& R. H. Paul, *Cesarean Delivery for Fetal Distress without Maternal Consent,* 63 OBSTET. GYNECOL. 596 (1984); E. Raines, *Editorial Comment,* 63 OBSTET. GYNECOL. 598 (1984). I can tell you from very practical, frontline, at the bedside obstetrical experience that the interests of pregnant patients may well place the life of the fetus, the yet unborn baby, in real and actual jeopardy. This may be so even when diligent efforts are made to comply with the full disclosure requirements of informed consent. To date, I have been informed by legal colleagues that the fetus is not a person and so the interests of the mother take legal precedence. However, it would seem that this is also in a state of flux as indicated by the recent Arizona Supreme Court ruling in the case of Jack and Charlene Summerfield, Mesa, Maricopa County, Arizona, where Justice Stanley G. Feldman writing for the Supreme Court wrote, "There is no logic in the premise that if a viable infant dies immediately before birth it is not a 'person' but that if it dies immediately after birth it is a 'person.' "

I wish to make quite clear that this communication is an expression of my own personal opinion and in no way reflects any expression or statement from the Kaiser Permanente Southern California Medical Group.

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To the Editor:

The comments of Dr. Fribourg are to my mind quite appropriate. The communication by Myra Gilfix indeed deserves criticism, coming as it appears to from a less than fair and uncritical point of view. She appears to be fulfilling a preconceived bias with a wealth of citations but she offers little insight. She ignores the burgeoning and persuasive evidence that electronic fetal monitoring does indeed improve outcome by diminishing the risk of both antepartum and intrapartum stillbirth, and by ameliorating the outcome of babies as measured by Apgar scores and neurological performance. Furthermore, these benefits are not restricted to mothers identified as high risk.

Electronic fetal monitoring offers insight into the fetal state, well-being, mechanism of distress, and likelihood of fetal depression from asphyxia, as well as the severity of respiratory distress syndrome in babies delivered prematurely. No other technique approaches this specificity or permits this insight. The studies confirming these benefits comprise more than 200,000 patients but do not pretend to offer conclusive proof of the benefit of electronic fetal monitoring. The implications, however, are compelling.

The several randomized controlled studies which have not found monitoring to be of benefit when compared with auscultation, are plagued by grievous limitations precisely because they aspire to definitively decide the issue. As discussed elsewhere, these randomized control trials, even in the aggregate, do not contain sufficient numbers of patients to warrant the conclusions reached. As an example, the high risk patients monitored in labor by Haverkamp et al., had previously been screened for fetal risk by the contraction stress test, a test based upon electronic fetal monitoring. Only those patients with normal tests were candidates for the controlled study. It seems naive to argue that a patient who has previously been defined as normal by electronic fetal monitoring is a reasonable subject for a randomized control protocol to test the benefits of electronic fetal monitoring.

The communication of Ms. Gilfix, however, should not be criticized too severely. She is, in fact, reflecting an opinion, more commonly held previously than now, that monitoring could not be of benefit over so long-standing a reference as auscultation. It is unfortunate, indeed, that the various publications faulting electronic fetal monitoring have failed to apply the sane scrutiny to auscultation. Despite simplicity of technique and proximity to the patient required by the stethoscope, there remains no evidence, however slight, to suggest that fetal stethoscopy predicts either outcome, state, or condition of the newborn.

Ms. Gilfix is adding yet another voice to the cry of intrusion into "a natural process." Simply, monitors do not dehumanize pregnancy—humans do. Nevertheless, there is a choice. The equipment may be so obtrusive and inconvenient as to preclude widespread application. The technique may be too expensive to implement, and the patterns may be too arcane to interpret. There is broad divergence in the skill of those reading the patterns, and some divergence of opinion of the significance of certain features of the tracing. Underinterpretation probably increases bad outcomes in the baby and overinterpretation doubtless increases the morbidity both for mother and baby by increasing the frequency of cesarean section and perhaps operative delivery. There is little doubt that bad monitoring is worse than none at all, and that ominous patterns may be overlooked. This litany of deficiencies is a problem of education, not of the potential usefulness of the monitor.

Thus, the available data clearly demonstrate that electronic fetal monitoring is of benefit in both high and low risk patients. Perversely, failure to monitor during labor makes the "low risk patient" "high risk." While the risks of adverse outcome in unmonitored fetuses are not great, the stakes, I submit, are considerable.

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