceptable because it leads obstetric ethics to conceptual and clinical failure. This reductionism therefore should be abandoned in obstetric ethics and practice.

### **Shared decision making**

The professional responsibility model supports an important, but limited role for shared decision making [8]. The limitation derives from the recognition that sometimes there is only one medically reasonable alternative, which should be strongly recommended [2]. When there are two or more medically reasonable alternatives, any one of them can be implemented consistent with professional integrity. In such clinical circumstances the pregnant woman's informed decision process justifiably takes center stage, resulting in shared decision making properly understood.

Shared decision-making can help to prevent dehumanizing paternalism. A particular plan of action should not be mandated unless it can be justified by its benefits or even potential benefits on the basis of the best available evidence. Obstetricians must engage in conversation with the patient, in order not to neglect an important implication of patient autonomy: when there is real uncertainty about clinical benefits and risks of reasonable alternatives, competent adult patients should be given the opportunity to make their own decisions about how to manage such uncertainty.

In cases with the highest levels of evidence, such as well-documented, intrapartum complete placenta previa, cesarean delivery can be recommended with confidence. However, when levels of uncertainty are high, as in using mid-forceps or allowing a prolonged second stage of labor, the pregnant woman's preferences should be given prominence in the decision-making process. The obstetrician is obligated to take the time to provide her with information and advice, elicit her values, explore her concerns and emotional and social needs and work with her to make a thoughtful decision.

### **Clinical decision making about cesarean delivery**

#### *Patient-choice cesarean delivery*

Patient-choice cesarean delivery (also known as maternal-choice cesarean delivery) has become controversial throughout the world. In the United States, for example, the American College of

Obstetrics and Gynecologists (ACOG) stated that, while the right of patients to refuse unwanted surgery is well accepted, less clear is the right of patients to have a surgical procedure when scientific evidence supporting it is incomplete, of poor quality, or totally lacking [17]. The Committee concluded that the evidence to support the benefit of non-indicated cesarean delivery is still incomplete and that there is not yet extensive morbidity and mortality data to compare cesarean delivery with planned vaginal delivery. Subsequently, the United States National Institutes of Health (NIH) convened a conference that concluded that there is insufficient evidence to evaluate fully the benefits and risks of primary cesarean delivery as compared to vaginal delivery, and that more research is needed [18]. This NIH conference concluded: “The magnitude of cesarean delivery on maternal request is difficult to quantify. There is insufficient evidence to evaluate fully the benefits and risks of cesarean delivery on maternal request compared with planned vaginal delivery. Any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with ethical principles” [18].

In a United Kingdom the National Institute for Health and Clinical Excellence (NICE) report notes the increasing rates of “maternal request for cesarean delivery” and that a common reason for such requests is the pregnant woman’s concern for the safety of her baby [19]. This report also notes that obstetricians implement as much as half of such requests that they receive. This report provides guidance for obstetricians in response to maternal request for cesarean delivery: “When a woman requests a CS the first response should be to determine the reason for the request and the factors that are contributing to the request. This can then be followed by the provision of information that compares the risks and benefits of planned CS and vaginal birth” [19]. The report makes the following recommendation: “For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS.” Obstetricians unwilling to perform cesarean delivery on maternal request “should refer the woman to an obstetrician who will perform CS” [19].

These US statements and the UK report emphasize clinical benefits and risks and the communication of these in the informed consent process. This is to hold implicitly that ethics is an essential component of patient-choice cesarean delivery [20]. Ethical reasoning should be explicit. We therefore now provide an ethically justified, practical guidance for obstetricians in response to the patient-choice cesarean delivery based on the professional responsibility model of obstetric ethics.

*Beneficence-Based Considerations.* Cesarean delivery has become safer over time with the improvement of surgical techniques, anesthetic options, antimicrobial availability, and blood banking techniques. Comprehensive beneficence-based clinical judgment requires that the alleged benefits of cesarean delivery be balanced against the benefits of planned vaginal delivery and the risks of cesarean delivery.

Currently, beneficence-based clinical judgment favors vaginal delivery [21]. Hence, counseling should be directive, as opposed to non-directive counseling, clearly recommending vaginal delivery where appropriate [4], which significantly limits the role for shared decision making. We therefore disagree with the NICE report’s purely non-directive approach [19]. The NICE report implicitly supports shared decision making as the universal approach to patient-choice cesarean delivery.

*Autonomy-Based Considerations.* Respect for autonomy remains the only possible rationale for promotion of non-indicated cesarean delivery. Respect for autonomy surely is a core ethical obligation and has a prominent place in the professional responsibility model. Only in women’s-rights-based reductionism does respect for autonomy create an absolute obligation, i.e., an obligation that admits of no exceptions. The professional responsibility model rejects this account, as explained above. Autonomy-based obligations are the beginning but not the end of the decision-making process, because autonomy-based obligations must be balanced against beneficence-based obligations to the pregnant and fetal patients. A physician therefore should not conclude that every request for a cesarean delivery should be implemented routinely.

Respect for autonomy is implemented by adherence to the informed consent process. In this process the obstetrician should exercise professional, beneficence-based clinical judgment when making clinical recommendations and present the medically reasonable alternatives as well as the alternative of nonintervention. The patient can then exercise her rights to accept or refuse intervention. Respect for autonomy does not warrant routinely offering of cesarean delivery as medically reasonable, because doing so is not supported in beneficence-based clinical judgment.

*Benevolence and Autonomy Considered Together.* Considering benevolence-based and autonomy-based obligations together, there is no ethical obligation to offer non-indicated cesarean delivery in an appropriate informed consent process. The impact of offering cesarean delivery to all patients does not promote their health-related interests. Obstetricians must rigorously adhere to the requirements of professional integrity, to prevent potential bias from influencing the physician's discussion with the patient introduced by economic gain or other forms of self-interest. The NICE report's indications for offering planned cesarean delivery do not include routine offering of cesarean delivery and therefore reflect this ethical position.

It is important not to misinterpret the ethical principle of respect for patient autonomy. The physician's medical expertise and authority should not be marshaled to convince a patient to choose cesarean delivery. Respect for patients' autonomy should not be used as an excuse to persuade more women to undergo cesarean delivery for reasons such as the physician's convenience or desire to reduce professional liability. When patients request cesarean delivery, obstetricians—in their capacity as patients' advocates—must guide patients through the labyrinth of medical information toward a decision that respects both the patient's autonomy and the physician's obligation to optimize maternal-fetal health. Providing evidence-based information about the clinical benefits and risks of non-indicated cesarean delivery, as called for in the NICE report, meets this important autonomy-enhancing goal.

*Responding to Requests for Cesarean Delivery.* Although the risk-benefit paradigm for cesarean delivery has evolved, vaginal delivery as a rule is still considered the safest mode of delivery as the short- and long-term safety issues of cesarean delivery need further study before the professional standard is changed. However, physicians do need to respond to requests for counseling regarding cesarean delivery by recommending against non-indicated cesarean delivery. Current evidence supports a physician's decision, which should be rare, to accede to a patient's request for such a delivery but only after a thorough informed consent process and vigorous attempts to persuade her to accept vaginal delivery [2,6,7,21]. We emphasize that spontaneous and uninformed requests for non-indicated cesarean delivery do not count as such well-informed and carefully requests.

Obstetricians are not obligated to perform cesarean deliveries if they morally disagree, as the NICE report emphasizes [19]. In this case, the physician should arrange for a second-opinion or arrange for the woman's care to be transferred to a physician willing to respect her request.

The research challenge for the medical profession is to study and define groups of women at high risk who may benefit from planned cesarean delivery. Once identified, such women can then be offered cesarean delivery consistent with benevolence-based clinical judgment about what is medically reasonable. Simplistic, "all-or-none" thinking on the part of obstetrician is clinically and ethically not justified, and a more nuanced approach is more appropriate for managing patients with regard to cesarean delivery [22,23]. In addition, the role of patient-choice cesarean delivery during the intrapartum period needs further exploration as well. We have previously shown that 1 in 8 intrapartum cesarean deliveries at our institution had an element of patient or physician choice [22]. Further research is needed about the experience in other settings.

### *Trial of labor after cesarean delivery*

Both a United States National Institutes of Health (NIH) Consensus Panel [24] and American College of Obstetricians and Gynecologists (ACOG) [25] issued updated statements on vaginal birth after cesarean delivery (VBAC). In the United Kingdom, the NICE report provides a thorough review of the clinical benefits and risks to both pregnant and fetal patients and calls for an evidence-based approach to the informed consent process [19]. There is general agreement that there should be a thorough, evidence-based informed consent process in which pregnant women with a prior cesarean delivery be counseled concerning VBAC. Here we provide an ethically justified, practical approach to the informed consent process for trial of labor after cesarean delivery (TOLAC).

*Offering and Recommending TOLAC in the Informed Consent Process.* When both repeat cesarean and TOLAC are supported in evidence-based, benevolence-based clinical judgment, both are medically reasonable and therefore both should be offered in clinical settings where TOLAC can be performed safely. The NIH Consensus Panel [24] and ACOG [25] statements are in consensus that TOLAC after a previous single low transverse uterine incision is medically reasonable and should be offered when there has been

one previous low transverse incision. In the professional responsibility model of obstetric ethics, the evidence supports the beneficence-based clinical judgment that the clinical risks of TOLAC to both pregnant and fetal patients are acceptable when there has been one previous low transverse incision. Planned repeat cesarean delivery also has acceptable risks to both pregnant and fetal patients. Both therefore should be offered in the informed consent process to the pregnant woman with one previous low transverse incision, because both are medically reasonable in this clinical circumstance. Counseling about these alternatives should be non-directive in a shared decision-making process.

Sometimes planned repeat cesarean delivery is substantively supported and TOLAC is not supported in beneficence-based clinical judgment. When the pregnant woman has had a previous classical incision on her uterus, planned cesarean delivery is clearly preferable to TOLAC. Planned cesarean delivery prevents the fetal and maternal risk of a ruptured classical incision in the uterus and vaginal delivery would result in a substantial increase in morbidity and mortality for both the pregnant and fetal patients and would therefore not be supported in beneficence-based clinical judgment. It follows that in beneficence-based clinical judgment only planned cesarean delivery should be offered and recommended to pregnant women with a previous classical incision. It also follows that the obstetrician has a beneficence-based obligation in the informed consent process to recommend against TOLAC in such cases. Counseling should be directive and shared decision making is not appropriate [8].

Controversy exists about TOLAC after two low transverse incisions. The ACOG statement, on the basis of Level B evidence, states: "Women with two previous low transverse incisions may be considered candidates for TOLAC" [25]. The NIH Consensus Panel was silent on this topic [24]. Level B evidence is inherently controversial in beneficence-based clinical judgment. As a result, obstetricians should responsibly manage competing evidence-based, beneficence clinical judgment about the safety for pregnant and fetal patients of TOLAC when the pregnant woman has had two previous low transverse incisions. In the informed consent process responsible management is achieved by offering TOLAC but only when the obstetrician explains the uncertainties of the current state of the evidence in this clinical circumstance and engages the pregnant woman in deliberative shared decision-making process.

The professional responsibility model of obstetric ethics provides the basis for an ethically justified, practical approach to offering and recommending TOLAC in the informed consent process with pregnant women with a prior cesarean delivery. For women with one previous low transverse incision, both TOLAC and planned repeat cesarean delivery should be offered only in clinical settings properly equipped and staffed to do so. Obstetricians should recommend against TOLAC when the pregnant woman has had a previous classical incision. TOLAC after two previous low transverse incisions may be offered provided that the informed consent process presents the uncertainties of the evidence.

## Conclusion

The professional responsibility of obstetric ethics is based on the pioneering medical ethics of two major figures in its history, Drs. John Gregory and Thomas Percival. The ethical concept of medicine as a profession introduced into the history of medical ethics in the eighteenth century by these two remarkable physician-ethicists has proven to be both durable and clinically applicable today. The professional responsibility model of obstetric ethics protects clinical judgment and practice from the simplistic, clinically inadequate womens-rights-based reductionism. The professional responsibility model does so by requiring in all cases deliberative consideration of beneficence-based and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient. The informed consent process should be used as a preventive ethics tool to empower pregnant women to make informed and deliberative decisions with shared decision making employed when appropriate. The informed consent process should guide obstetricians in their response to requests for cesarean delivery and in trial of labor after cesarean delivery.

## Conflicts of interest

Frank A. Chervenak and Dr. Laurence B. Cullough have no conflicts of interest.

### Practice points

- Obstetric ethics should not be based on woman's-based-reductionism.
- Obstetric ethics should be based on the professional responsibility model.
- Physicians should respond to requests for counseling regarding cesarean delivery by recommending against non-indicated cesarean delivery. It is ethically permissible, but should be rare, to accede to a patient's request for such a delivery but only after a thorough informed consent process and vigorous attempts to persuade her to accept vaginal delivery.
- For women with one previous low transverse incision, both trial of labor after cesarean delivery (TOLAC) and planned repeat cesarean delivery should be offered only in clinical settings properly equipped and staffed to do so. Obstetricians should recommend against TOLAC when the pregnant woman has had a previous classical incision. TOLAC after two previous low transverse incisions may be offered provided that the informed consent process presents the uncertainties of the evidence.

### Research agenda

- Description of the incidence of and women's reasons for requests for non-indicated cesarean delivery in diverse populations and settings.
- Identification of high-risk groups in which the pregnant or fetal patient would be benefited by cesarean delivery.
- Identification of risks for pregnant or fetal patients of trial of labor after two or more low transverse cesarean deliveries.

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