the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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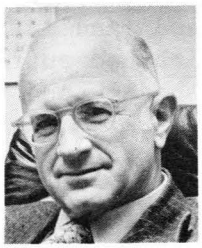
Fetal Screening—Alpha-Fetoprotein, Chorion Villus and Ultrasound



Dr. Robert Mendelsohn

When a pregnant woman goes into her doctor's office, what awaits her? Will the doctor simply weigh her, take a urine speciman, and talk to her about how she feels, the way doctors did a few decades ago? Will she then go through a normal pregnancy, free of doctor-produced anxiety?

Not likely. Today's doctor is likely to offer her amniocentesis, ultrasound screening, chorion villus sampling, and the new alpha feto-protein blood test, examinations which can produce false positives, false negatives, possible danger to the fetus itself and certain anxiety to the pregnant woman who takes them.

What if a test shows something to be wrong with the baby? Does the mother choose to have an abortion? What if the test result was wrong, and the aborted baby is normal in every way? What if the test results show the baby to be normal, but he's born defective? What if the test itself causes a miscarriage or a stillbirth?

But even worse than the prospect of what today's doctor can do is the prospect of the brave new world that technology will open for tomorrow's doctor. What will happen when he can screen for a gene that will show the baby may develop heart disease or cancer sometime later in life? What if he can screen for length of nose and color of hair? Who will live and who will die? And what kind of people are those scientists who are seducing us into making today's decisions and who will be forcing us into making tomorrow's decisions?

(Some of the material on chorion villus sampling and ultrasound has appeared in my earlier Newsletters. I feel this subject is so important that readers, new and old, should have access to most of this information within the pages of a single Newsletter--this Newsletter is longer than usual. Earlier reports of the dangers of these and other fetal tests can be found within the pages of Volume 7, Number 11 and Volume 3, Number 11.)

Risks of alpha-fetoprotein screening

As tests for fetal defects continue to proliferate, every prospective parent should be warned about the dangers of these procedures.

One of the newest tests, AFP (alpha-fetoprotein), is used to determine whether a fetus has defects of the brain or spine--defects such as spina bifida (splitting of the end of the spine) or anencephaly (absence of the brain). An estimated 3,700 children with these defects are born every year in the U.S.

As wonderful as such a test of maternal blood might sound, there are certain problems:

1) The test cannot be given early in pregnancy. This means that if abortion is contemplated, it will fall into the riskier class of second trimester abortion.

2) Even though the incidence of these defects is quite low, five out of every 100 women receiving this screening test will have high levels

of AFP, leading to considerable anxiety and the necessity for repeat tests.

3) Upon receiving a second test, three of every 100 women who are screened still have a high AFP level. This will lead to an ultrasound scan which itself is surrounded by controversy regarding its safety.

4) "False positive" AFP tests can be caused by the presence of twins or by miscalculating the onset of pregnancy.

5) For those women with positive tests who are not having twins and who can accurately date their pregnancy, the next step is amniocentesis with its own risks of fetal damage and death.

6) If the amniocentesis reveals amniotic fluid high in AFP, another (high-resolution) ultrasound test must be done, or else the amniocentesis must be repeated.

A representative of the Spina Bifida Assocation of America has pointed out (American Baby Magazine, April, 1986) that misuse of the test is occurring. In some cases, physicians are recommending abortion upon the basis of a positive blood test. Thus, AFP screening can lead to abortion of many healthy fetuses.

The mental stress of undergoing an AFP screening has been well documented. As reported in the British Medical Journal, 68 percent of women interviewed who had high AFP levels in their blood (and later a normal result on an amniocentesis) felt that their health had suffered from the anxiety of waiting for test results. Some even had turned to increased cigarette smoking, alcohol use and tranquilizers. A further study indicated that anxiety continued, even in those women whose further tests ruled out a defect. Keep in mind that psychological stress in the mother has been linked to premature delivery and low birthweight.

Some women may be so anxious about the danger of having a baby with a nervous system defect that they will opt for the AFP test. Others, knowing the dangers of the test, may be even more anxious. In any case, make sure that the doctor, prior to performing pre- and post-natal tests (anything from AFP to PKU), informs you about their darker side.

Q Could you write more about maternal serum alpha-fetoprotein screening? It is being used routinely in North Dakota, and it is very hard on mothers who show "elevated" levels. Here's what I've discovered about it so far:

1) The error rate is very high.

2) The test was lobbied through the American Medical Association and the American College of Obstetricians and Gynecologists to become a standard part of prenatal care by the drug companies which manufacture the test kits.

3) In North Dakota, the use of this test (for screening pregnant women for the two-to-nine cases per year of neural tube defects that occur in this state) will cost us nearly $500,000. That's the price of the original tests, repeated tests, subsequent ultrasound scans, amniocentesis, etc.--and this in a small state that has only between 11,000 and 12,000 births per year.

That's what I have learned. What about you?--J.M.

A I first wrote about the dangers of this new test for fetal malformations in May, 1985. Since then, medical columnist Eugene Robin, M.D., professor of medicine and physiology at Stanford University, has also warned the public about the unusually high error rate of this blood test. Women who show false-positive tests can have their anxiety relieved only by submitting to even riskier tests--ultrasound scanning and amniocentesis included.

There also are false-negative results, i.e., babies who do have spina bifida and associated defects but show normal test results.

In his Third Edition of "The Patient's Guide to Medical Tests," Dr. Edward Pinckney presents evidence against making the AFP test a part

of routine screening. Incidentally, your state of North Dakota is not alone in routinely screening for AFP. California has mandated that a doctor must offer this test to every pregnant woman.

Pregnant women should keep in mind that the AFP test is not the first of its kind to carry a high error rate. The incidence of false-positives in the PKU test (performed right after birth and used for detecting another form of damage to the central nervous system) is 99 percent.

Doctors say a woman and her baby should have these tests in order to prevent damage and unnecessary anxiety. But do they also tell you how the very same tests may themselves cause damage and unnecessary anxiety?

Two cases of fetuses who were born with neural tube defects (NTD) and chromosomal abnormalities without there being an increase in maternal serum alpha-fetoprotein were reported by three doctors from the Departments of Obstetrics and Pediatrics at Iowa City University Hospital. For some strange reason, this article, which has to be of interest to all American doctors and pregnant women, appeared in a British medical journal (The Lancet, September 27, 1986).

Neural tube defects refer to abnormalities of the spinal cord and surrounding structures. The abnormality may be as relatively mild as a split spine (spina bifida) with no clinical symptoms. Or, as in these cases, it may be as severe as thoraco-lumbo-sacral-meningomyelocele. That means that the spinal column is defective all the way from the top of the chest right down to the tailbone, allowing the spinal cord to bulge out--with severe functional consequences.

This new test joins the others used by obstetricians and pediatricians which have significant error rates. Just because the test is positive doesn't mean the baby will be damaged. And just because the test is negative doesn't mean the baby will be healthy. When the obstetrician says to a pregnant woman, "Don't you want to know everything that's going on with your baby," maybe that's the time to quote George Bernard Shaw: "There are certain things a decent human ought not to want to know--for example, how his children taste when boiled."

Headlined "AFP Anxiety," the following Letter to the Editor appeared in the September, 1986, issue of the Western Journal of Medicine. The letter was written by Philip C. Stillman, M.D., MPH, and James Hoffman, M.D., both of Salinas, California:

"Based on our experience in California with a new screening modality, we believe society has created a new form of mental anguish: AFP anxiety. We have seen severe psychologic and physiologic disturbances in patients and family members after a 'positive' result is reported from maternal serum in the California Alpha Fetoprotein Screening Program. A recent report in the public health literature warned us that, despite our efforts in education, women would have substantial gaps in their understanding of the test. In our experience, this is especially true in dealing with the relatively large number of 'false positive' results. Furthermore, this anxiety is only partially relieved when the repeat blood test or amniocentesis is 'negative,' in that a normal baby cannot be assured with 100% certainty. We cannot even prescribe anxiolytics [tranquilizers] in this case since the prototype drug [Valium] has been associated with a number of congenital abnormalities when used in pregnancy.

"We are not fond of delivering anencephalic [absence of brain]

babies, but we also hate to see such intense anxiety in our pregnant patients. Most women with 'positive' results in the AFP screening go on to have normal babies. The California Alpha Fetoprotein Program is doing more harm than good and should either be altered to prevent 'AFP anxiety' or abolished altogether."

Chorion villus sampling

When I grew up in Chicago, the initials CVS stood for Chicago Vocational School. But no more. Today, those same initials stand for a new fetal testing technique--chorionic villus sampling. The chorion is the outer tissue of the sac which surrounds the embryo inside the uterus. The villi (plural of villus) are tiny fingerlike projections of the chorion, but they are not actual parts of the fetus. While some of the villi disappear by the twelfth week of pregnancy, those which remain become the placenta.

Within the past 20 years, Scandinavian and Chinese researchers began to biopsy these villi in order to make fetal diagnoses. When the procedure first was used by American researchers, it was called chorionic biopsy, but since the word "biopsy" conjures up visions of cancer in the minds of many people, the researchers turned to the allegedly more accurate (and certainly more reassuring) word, "sampling."

But what is the truth about this new procedure, which is being widely promoted as a replacement for amniocentesis in detecting fetal abnormalities?

CVS can be performed earlier in pregnancy than amniocentesis and can be more quickly analysed. Ultrasound scanning--with all its known and unknown risks--is used to guide the CVS catheter just as it guides the amniocentesis needle. (The amniocentesis needle is inserted through the mother's abdomen into the amniotic fluid which surrounds the fetus, while the CVS catheter is inserted through the cervix into the chorionic villi.)

Concerns about CVS are presented honestly in "Family Planning Perspectives," November/December 1983. First, no-one knows for sure that the tissue collected by CVS is genetically identical with that of the fetus. In other words, maybe the biopsy truly represents the fetal condition, or maybe it does not. Second, the effect of the biopsy procedure itself on the fetus is unknown. Researchers simply "assume" that the removal of apparently "useless" villi has no effect on fetal development. But since they don't know whether or not this is true, CVS may increase the likelihood of spontaneous miscarriages. Third, CVS cannot detect all the problems which amniocentesis can detect. For example, neural tube defects cannot be detected in the first trimester, nor can a number of other malformations. Thus, for some women, both CVS and amniocentesis may be necessary. Fourth, CVS may detect apparent genetic defects that never appear in the infant. Through CVS, Eugene Pergament, M.D., a Chicago researcher, has diagnosed a fetus with a chromosomal abnormality (known as trisomy 16), but other researchers say it is quite possible that trisomy 16 is a defect of the chorionic membrane, rather than of the fetus itself.

CVS linked to congenital malformations

Chorionic villus sampling now has been linked to a case of congenital malformations.

Writing in The Lancet, September 27, 1986, three doctors from The Netherlands' Streeklaboratorium Zeeland report that CVS (in which a piece of the membranes surrounding the fetus is removed for examination) was done on a 24-year-old woman at nine-and-a-half weeks' gestation. The procedure was performed in a university hospital with a

great deal of experience in performing this procedure.

At term, a baby girl was born with a clubfoot on the right side and malformations of the left hand, consisting of fusing of the second and third fingers, constriction rings of all except the little fingers, and bulbous distal swelling of the fingertips. (The medical terminology for these anomalies is "amniotic band sequence.") The placenta showed a variety of abnormalities, including many amniotic bands.

The Dutch doctors conclude, "In this case, a procedure designed to detect congenital malformations in an early stage probably caused anomalies of a foot and a hand in an otherwise-normal child. In addition, the doctors provide references to cases of amniotic band sequences after another procedure used in prenatal diagnosis--amniocentesis.

If your doctor recommends these newest prenatal tests, ask him if he knows about these reports which link the tests (in which needles, catheters and ultrasound are used) to the production of fetal abnormalities. If not, make sure he obtains these articles from eminent British, Scandinavian and American medical journals.

From the Canadian publication, Maternal Health News (October, 1986) comes the following information about chorionic villus sampling:

"The miscarriage rate is high (about three percent on the average, compared to about .5 percent for amniocentesis). In four percent of the cases, the chorionic tissue shows chromosomal abnormalities that are in fact not present in the fetus itself. Infection is a major problem with the transcervical entry into the uterus, requiring all women who want CVS to have a cervical culture done first."

Q I currently am about three months pregnant. On my first visit to the doctor, I explained that my menstrual cycles are long (approximately 38 days), but he still figured my due date in terms of the conventional 28-day cycle.

The doctor now tells me that the size of the fetus is somewhat small (since he assumes the date of conception is about two weeks after my last period), and he wants me to have an ultrasound test after I'm four months pregnant. I assume I ovulated about 10 days late, since my cycle is 10 days longer. When I told him how far along I thought I was, he agreed that was the size the fetus was, but he still wanted to have the ultrasound.

Here are my questions: How important is it to find the exact due date within a 10-day span? What, if any, risks are involved? Do doctors really know the long-term effects of bombarding a fetus with sound waves? Haven't the Japanese stopped using ultrasound routinely because of the risks associated with it? I would appreciate any light you can shed on this subject.--K.W.

Risks of ultrasound

A The lead article in the April 23/30, 1982 Journal of the American Medican Association was headlined, "Question of risk still hovers over routine prenatal use of ultrasound." The article described a study at the University of Manitoba, Winnipeg, in which the investigators found "a small but significant rise in the number of children [who had been exposed to diagnostic ultrasound] who were underweight at birth." Most of the panelists at the symposium quoted in this article "expressed concern about the possibility of delayed or subtle manifestations" of diagnostic ultrasound.

Ultrasound produces two biological effects--heat and a process called "cavitation" in which bubbles are created that expand and contract in response to sound waves. The first time I saw this cavitation process in action, a chiropractor turned on the therapeutic ultrasound machine in his office and placed a few drops of water on the part of the machine that was applied to the patient. I wish every reader of this Newsletter could have been with me to watch that water suddenly boil and bubble.

Speaking at that Winnipeg symposium, an investigator of the FDA's Bureau of Radiological Health said that ultrasound can produce shock waves in liquid (and I remind you that the infant inside the uterus is surrounded by liquid). In animal fetuses exposed to ultrasound, investigators from the University of Rochester School of Medicine reported that the cavitation process can produce damage in insect eggs and in plant and mammalian cells.

Doreen Liebeskind, M.D., assistant professor of radiology at Albert Einstein College of Medicine, suggested that long-term human studies of children exposed to ultrasound should look for behavioral changes, nerve reflex changes, I.Q. deficits and shortening of attention spans. Although Dr. Liebeskind observed changes in cell appearance, motility, and DNA synthesis that were passed on in succeeding cell generation, neither she nor Arthur D. Blum, M.D., professor of pediatrics at Columbia University, felt they would be seeing cancer until a large number of exposed children had been followed for 15 to 20 years.

I hope your physician follows Dr. Liebeskind's recommendation that physicians should discuss the benefits and risks of ultrasound with their patients. The Winnipeg panelists recommended that physicians should not assume that diagnostic ultrasound is innocuous. Furthermore, the American College of Obstetrics and Gynecology has emphasized that physicians who operate ultrasound equipment must be properly trained.

If your doctor tries to reassure you by telling you that ultrasound is not x-ray, you might answer him that just because it isn't x-ray does not mean that this form of energy wave is safe.

Three years ago, a 14-member task force, organized by the National Institutes of Health, warned that ultrasound tests should not be given routinely because the safety of the procedure has not been proven.

The chairman of the panel, Dr. Fredric Frigoletto, professor of obstetrics and gynecology at Harvard University Medical School, said, "We could find no evidence to justify the recommendation that every pregnancy be screened by ultrasound." He continued, "In the face of even a theoretical risk, where there is no benefit, then the theoretical risk cannot be justified."

Ultrasound works by using high-frequency sound waves to produce an image of the fetus on a television screen. This report pointed out that lengthy and intense exposure to ultrasound waves can cause cell damage, an effect the task force said has not been demonstrated in humans.

But where was it ever written that ultrasound should be used routinely? Who were those doctors who recommended routine diagnostic ultrasound for pregnant women? Was your own doctor on the right or wrong side of this issue, and where does he stand today? According to Newsweek Magazine, there are 27 indications for using ultrasound, but those indications have not been spelled out, to my knowledge, in the popular press. Why aren't the experts at NIH publicizing those indications so that women can have this information in hand when they go to their doctors?

Since there is a tendency among some doctors to classify far too many pregnancies as "high risk," it is not sufficient to merely say that ultrasound should be used in "high risk" pregnancies. Clear criteria

for what constitutes high risk pregnancies should be publicized so that each pregnant woman can judge for herself whether her pregnancy is high risk or low risk, instead of depending blindly on the doctor's evaluation.

If doctors who now are overusing ultrasound cut back, how are they going to afford those expensive machines? Furthermore, the NIH/Harvard authorities have not spelled out the kind of disciplinary measures that should be taken on doctors who continue to overuse ultrasound. Will these errant docs be disciplined by their state medical licensure boards, specialty societies, county medical societies? Or will we have to wait for the lawsuits that may develop 10 or 20 years from now if the early statistics suggesting ultrasound-induced leukemia and other forms of damage are confirmed?

The ultimate question (which the researchers thus far have failed to answer) is why--since ultrasound has never been shown to improve the outcome of pregnancy for either mother or baby--should it be used at all? Shouldn't parents be clearly informed that diagnostic ultrasound is an experimental procedure? And shouldn't they be required to sign the special consent forms for experimental procedures?

Dr. Ted Li of Harvard Medical School has joined the growing number of physicians who are attacking diagnostic ultrasound. Dr. Li delivered his message to the 1985 national meeting of the American Federation for Clinical Research. His research showed that the diagnostic value of obstetrical ultrasound as a routine screening procedure is "marginal," its therapeutic utility is "slight," and its cost is disproportionately high.

Dr. Li's research investigation showed that, based on the records of 3,100 women, there were 18 false-positive fetal anomalies. In other words, the ultrasound reading "found" the following abnormalities which really weren't there: Three cases of intrauterine birth retardation, four cases of polyhydramnios (too much fluid surrounding the infant), one case of oligohydramnios (too little fluid surrounding the infant), four cases of abnormally increased fetal size, and six cases of placenta previa (abnormal location of the placenta). Think of all those mothers and fathers who worried unnecessarily about these abnormalities (which existed only on the ultrasound tape) during the pregnancy, at delivery and even afterwards.

The ultrasound examination also made mistakes in the other direction. Thus, six babies were born small for gestational age, even though their ultrasound readings were normal. Two cases of renal agenesis (failure of the kidney to develop) were missed, as was one case of an infant with an absent hand and wrist.

For your information, "minor" anomalies included four cases of hypospadias (abnormal location of the urethral opening in males), three cases of clubfoot and one case of undescended testes. Dr. Li stated, "Ultrasound failed completely to pick up minor anomalies. Its success rate was absolutely zero."

Q My healthy 26-year-old wife is in her third month of pregnancy. Our first child was delivered by Caesarean section.

After reading your writings, we tried to find a conservative obstetrician. The one we found advised my wife to have a sonogram after her first exam. I called this doctor, asked him why he thought my wife needed this procedure, and asked if he was up on the dangers of ultrasound. He said he never had read or heard of any such dangers.

I promptly discharged this doctor and went in search of a more know-

ledgeable obstetrician. I went through half the names in the phone book and questioned every doctor I could talk to. Each and every doctor advised that my wife would need at least one or two sonograms. Each doctor insisted there were no dangers in ultrasound.

Dr. Mendelsohn, I cannot believe that doctors in a large metropolitan area such as mine could all be ignorant of the current literature. My wife's pregnancy is not considered high risk. How can people fight back when there is a conspiracy by a monopoly?--S.F.

A

Your experience with obstetricians is far from unique. Many ob/gyns have indeed not learned about the accusations against ultrasound. Others, although aware of the possible danger, do not "believe" the reports. Still others feel that the downside reports on ultrasound are valid, but they are reluctant to frighten their patients. Many obstetricians don't even tell their patients that they are receiving ultrasound when the doctor uses the Doppler stethoscope, performs amniocentesis, or carries out fetal monitoring during labor.

I advise that you refrain from further expenditure of energy in trying to understand doctors. And I do not regard "fighting back" as an ideal solution. After all, doctors are very powerful people, and only the most courageous and informed patients can successfully battle this kind of adversary. Furthermore, when it comes to childbirth, an alternative method of management has been available throughout human history. Modern high-tech obstetrics, a radical experiment in delivering babies, is only 40 or 50 years old. Since my five grandchildren have all been born at home (with the assistance of homebirth doctors or midwives), why shouldn't your wife, who is not considered at high risk, follow my daughters' example?

British researchers reporting in The Lancet (November 3, 1984) concluded that "diagnostic ultrasound is safe with regard to the risk of cancer and leukemia between birth and the sixth year of life..." That's the good news.

The bad news is contained in the rest of the sentence--"...but an unresolved question remains regarding onsets and deaths after this age."

Analogies between ultrasound and DES

There are several remarkable analogies between the antimiscarriage drug DES, given to women decades ago, and ultrasound, which now is being recommended for many pregnant women. In both cases, experimental (and some clinical) evidence pointing to potential damage existed right from the start. In both cases, an untested procedure was applied to vast numbers of healthy pregnant women. An estimated two million to six million women received DES between 1940 and 1980; similarly, very few pregnant women today escape one of the four forms in which ultrasound is given (Doppler stethoscope, the ultrasound scan, amniocentesis and chorion villus sampling, internal and external fetal monitoring). In both cases, early studies failed to show any proven benefit from the procedure. The University of Chicago controlled studies of DES in the late 1940s showed no difference in the number of miscarriages between treated and untreated groups. But 20 years after exposure to DES, the risk of breast cancer is 40 percent greater for women who took this drug during pregnancy. In 1982, the Department of Health and Human Services was unable to show any difference in outcome between pregnancies that were exposed to ultrasound and those that were not.

On the basis of five-year studies showing no damage from ultrasound, doctors today are frantically trying to reassure mothers that ultrasound given during pregnancy will not harm their offspring.

If your doctor tries to use these early five-year studies as reassur-

ance to you that ultrasound is safe, ask him about DES. Remind him of the story of the man who jumped off the top of a 50-story building: As the man passed the 35th floor, a worker looking out the window shouted, "So far, you're doing fine!"

Potpourri

Of docs and detailmen

I recently received a "Dear Colleague" letter from the American Academy of Pediatrics, along with which was enclosed a free copy of the Academy's new 140-page publication entitled "Management of Pediatric Practice." Conceding "It is no longer adequate for pediatricians to enter practice with clinical competence alone," the Academy offers this manual as "an important resource for pediatricians who are committed to providing high-quality pediatric care."

The letter's penultimate paragraph (the one that usually gives the gist of any letter) stopped me short. This publication, I read, "is provided under an educational grant made possible by Wyeth Laboratories." And what, I wondered, did Wyeth, a division of American Home Products, whose detail men fan out in every direction, promoting to pediatricians the company's SMA infant formula, antibiotics, etc., receive in return for this "generous" educational grant?

To discover the answer to that question, I turned to the index and looked under "P" for pharmaceuticals. Sure enough, on page 13, I could find information about "Pharmaceutical representatives, appointments for."

Let me share with you the two key paragraphs on that page:

"Pharmaceutical representatives are professionals. It makes little sense to refuse to see these individuals because both the pediatrician and the representative can learn much by such sessions. Because gains are mutual, the representative should never be turned away, even if he or she has to be asked to return later because of an office emergency or jam-up. Representatives have important information for the pediatrician about pharmaceuticals....They sometimes make drugs or biologicals available directly to the pediatrician in emergency situations. Representatives also make starter samples available to patients and may even provide treatment supplies for patients who have difficulty paying for medical care.

"...Instead of having the representative wait in the reception area, he or she should be sent to a nonpublic area (e.g., library, conference room, lounge) to meet with the pediatrician. If time permits, coffee with conversation is appropriate....The privacy prevents patient annoyance about what appears to be a 'social chitchat.'"

Never before have I seen my distinguished organization, the AAP, tell its members in print how to relate to drug detail men. My own history of interacting with these drug company representatives falls into two eras. In my first decade or so of practice, when I followed the example set by my teachers, I was courteous and respectful of these people who filled my cupboards with samples while reciting the merits of their latest offerings. They seemed to have no objection to sitting in my waiting room with the mothers and children, and it never even occurred either to me or to my senior partner that we should offer them coffee. As my practice grew, our interaction became more limited, often consisting of no more than a quick handshake and an interchange about the most recent accomplishments --or lack thereof--of the Chicago Cubs.

The second era, spanning the past two decades, has been marked by an almost total absence of drug representatives from my office. Word gets around!

In view of the poor pharmacological education of doctors, those "post-graduate" visits of pharmaceutical representatives may have some justification, especially if these men and women teach doctors the dangers of the drugs and infant formula they are pushing. But I do hope that the Academy's policy of letting a drug company pay for its publications doesn't spread to other publishers.

Another View

by Marian Tompson

A childbirth teacher named Joy remarked to me, "I've been noticing for a long time now that when women go to their doctors for prenatal visits, they usually return filled with anxieties. The visits seem to focus on potential problems, which for the most part turn out to be groundless. But in the meantime, they are left apprehensive until the next checkup."

Rosalyn currently is caught up in this dilemma after she had an alpha-fetoprotein test. In her home state of California, it is mandatory that doctors offer this test to pregnant women. Rosalyn was told that her test indicated that her baby has spina bifida. But according to an ultrasound test which was scheduled several weeks later for confirmation, the baby is fine. Rosalyn won't know which test is right until her baby actually is born.

In the March 1986 issue of Obstetrical and Gynecological Survey, Doctors Thacker and Berkelman of the Centers for Disease Control reviewed published studies on the stress test and non-stress test of monitoring of fetal movement, revealing that both tests generally demonstrated low sensitivity and high rates of false positivity. The authors point out that the direct costs of these tests exceed $200 million per year in the U.S., even though they have not been demonstrated to be useful diagnostic tests.

We're all aware of the contribution the overuse of technology has made to the soaring rate of Caesarean sections. But is anyone measuring the psychological effects of these tests on the mother and its impact on her relationship with her baby in utero as well as her subsequent labor? If abortion isn't a consideration, and if there is no immediate remedy for supposed defects uncovered by prenatal testing, particularly when the tests themselves can produce damage, is there even a justification for performing those tests?

Michele Odent, M.D., has addressed these questions in a revolutionary manner in his management of the maternity clinic in a public hospital in Pithiviers, France. In "Birth Reborn" (Pantheon Books, 1984), Dr. Odent explains that a good birth begins long before labor. Pregnant women are encouraged to come to weekly events at his hospital so that they will feel comfortable with the setting when labor begins. On Tuesdays, prospective parents, doctors and midwives gather around a piano and sing. Dr. Odent points out that singing provides a simple way for women to exercise their diaphragm muscles while learning to concentrate on breathing that can help them relax during labor. "When we all sing together," he explains, "the usual separation between consumer and professional dissolves, and a new relationship emerges."

Dr. Odent keeps prenatal visits brief and to a minimum, having observed (as Joy did) that "These sessions frequently lead to more problems than they solve." Ultrasound is rarely used because "It seldom tells us more than the diagnosis of a skilled doctor. Even when such an examination does tell us something we could not have discovered by other methods, we have found it seldom leads us to a procedure change." Regardless of age, women are never urged to undergo amniocentesis--this procedure involves a risk of miscarriage of 0.5 to two percent. Dr. Odent does not believe in bedrest to prevent premature labor, pointing out that no study has ever demonstrated that bedrest works. He worries that prolonged immobilization may lead to fetal sensory deprivation.

It is well to remember these remarks of Dr. Odent: "Sometimes we can't help wondering whether pregnant women wouldn't get more out of singing with us than from going to yet another prenatal examination."

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