ultrasonography in the assessment of different aspects of fetal growth in both the second and third trimesters.

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REFERENCES

1. Baker PN, Johnson IR, Gowland PA, Freeman A, Adams V, Mansfield P. Estimation of fetal lung volume using echoplanar magnetic resonance imaging. Obstet Gynecol 1994; 83:951-4.
2. Campbell S, Wilkin D. Ultrasonic measurement of fetal abdominal circumference in estimation of fetal weight. Br J Obstet Gynaecol 1975;82:689.
3. Johnson IR, Stehling MK, Blamire AM, et al. Study of internal structure of the human fetus in utero by echoplanar magnetic resonance imaging. Am J Obstet Gynecol 1990;163: 601-7.
4. Duncan K, Baker PN, Johnson IR, Gowland PA. Treat patients with kindness during magnetic resonance imaging. BMJ 1996;312:1421.

6/8/82735

Reply

To the Editors: We appreciate your interest on our study of fetal lung volume estimation by three-dimensional ultrasonography. The question on performance of three-dimensional ultrasonography in cases of low contrast (e.g., oligohydramnios) is of significance for this technique. The technical equipment has developed fast, and imaging quality is even sufficient in cases with oligohydramnios. This allows application of this technique also in cases with low contrast. We already are using three-dimensional lung volume estimation in selected abnormal cases in prenatal diagnosis. Although many of these cases had oligohydramnios, we could easily estimate fetal lung volume in most cases. The results of this measurements have correlated with the clinical outcome. We need far more cases to give qualified answers to the question of clinical usefulness.

We pointed out that long acquisition times limit the application of magnetic resonance imaging in prenatal diagnosis. Of course, echoplanar magnetic resonance imaging can eradicate this limitation. However, this technique is not available in our university hospital and only very few centers around our country can provide it. We think that this lack of centers equipped with echoplanar imaging, is true in many European and overseas countries. Another problem when echoplanar imaging is used in obstetrics is the lack of detailed studies of possible hazard effects of magnetic resonance imaging to the fetus. This always raises discussion regarding this issue. For example, the company that produced the magnetic resonance imaging equipment in our hospital suggests not using it during pregnancy. In contrast, three-dimensional ultrasonography is approved in obstetrics and can even reduce the exposition of the fetus to ultrasound.[1, 2] We think that today both three-dimensional ultrasonography and echoplanar imaging could give important additional information to the physician and that in future the general availability of these techniques as well as aspects on safety and costs will decide which imaging technique will gain importance for routine use.

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REFERENCES

1. Lee A, et al. Three dimensional ultrasound: abnormalities of the fetal face in surface and volume rendering mode. Br J Obstet Gynaecol 1995;102:302-6.
2. Merz E, Bahlmann F, Weber G, Macchiella D. Three-dimensional ultrasonography in prenatal diagnosis. J Perinat Med 1995;23:213-22.

6/8/82734

A new ethical and clinical dilemma in obstetric practice: Cesarean section "on maternal request"

To the Editors: The recent article by Pinkerton and Finnerty (Pinkerton JV, Finnerty LL. Resolving the clinical and ethical dilemma involved in fetal-maternal conflicts. Am J Obstet Gynecol 1996;175:289-95) outlines the possible ethical conflict between the patient's right to autonomous decision and the physician's right to autonomy in practicing according to acceptable procedures, and many examples are discussed of patients who refuse intervention. Our experience is paradoxically opposite.

In Italy, the Regione Marche, where our Department of Obstetrics and Gynecology of the University of Ancona is located, has been ratified the law on the rights of pregnant women[1] that "warrants the active participation of pregnant woman in (decision making during) all the stages of labor and delivery, and in the choice of the route of delivery." The knowledge of the rights that such law grants pregnant women led some of them to demand elective cesarean section, avoiding labor and every risk that they believe—properly or not—may be related to labor and vaginal delivery.

Last year therefore (the first year of wide application of "law 23") we first observed the phenomenon of elective cesarean section "on maternal request" as a small but not negligible (4%) part of the indications. Such indications, although not necessarily justified by obstetric conditions, cannot be considered an example of "bad medicine" but pose new and wider borders to our practice and allow room for ethical and legal discussion.

We strongly support patients' right to autonomy, but we foresee that special considerations will have to be given in assessing the standards of care because that will possibly cause a change in health care management by increasing the rate of cesarean section, while there is a general attempt to reduce it to the real obstetric need, or a clinical conflict in special issues, such as that of a multiparous patient who fears to labor again and refuses to be delivered vaginally. Although these are now iso-

lated and extreme cases, it is possible that in some years they will be part of our daily practice.

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REFERENCE

1. Legge Regionale n.23 2/6/1992: Diritti della partoriente e del bambino ospedalizzato. Boll Uff Reg 1992;32:2155-9.

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Reply

To the Editors: The correspondents pose the dilemma that has been thrust upon them by a law enacted by the Regione Marche, where their medical school is located in Italy, that warrants the active participation of the pregnant woman in decision making during all stages of labor and delivery *and in the choice of the route of delivery*. This has led some pregnant women to demand cesarean section as an elective procedure to avoid labor in the absence of any obstetric indication for an operative delivery. What is the obstetrician to do in such a circumstance?

Merit may be had in an examination of the balance and difference between negative and positive rights. When a patient refuses an intervention that the caregivers propose as being medically appropriate or even, at an extreme, life-preserving, she is exercising a sacred and protected right to be left alone. This is guaranteed in most ethical constructs on the basis of autonomy, justice, and freedom from unwarranted interference. Thus we usually accept the statement that the competent adult has an almost absolute right to accept or refuse any therapeutic intervention as long as she is fully informed and is not causing harm to another individual of equal standing. A negative right is a very strong right that we would be wont to violate except in the most dire circumstances.[1]

However, when the patient actively demands an intervention, she is now exercising a positive right. In most accepted ethical constructs positive rights do not have the same weight or privacy protection as do negative rights. When the patient is demanding an intervention that is against conventional medical practice, her positive right to demand such an intervention can be balanced over and against the autonomy claims of the caregivers to practice their craft on the basis of reasonable and sound medical principles. The issue of distributive justice can also be invoked here in that the patient is demanding a costlier intervention that cannot be justified as medically necessary. The caregiver may also invoke a beneficent interest in avoiding an occasion of harm to the patient by not performing a more dangerous operative procedure in place of a simpler spontaneous delivery. Finally, nonmaleficence would encourage us to "do no harm" and to avoid the more dangerous surgical intervention.

If these measures fail and the caregivers do not feel justified in acceding to the request from the patient for unwarranted intervention, the option to transfer the care of the patient to another practitioner or another institution willing to accede to the demands of the patient can be exercised.

We hope that the principles outlined here will help resolve the majority of conflicts. Active participation by the patient includes informed decision making with the caregivers recommending what they perceive to be the best alternative courses of action. While serving as patient advocates caregivers should not perform procedures for which there is no clinical justification nor predictable benefit over harm. Ethics consultation, if available, may be helpful if the conflict remains unresolved.

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REFERENCE

1. Chervenak FA, McCullough LB. Justified limits on refusing intervention. Hastings Center Rep 1991;12-8.

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The preoperative evaluation of ovarian tumors can be improved?

To the Editors: We read with interest the article by Osmers et al. (Osmers RGW, Osmers M, von Maydell B, Wagner B, Kuhn W. Preoperative evaluation of ovarian tumors in the premenopause by transvaginosonography. Am J Obstet Gynecol 1996;175:428-34) who investigated the use of simple sonomorphologic criteria. We appreciate the interest of the authors on the crucial role of persistence of the mass to reduce unnecessary surgery in premenopause but, in our opinion, the conclusion that, with the exception of simple ovarian cysts, the cancer should be encountered in all other ultrasonographic groups is misleading, also because it is not supported by an adequate statistical analysis. As a matter of fact, with use of the suggested criteria in a premenopausal population that is characterized by a high rate of endometriomas and dermoid cysts (33% and 14%, respectively),[1] a safe laparoscopy could be never performed. On the contrary, these benign ovarian masses are characterized by very simple ultrasonographic findings not described by Osmers et al. In fact, the presence of a round homogeneous hypoechoic "tissue" of low-level echoes with a clear demarcation from the parenchyma and without papillary proliferations is characteristic of endometrioma,[2] and areas of focal or diffuse dense echogenicity frequently associated with posterior shadowing were present in dermoid cysts.[3] These ultrasonographic findings demonstrated a strong agreement between test result and surgery with both κ values of 0.84.[1, 3] Ovarian cancer in premenopause showed ultrasonographic aspects different from those described as characteristic of endometriomas and dermoid cysts. With these two sim-