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**Screening through the Media
The public presentation of science
and technology in the ultrasound
diagnostics controversies**

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SCREENING THROUGH THE MEDIA

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Introduction

Ultrasound technology was introduced into Norwegian maternity care in the late 1970s, which is late compared with other Nordic and western countries. By the mid-1980s, however, ultrasound had come to be offered, *de facto*, as a matter of routine prenatal care (i.e. offered to all pregnant women even in the absence of symptoms of pathology). This practice of routine diagnostics in the absence of symptoms is known as screening. Most hospital districts offered one such ultrasound scan per pregnancy, some two. A single-digit percentage of hospitals did not officially offer screening, but the majority of their patients received a scan nonetheless at the request of their primary care physicians. A consensus conference in 1986 concluded that a single, non-mandatory ultrasound examination should be offered during each pregnancy.¹ Both the practice and policy of ultrasound screening in pregnancy have remained stable since the mid-1980s, but have also remained controversial throughout that time. *The subject of this paper is the media's role in the controversies surrounding use of ultrasound diagnostics in pregnancy in Norway.*

This paper is part of a larger project called "FETAL IMAGES AND FETAL INFORMATION. The meanings of ultrasound reconstructions of the fetus to pregnant women and their partners." The project is led by Ann Rudinow Sætнан at the Centre for Technology and Society, NTNU, Trondheim. As research assistant during the Fall of 1995, my task was to sift through the mass media in order to trace their role in the controversy.

One way of mapping one's way through a controversy is to envisage it as a four-dimensional structure.² A controversy must necessarily have participants - at least two, representing different positions. Often positions taken in a controversy will appear contingent on the basis of positions in a social structure. For instance, physicians might be expected to have different structurally conditioned interests and views than hospital administrators. One might study this dimension of a controversy separately: What are the power

¹ Bjørn Bakke and Harald Buhaug (eds.); *Bruk av ultralyd i svangerskapet*, report from the consensus conference 27.-29.08.1986. Trondheim; NIS-rapport nr. 8/86, 1986.

² This model has been presented by Ann R. Sætнан, and will be developed further through the project.

relations among participants in the controversy? Who speaks with authority? Who form mutual alliances? Are there groups and individuals with an interest in the outcome who are nonetheless non-participants? Do others claim to speak for them? In case of prenatal diagnostics, the fetus is one such instance of an interested party spoken for by others. One of the claims in the ultrasound controversy is that the technology moves the power to speak for the fetus from the pregnant woman to the ultrasound operator.

The second dimension of the figure is the themes of controversy: What do the participants talk *about*? Again, one could analyze this dimension separately in terms of relationships between themes. For instance, Ann Sætнан has looked at the ways in which gender issues are intertwined with issues of science, safety, division of labour, etc.³ One could also analyze relations between the two dimensions: Who brings up which themes? Do different groups speak with authority on different themes?

The third dimension is the sites where the discourse is carried out. Here too one could analyze the dimension separately, for instance by asking how parliamentary debate spills over into the mass media and/or vice versa. And one can examine relations between this aspects and the previous two dimensions: Where are women's voices heard? Where physicians'? Where are safety issues discussed? Or, as in this paper, one could look back to the other dimensions from the point of a single site: *Who appears in the media and what themes are discussed there?*

The fourth dimension is that of the dynamics of the discourse over time. As an historian I have paid particular attention to this dimension. Concentrating on the last 10-15 years, I have identified three phases of media discourse concerning ultrasound screening in pregnancy. These are characterized by different themes, different modalities, and to some extent different participants. I will present these phases shortly.

The media material

My material for this analysis has been gathered from some of the main newspapers and the national broadcasting channel in Norway, trying to find out in what way the mass media deal and have dealt with questions concerning the use of ultrasound diagnostics in pregnancy since 1982.

Norwegian newspapers are characterized by diversity. Despite of a population of only 4 millions, there are about 150 newspapers, and Norwegian

³ Ann Rudinow Sætнан; "Ultrasonic Discourse. Contested Meanings of Gender and Technology in the Norwegian Ultrasound Screening Debate", in *The European Journal of Women's Studies*, Vol. 3, February 1996, London; Sage Publications.

households keep 1,8 newspapers in average.⁴ Most of the newspapers are local or regional, based on subscriptions, and to some extent governmental financial support. This means that even though they are dependent on advertisers, they have a rather high degree of editorial freedom. (At least in theory..) The newspapers I have analyzed, are the three largest regional newspapers from Oslo (the capital), Bergen (second largest city in Norway) and Trondheim (third largest city in Norway).⁵ They are all conservative, and share much of the same political views.

I have chosen not to go deep into the question of media power, economics, ownership, editorial functions and journalists' framework. My perspective has been the reader's: What has actually been written, or not written, in the news? How have the newspapers presented the technology and the scientists? What attention has been drawn to the various aspects of ultrasound diagnostics? Whose voice has the mass media given room for? And what kind of news have got the biggest photos and the front page paragraphs? These have been the main questions for me, in order to analyze what information and impression pregnant women have got from media when they themselves have to consider whether to be examined or not. The purpose has been to find out both the information value of the news, and to some extent to analyze the discourse(s) on ultrasound technology, as it is presented in the media.

Recent media research emphasizes that there is no one-way influence from media reports to people's consciousness and opinions.⁶ What the public actually knows, and what the pregnant women feel about being examined with ultrasound, is a main question for this project; but still we lack data about this. The readers are free to analyze the news as they want and have qualifications for. None the less they are confronted with the "reality" as the journalists present it. The readers have to watch the subject through the journalists' eyes. I have thus paid special attention to modalities in the way of presenting the ultrasound field.

A positive modality is for instance articles where the news are presented as the journalist's own statements. Such articles usually seem more positive than articles just referring to the participants' statements. More positive effects can also be achieved by use of photos and headlines, which affect degrees of

⁴ Sigurd Allern; *Kildenes makt. Ytringsfrihetens politiske økonomi*, Oslo; Pax forlag 1992. Figures from "Aviskatalogen", Norske Avisers Landsforbund 1991.

⁵ Oslo: "Aftenposten", Bergen: "Bergens Tidende", Trondheim: "Adresseavisen". I have analyzed a collection of more than 500 articles and paragraphs from these newspapers, and 9 TV programmes.

⁶ Svernik Høyer; *Små samtaler og store medier* (Small conversations and big media), Oslo; Universitetsforlaget 1989.

attention. A negative modality is for instance articles just referring to the actors' claims and work, without trying to present a view of "how things really are".⁷

The media have several aims and roles. I have watched at this field with the following list in my mind: Media as disseminating knowledge/giving information, as a meeting place for authority and the public, as a framework for social discourse and as a culture bearer; i.e. education, socialization, and (political) agenda formation. These aspects have functioned just as a reminder for my investigation and not as a model to fill in.

I have also been asked to say something about inter- and intraprofessional rivalries in Norway when it comes to practice and competence within this field. Although this hasn't been an explicit approach in my research, I will try to emphasize some points of rivalries and organising approaches as they are presented in Norwegian newspapers.

Main tendencies in the media's presentation of ultrasound technology and practice

The period 1982-86: The battle of statistics

The controversies surrounding use of ultrasound diagnostics have changed over time. The first years the main question was whether all pregnancies should be examined this way, or only high-risk pregnancies.⁸ A research report from 1982⁹ stressed that the death rate among newborn children in Norway was higher than in other Nordic countries, for instance 50% higher than in Sweden, and concluded that 1/3 of all perinatal¹⁰ deaths could be avoided by better organisation within hospitals and maternity care.¹¹ However, the researchers did

⁷ About positive and negative modality (although not in the mass media in particular), see Bruno Latour; *Science in Action. How to follow scientists and engineers through society*, Milton Keynes; Open University Press 1987, chapter 1.

⁸ Adresseavisen 17.02.1983, 10.06.83, 19.01.84, 21.01.84, 14.09.84, 13.06.85, 26.11.85, 28.08.1986. Aftenposten 18.01.1984, 20.01.84, 01.02.84, 20.06.84, 29.09.84, 01.10.84, 12.06.85, 22.10.85, 31.07.86, 28.08.86, 29.08.1986.

⁹ Karl-Erik Larssen, Leiv S. Bakketeig, Per Bergsjø, Per H. Finne (et al.); *Vurdering av perinatal service i Norge 1980*, (Assessment of perinatal service in Norway 1980), Oslo; NIS-rapport 7/1982.

¹⁰ The perinatal period is defined as the period from 26 weeks gestational age until one week after birth.

¹¹ NIS-rapport nr. 7/1982, jfr. Adresseavisen 17.02.1983

not conclude that screening of pregnancies with ultrasound would be an adequate resource in this approach. The following year, in 1984, a governmental report about maternity care was presented.¹² The conclusion was that different aspects of the health care system could and should be improved, a.o. by a stronger degree of centralisation. An ultrasound screening programme was also discussed, but not recommended: Medical gains were not documented, and the costs were too high.

Some interesting articles then occurred in the newspapers, which illustrates one of the main controversies from these first years. The researchers (a.o. epidemiologists) stressed the point of negative cost-benefit-assessment, and got some publicity on this. Rather boring articles, in some ways; informative about the research work, but not suitable to engage the general readership.¹³ Two days later the same newspapers presented the medical team of a hospital which had reduced the death rates for infants with 50% - thanks to ultrasound diagnostics and some other efforts.¹⁴ These articles are what I will call the start of a rivalry for public attention and legitimacy through the mass media. On the one hand the researchers concerned with statistics, public and health economics, telling that ultrasound diagnostics for every pregnancy are expensive and without known medical gains. On the other hand, a clinical staff (gynecologists, obstetricians), stating – through the presentation of their own statistical material – that they saved newborn babies.

In this first period both pregnant women, midwives and female medical professionals, are lacking from the media's presentation. It is strange to see how mass media dealt with this important issue for maternity care, without taking pregnant women into account. Instead, the clinical professional men were in a sense presented as talking on behalf of the women.

In this introduction phase for ultrasound diagnostics, the activities were not a dominant subject in the mass media. Discussions among professionals emerged from time to time, but always on a very general level. In part this may be because the practice was rather un-established, and there were still no sensations to talk about. The reports were also characterized journalistic distance (negative modality), in the sense that they mostly referred to what the actors said. Without any special public engagement, the clinicians could define their own practice, deciding who and how many to examine etc. within each hospital.

¹² NOU 1984:17, *PERINATAL OMSORG I NORGE. Helsearbeid blant svangre og fødende kvinner samt nyfødte barn.*

¹³ Aftenposten 18.01.1984, Adresseavisen 19.01.1984.

¹⁴ Aftenposten 20.01.1984, Adresseavisen 21.01.1984.

In 1986 the first Norwegian consensus conference was held. The subject was the use of ultrasound diagnostics in pregnancy, particularly the question "to screen or not to screen" all pregnancies this way. The conference went for screening, which later became formalized policy. From 1986 all pregnant women have the opportunity to get an ultrasound examination, but they are free to refuse it.¹⁵ The consensus conference did not result in closure of the statistical debate, but rather in its confirmation. For the mass media, however, the ultrasound issue lost interest as long as it remained a question about statistical benefit analysis. When the question later came on the agenda, it was as a question about ethics – an issue which was largely ignored by the media in this first phase.

Ethical aspects connected to ultrasound diagnostics, were neglected by Norwegian journalists through most of the 1980s. The media focused on ethical problems concerning IVF (in vitro fertilization) and amniocentesis, while ultrasound diagnostics were treated as an economic issue. For the clinical experts this was not the case. They examined fetuses, they sometimes found malformations, and they had to deal with the problems of selective abortions etc. Dr. Eik-Nes argued for discussing the ethical issues at the first consensus conference, on the basis that findings of malformations would be the central issue confronting ultrasound diagnostics in the following years. During the 3 days the conference went on, the professor was given 10 minutes to present that theme: The organizers did not want to stress these aspects at the time.¹⁶

Nevertheless one might imagine that the media took ethical approaches into account, but they were silent. Prenatal diagnostics were discussed in general, but the focus was implied to be amniocentesis. The main subject in these discussions became the possibility to choose what kind of babies we want. Actors in these discussions were men; experts within medicine, genetics or philosophy, and laymen – the latter particularly from Christian organisations. But the subject of ultrasound technology seldom was mentioned in these discussions, nor were the clinical experts who worked with ultrasound active. And the mass media let them be silent, though it of course was known that ultrasound diagnostics deals with the same ethical issues as amniocentesis, when it comes to diseases.

¹⁵ One argument against this policy has been that the voluntariness is illusory: To refuse an offer of ultrasound examination makes the mother more responsible for her child's health. Berit Schei; "Gynekologen - på hellig grunn?" in Agnes Andenæs et.al.; *Epler fra vår egen hage*, Trondheim/UNIT; Senter for kvinneforsknings skriftserie nr. 4/92.

¹⁶ Interviews done by Ann R. Sætнан, presented at the joint annual meeting of 4S and SHOT Oct. 1995: *Command Performance - a sign of success or failure for Norway's first consensus conference?*

Other issues were also largely ignored by the media. During this introduction phase, there were a lot of decisions to be made about the organisation of ultrasound activities. The media didn't give much attention to this, but some aspects came up. The expensive technology was mainly obtained by the regional hospitals, while most general practitioners neither had competence nor money to get it. In a small country like Norway, this seemed to be the most rational way to do ultrasound screening. This centralisation of health service has, as I found, been subject to only limited protests from general practitioners.¹⁷ This doesn't have to mean that consensus was achieved, but the media were not concerned about this.

Another issue was which profession(s) would perform the ultrasound examinations. From the beginning it seems to have been gynecologists, some of whom had studied abroad and brought the technology and competence into Norwegian hospitals. When ultrasonography became a routine, however, the question about professional competence came up. In 1986, when 85-95% of all pregnancies were examined by ultrasound, midwives laid claim to this work as a part of routine prenatal care and thereby of midwifery. The Norwegian association of midwives got support from the leading professor in ultrasound practice, dr. Sturla Eik-Nes in Trondheim. He emphasized that qualification for ultrasound examinations only could be achieved by long training and special education. He wanted midwives to be responsible for the routine screening; a.o. because they were clever at communication and explanations for the women.¹⁸ He pronounced that the examination would be qualitatively better if performed by midwives.¹⁹

The Norwegian association of midwives then contacted dr. Eik-Nes to prepare a national standard for ultrasound education at his laboratory in Trondheim. At this time, dr. Eik-Nes was trying to make this laboratory a national centre for ultrasound examinations. In Trondheim, the training of midwives for this purpose was started in 1985. The inquiry from the midwives' association the year after was positively replied to, but it had to be followed by higher grants. A national certification was formalized around 1989.²⁰ The model from Trondheim implied a certification after theoretical education and 1.500 examinations. When any anomalies or malformations were found, midwives were to hand over responsibility to the gynecologists.

¹⁷ Adresseavisen; (distriktslege Harald Kamps, Bjugn) 16.06.83, (dr. Østensen) 26.11.85.

¹⁸ Aftenposten 11.06.86

¹⁹ Adresseavisen 21.06.86

²⁰ Adresseavisen 08.03.89

An agreement was made between The Regional Hospital in Trondheim and Johns Hopkins Hospital in Baltimore, to exchange students. From Baltimore sonographers were sent to Trondheim, and from Trondheim midwives went to Baltimore for one month stays.²¹ (In Norway education within sonography did not exist.)

These aspects of the organisation of ultrasound services – their geographical distribution, the division of labour, training requirements – have all been subjects of some controversy within and among the professions. Debate can to some extent be found in the professional journals, but has not been opened up to the general public through the mass media.

The period 1986-1990: Age of heroics

Statistical battles aside, the 1980s was a time of "good news and great technological improvements" (!) in obstetric ultrasound. From 1985 the professor mentioned above, dr. Eik-Nes, established an ultrasound laboratory at the regional hospital in Trondheim, seeking to make a national competence centre in prenatal diagnostics and fetal medicine. There were already established connections to the Norwegian Institute of Technology, and an interdisciplinary team worked with clinical and technological improvements. In 1986 the technicians had developed a new Doppler blood flow instrument, which became a success on the international market. Primarily this instrument was developed within cardiology, but it soon became clear that it would be important also for the gynecologists and obstetricians.

From -86, the public presentation of ultrasound diagnostics changed. Now we could see the professor and his staff with babies in their arms; babies who (it s claimed) would have died if their mothers had not attended for routine ultrasound examination. Of course this was good news; both by themselves and as news. They contained all the makings of a front page article: A newborn child, saved from death; happy parents, humanity, technological "revolution" and clinical masterstrokes.²² This kind of articles were often written as the journalists' own statements, and the journalists didn't conceal that they were great admirers of the ultrasound laboratory staff. The positive aspects of these activities were presented without questions. In this way the writings were characterized by technological optimism and technological imperative.

²¹ In 1988 the staff in Trondheim planned to extend this stay to one year. (Adresseavisen 25.06.1988). About Johns Hopkins Hospital; Adresseavisen 20.05.1987, 25.06.1988, 08.03.1989.

²² Adresseavisen 05.06.86, 15.12.87, 23.01.88, 18.06.88, 24.12.88, 12.08.89, 18.11.89, 09.02.90, 23.08.90., 25.10.91, Aftenposten 08.12.84, 07.04.87, 19.04.88, 18.06.88, 24.12.88.

It is often stated that Norwegians have a great deal of patriotism. This has also been a part of the presentation of successful prenatal therapy. The ultrasound technology has been developed and partly produced in Norway, and the scientific and clinical competence has caused attention abroad. Thus these rescues of diseased fetuses in Trondheim have been reported in several regional and national newspapers; with a tendency to emphasize the aspects of fantastic technology and clever medical professionals.

I found it particularly interesting to see how different regional newspapers spoke of the ultrasound laboratory in Trondheim, where most of the fetal therapy takes place. The presentation of events and experts shows variations from newspaper to newspaper, though they are apprehended as sharing the same political views. The newspaper which in general has been most patriotic and uncritical to the technological development and practice, is - not surprisingly - the newspaper from Trondheim, where the ultrasound laboratory is located. Another regional newspaper, from the western Norway, has presented the subject with somewhat more distance and ethical doubt (at least not uncritically to technology and practice). For example, this newspaper has given more room for articles about choice and alternatives to abortion as therapy. These differences are in one way just shades of variation over the same theme; but by comparing articles from different origins over several years, a structure of differences in rhetorics and use of language, headlines and photos becomes visible.

The perspective of the "marvellous new technology" in the late 1980s, gave a lot of attention to dr. Eik-Nes and his staff in Trondheim. Of course because of their competence, but also helped by the mass media, they became the authority within this field; an authority they later have kept and brought into the ethical discussions. The public presentation of their activities has also given weight to the arguments for routine screening of all pregnancies, because many of the malformations found would not have been discovered otherwise. At least this argument has been pointed at in the articles about rescued babies. In this sense, this kind of stories has become a heavy input into political discussions about screening. No statistical materials about health care economics can get the same level of media popularity. This kind of presentation of the new technology gives attention to the clinical professionals, indirectly against the critics of ultrasound screening.

This perspective dominated so clearly in this period that one hardly could find any criticism against the ultrasound experiences.²³ But a new problem turned up in the media, which indirectly was a result of the increased ultrasound control. This was also a kind of professional rivalry:

²³ One exception is a written contribution against dr. Eik-Nes in Aftenposten 08.04.1987 by the female (and feminist) doctors Åsa Rytter Evensen, Janecke Thesen, Kirsti Malterud and Reidun Førde.

Parallel to the positive talk about technology and competence, some of the neonatal departments within hospitals experienced a resource crisis because of an increased number of premature births. The worst conditions seem to have occurred in Trondheim, where the National centre of prenatal therapy is located.²⁴ I didn't expect to find any blame against the prenatal diagnostics, but some of the media talk was clear: Politicians and doctors at the premature department asked, more or less discreetly, whether it could be justifiable to put so much money into the ultrasound diagnostics and therapy when the premature department hardly could keep the small babies alive.²⁵ This was not professional rivalry as such, but a struggle for resources. It is a borderline situation between one group using another for leverage, and criticizing resource distributions which favour that other group. Over several years there has been some dissatisfaction among doctors in Trondheim because the ultrasound team have got a *national* status, which give them extra money. Usually this controversy is handled very carefully, or not at all, in the media. Thus it has not become so much of a criticism against the ultrasound team and their activities.

In this period as well, certain themes discussed elsewhere and at other times during the discourse are more or less ignored by the media. For instance, as in the previous period, pregnant women were not given serious attention in the newspapers – apart, that is, from the articles of successful therapy. In these articles they appeared as relieved mothers, photographed beside the medical doctors, telling that they were taken good care of. These exceptions could not present the views of the "normal" pregnant women, attending for a "normal" routine examination, and finding the fetus OK - as in most cases. The question about what is going on when the pregnant women are offered an ultrasound examination, has therefore not been taken into account in the public presentation of ultrasound diagnostics.

The conclusions from the 1st consensus conference state that information beforehand must be taken seriously; the pregnant women should have a real opportunity to refuse ultrasound diagnostics on the basis of information. At the 2nd consensus conference about ultrasound in pregnancy, in 1995, research was presented which showed that many of the pregnant women believed the ultrasound examination was obligatory. During the about 10 years such an examination has been offered, the share of women examined has always been about 98-99%. If the women believe they have no choice, the health personnel haven't done their duty of inform. But it also illustrates that these questions haven't been properly treated by the press. The reason is probably that this

²⁴ Adresseavisen 29.11.85, 15.10.87, 22.12.88., 11.11.89, 22.11.90 m.fl.

²⁵ Adresseavisen 29.11.85, 11.11.89, 22.11.90, and a lot of articles in Adresseavisen 1993.

subject is not attractive to journalists. The normal and general is not news. It's nothing to talk about...

The same fate, I think, has met the doctors who disagree in the use of ultrasound technology in normal pregnancies. There has always been some opposition, a.o. from a group of feminist doctors and midwives stressing the point of natural (i.e. non-technological) pregnancies and births. These groups have had no news of interest for journalists. Thus they haven't got the possibility to present their views through media, except for some personal writings. In this way the practice of ultrasound screening could become "normal" and heavily established without public influence or criticism worth mentioning. Instead the progress of technological and scientific development got almost hegemony for some years.

The period 1990-1995: Age of humility

In the 1990s, however, the ultrasound screening practice became something to talk about, in a sense which interested the journalists as well as other groups in society. The background was a public report ordered from the government on the subject of "Human beings and biotechnology".²⁶ This report dealt with new technologies within medicine and ethical challenges in this approach. The public discussion lasted (periodically) for 3 years, until the parliament discussed the subject.²⁷ Ultrasound diagnostics was one of the issues in focus over these years, and now the media discourse changed a bit - again. Suddenly the dark side of the marvelous technology appeared. Media now started to describe what happens when malformations are found, malformations which cannot be repaired.²⁸ The "therapy" in many of these cases are abortion, unless the parents want to bear a handicapped child. It was already accepted and well known that the unborn who couldn't survive, or who were very seriously diseased, were aborted. But the question of what a "very serious" disease is, wasn't a subject of public presentation or discussion until the 1990s. (Except for discussions on amniocentesis..)

²⁶ NOU 1991:6, *Mennesker og bioteknologi*.

²⁷ St.meld. nr. 25 (1992-93): *Om mennesker og bioteknologi*, presented by the government 12.03.1993, parliament discussion 10.06.1993.

²⁸ Aftenposten 18.07.1989, 19.07.89, 03.12.90, 27.04.91, 24.11.91, 23.02.92, 26.02.93, 16.03.93, 18.03.93, 01.04.93, 17.04.93, 18.04.93, 21.04.93, 24.04.93, 23.05.93, 10.06.93, 17.06.93, 20.06.93, 05.07.93, 06.02.94, 16.02.94, 18.02.94, 06.06.94, 20.06.94, 10.07.94, 01.02.95, 24.02.95, 25.02.95. Adresseavisen 18.07.1989, 20.07.89, 10.11.89, 17.02.90, 08.08.90, 03.12.90, 22.01.92, 08.12.92, 13.03.93, 10.06.93, 21.12.93, 11.06.94. Bergens Tidende 02.10.1990, 25.01.92, 11.03.92, 30.03.92, 09.04.92, 15.04.92, 10.03.93, 07.02.94, 11.02.94, 14.02.94, 20.04.94, 14.-15.06.94, 28.02.95, 01.03.95, 02.03.95.

Since the subject emerged, the most discussed disease has been Down's syndrome. This diagnosis has given the right to abortion, though it isn't by itself lethal. The prognosis for people having this handicap is quite open: some grow up and act almost "normal", others have great problems of physical and/or mental functions. In 1990, after the presentation of the public report, this diagnosis of anomaly was given special attention in the mass media. It was then connected to ultrasound screening, which in many cases is the technology and the occasion through which the diagnosis is made.

The ethical dilemmas due to prenatal diagnostics should be well known and will not be repeated here. The mass media have to some extent treated these issues as they did with the articles about "the fantastic technology" in the late 1980s; by presenting individual stories, mostly in cases where parents against all odds chose to carry a diseased child to term. In some way these are "sunshine stories", with families who are doing well. (The most famous of these is the grandson of two former prime ministers in Norway: He's got Down's syndrome, and this was not discovered during pregnancy. His mother has several times been presented - saying she's glad she never got the opportunity to choose abortion.²⁹) Of course such individuals are easier to find for journalists than those who choose abortion, or those who regret the birth of a handicapped child and want to speak of that regret. In recent years, however, they have succeeded in finding also a few sad stories, so they can "keep the balance", so to speak. From time to time such individual stories get big headlines, in particular in the newspapers dependent on sale of single copies.

Who has been invited to participate in the media debate about the ethics? For the first time it seems like anybody could present their views of the ultrasound technology: Various political parties, parents, scientists, organisations for the handicapped etc. The media, and the national broadcasting channel in special, have emphasized the point of "objectivity" or "balanced presentation". Usually this means that both eager defenders and convinced opponents are given the opportunity to present their views.

The scientists and practitioners have, in media appearances, often acted as if they are the only ones who know how best to use technology for social benefit. This tendency also characterizes some of the scientists within prenatal testing. The leading professor and head of the national ultrasound laboratory, however, has not acted like this. Despite his conviction that ultrasound screening is an important help for pregnant women, and despite the fact that his staff also are doing late abortions, he has never concealed that the ethical dilemmas are uneasy. An engaging public debate in progress, is a condition for a defensible practice within this field, the sympathetic professor says. In this way he becomes a spokesperson for the common ethical doubt. I think the

²⁹ Last time; 1st page headlines in Verdens Gang (VG) 24.01.1996.

publicity and heroic part he was given by the media in the late 1980s, has led to an extra portion of authority and goodwill when the ethical issues came up. With his sensibility for public relations, it hasn't been easy for the critics of ultrasound screening to confront him in the media. My point is not to criticize the ultrasound laboratory staff, but to show how the media bias in the homogenous technological presentations late in the 1980s has had certain side effects on the ultrasound discourse later.

Conclusions...

Summing up, the media ultrasound presentation has gone through different, rather distinct, phases. The introduction phase 1982-86 was characterized by general discussions mainly on a statistical basis. From 1986-90 presentations of new technological possibilities in a very excited and positive way had almost hegemony in the newspapers. From 1990 main attention has been given to ethical problems and doubts.

The experiences from my analysis tell that the media's power and independence is used in a rather servile way. For instance, the ethical aspects weren't given proper attention until the political authorities put them on the agenda.

Legislation and political discussion about prenatal testing have been characterized by some unwillingness, doubt and bad conscience. This impresses the whole discourse: We want new technology for therapeutic purposes, to help expectant parents and their children, but we don't like to see the dark side of this progress. The Norwegian solution of this dilemma has been to give the main responsibility to the pregnant women themselves and their doctors.

The discourse, and also media's handling of it, deals with two different levels of assessments. There is one social, general level, and there is an individual one. It is a dualism between these two levels, which has also marked the media talk. At the general level, the main question is whether the current use of ultrasound technology is positive or negative for the society as a whole, and the pregnant women as a particular group. There is still no scientific (!) agreement about this question.

At the individual level, there are pros & cons too. But the media presentation is almost exclusively positive; and the way of presenting sunny individual stories has probably impressed the readers more than both general reports and the few negative individual stories. This has a.o. to do with the use of first page headlines and big photos of beautiful babies. I think this has been the main problem for the critics of ultrasound screening - they lack the individual touching stories, and it is therefore more difficult to engage the public - and the journalists. This refers to both the scientists and practitioners concerned about health economics and the feminists with their ideological talk

about "technological" versus "natural" pregnancies. This may help explain why ultrasound defenders have prevailed the media discourse.

— Ullevål sykehus, 21. da.
Helene har fått en søster.
Kathrine og Bernt Sveen.

Adopsjon

— Jons søster er kommet hjem,
født 5/7-88.
Ragnhild Rosenberg Hagen
og Knut Hagen.

Crzy galleri drar utenlands

Den nystartede nordiske kunstgalleri-kjeden, Crzy Gallery, vil markedsføre norske kunstnere på det internasjonale marked. Kunstgalleri-kjeden har langitt avtale om distribusjon av norsk kunst gjennom den nederlandske galleri-kjeden Verkerke International, som igjen har leveringsavtaler med nærmere 50 000 gallerier over hele verden, opplyser Morten Eikert, som er en av initiativtagerne til den nye norske galleri-kjeden.

Vossa Jazz må ha hjelp

Jazzfestivalen på Voss gikk med cirka 300 000 kroner i underskudd i år. Som en forebyggende tiltak, det opplyses, er det på 10 000 kroner, som arbeidsutvalget i festivalen har stilt seg personlig ansvarlig for. Å klare å nedbetale lånet over festivalbudsjettet over fem år blir imidlertid for tungt, forteller Bergens Tidende. Jazzfolket har derfor gått til kommunen, fylke og stat med søknader om hjelp til å betale gjelden.

Nye doctores

Under det medisinske fakultet ved Universitetet i Oslo er følgende kreert til nye doctores medicinae: Reino Heikkilä, Per Engnebret, Berdahl, Christian Fredrik Lindboe og Halldan Thlen.

Jon Einar Dahl er kreert til doctor odontologiae under Det odontologiske fakultet, Dag Hoffoss er kreert til doctor philosophiae under Det samfunnsvitenskapelige fakultet. (NTB)

Callfisk

Oslo (NTB)
Trekning nr. 44 i Statens premieobligasjonslans 1971 grønn farge ble foretatt mandag.

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Uten ansvar for mulige feil

NORDISK Ministerråd har bestemt at en utstilling av nordisk kunst fra 1890-tallet skal utenlands. I samarbeid med The Arts Council of Great Britain.



Professor Sturla H. Eik-Nes i ferd med å undersøke en gravid kvinne med ultralyd. En tid da hver helsekrone

bør brukes med omhu, bør alle gravide få ultralyd-undersøkelse, mener han. (Foto: Knut Enstad)

Norsk forskningsprosjekt viser:

Lønnsomt å gi alle gravide undersøkelse med ultralyd

— La alle gravide kvinner få tilgang på ultralydundersøkelse. Det lønner seg! En av våre fremste eksperter på ultralyd, professor Sturla H. Eik-Nes ved regionsykehuset i Trondheim har gjort et enestående forskningsarbeide på

SYLVI LEANDER

I tider da hver helsekrone bør brukes med fornuft, burde det være mulig å vinne geiser for forsøket om å innføre rutineundersøkelser med ultralyd på alle gravide kvinner, mener Eik-Nes, gynekolog og formann i Norsk Forening for Ultralyddiagnostikk. De kroner man investerer til ultralyd-screening, vil man blant annet få igjen i form av kortere sykehusopphold, påpeker han.

Måten kan det være nødvendig å bruke penger på til å opplyse om problemfri svangerskap? Ja, mener Eik-Nes. Fordi ultralydmetoden gjør det mulig å se fosteret med alle dets organer, vil man ganske ofte oppdage uventede ting, som den ytre undersøkelsesmetoden ikke kan avsløre.

I det forskningsprosjektet som Eik-Nes gjorde i samarbeid med barnelege Ove Økland, tok de for seg 1800 gravide kvinner. Det er dermed den største undersøkelsen som noen gang

er gjort på dette feltet. Halvparten av kvinnene ble undersøkt med ultralyd i 18. og 33. svangerskapsuke. Den andre halvparten fikk ikke tilgang til ultralyd. En analyse av materialet viser at ultralydgruppen ikke medførte noen kostnadsøkning i forhold til kontrollgruppen. Derimot var den medisinske gevinst åpenbar.

— Ultralydmetoden gjør det mulig å foreta visse målinger i 18. svangerskapsuke (ikke vekt og lengde) som forteller oss eksakt fosterets alder. Dermed får vi også en sikrere fødselstermin. Undersøkelsen har avdekket at det egentlig er langt færre kvinner som går over tiden enn hva man tidligere har trodd. Fordi terminene blir felberregnet, får vi en rekke kunstige fødselsdatoer. Disse blir prøvetert frem uten at fosteret er «fullmodent», noe som er medisinsk uheldig, understreker Eik-Nes. At terminene i ultralydgruppen ble riktig fastsatt, gav en betydelig reduksjon i antall liggedager på sykehuset.

området. — Menneskelig sett, medisinsk og økonomisk har rutineundersøkelser med ultralyd gitt overvelende positive resultater. Ultralyden har gjort fosteret til en selvstendig pasient, sier Eik-Nes.

Tallet på kunstig igangsatte fødsler ble redusert fra 11 til 10 prosent, påpeker han.

— For å få et mest mulig sunt barn, er det viktig at fosteret får tilstrekkelig med ernæring i livmoren. Også her kommer ultralyden oss til hjelp, forklarer Eik-Nes. Risikofostre som av en eller annen årsak får for lite næring i mora liv, kan legene vurdere å ta ut for å gi dem bedre vekstvilkår i kveve under intensivt bevakning. I ultralydgruppen var det følgende færre fostre som døde på grunn av veksthemming.

At man på et tidligere tidspunkt kan fastslå tvillingfødsel, er også en av de gevinster ultralydmetoden gir. Blant annet kan moren på et tidlig tidspunkt innstille seg på situasjonen og avlaste seg selv. Tvillingene i ultralydgruppen viste seg å ha høyere fostervekt enn de i kontrollgruppen.

Ultralyden gjør det også mulig tidlig å fastslå om fosteret har grove, dødelige misdannelser. Blir dette registrert, vil kvinnen kunne ta stilling til om

hun vil fullføre svangerskapet eller ikke.

I andre tilfeller kan man bli oppmerksom på misdannelser hos fosteret som krever sykelig behandling etter fødselen. Fordelen er da at legene kan forberede seg i tide på livreddende behandling.

— Ultralyden har gitt oss fosteret som pasient. Neste skritt i forskningen er å gi fosteret behandling mens det er i morens liv. Blant annet er det gjort forsøk med å gi fosteret blodoverføringer, opplyser Eik-Nes. Man arbeider nå med metoder for å ta blodprøver av fosteret.

Idag er rutineundersøkelser med ultralyd på gravide kvinner innført et par steder i landet. Selv i vrer Eik-Nes for at dette tilbudet må komme alle kvinner til gode. For selv om nesten alle svangerskap ender godt, så er dette en periode i kvinnens liv som ofte er forubundet med angst og uro. Å få vite at barnet du bærer er vel skapt og frikt, gir stor lettelse og trygghet, mener Eik-Nes.

Afri hjel ska kac

EINAR KR

Matvarehjelpelsene i Canada k. mengder t akkurat nå om hjelpel er blitt at forhold til gitt tjor. ligger over Sahel, takl med regn lagrene fle te. Tilsaget tusen tonn fra Europa ka truer r kaos, mek sjonale byi

Det er den t gingen av ti for en stor paradoksa enn et år eft all sin gru v opinion til i land er korn god høst. Side, redak Bulletin. — hel synes he at det blir ne gen i måned

Nå truer hjelp med nettopp på a Faso (tidl mottar i dia korn fra El og andre gi dig er det r tagerlandet. sjonen har Hjelpetrans utlandet til i sert på anak kekatastrofi ger alene a 340 000 tonn gal får 118 neberer en varehjelpen fra 700 000 t millioner to

Delet av komme til i slutningen den. Men eft i juni og br mengder, b umulig inn umuliggjort transport, i grenen var hjelpen så i rammet lar hadde fått matvarehje fram til sep En EF-k gjennomsnier av denne 400 dager fo

A typical presentation of pregnant women...

"Aftenposten" 22.10.1985.

nitt

8

det dode HTLV III. man reitit

Helbredet i mammass liv

Marianne laget medisinsk historie

Da lille Marianne så dagens lys for første gang på Regionsykehuset i Trondheim tirsdag ettermiddag, var hun aldeles ikke ukjent hverken for jordmor eller leger. De hadde studert Mariannes utvikling tre ganger i uken siden hun var et lite foster inne i mamma Gretes mag. Ja, Marianne

var utvunnet. Tilstanden utviklet seg videre til stor hjertesvikt med stor hevelse i fosterkroppen. Utten behandling ville fosteret med stor sannsynlighet ha dødd.

Normal anatomi

Med ultralyd konstaterte vi at fosterets anatomi var normal, men hjertet hadde altså en elektrisk rytmeforskyrning. På dette tidspunktet var fosteret 27 uker og for lite og svakt til å forløses med keisersnitt. Vi besluttet derfor å behandle fosteret via moren ved å

gjøre mer hjertesykende medikamenter. Hun fikk det som tablettene, og disse ble tatt opp i morens blod og videre til fosterets kretsløp. Medikamentene påvirket fosterets hjerte — etter tre dager slo hjertet normalt og etter to uker var størrelsen på fosterhertet normalt. Medikamentene hadde ingen negativ effekt på moren.

Det er ikke så ofte man behandler foster i mors liv. Det er ultralyddiagnostikken som har gjort dette mulig. Jeg har tidligere behandlet foster i Ålesund, men det er første gang at vi her ved Regionsykehuset både har diagnostisert og behandlet foster i mors liv og så forløst det, sier Sturla Eik-Nes.

Sammen med jordmor Eva Tegmøller og barnekardeolog, førstteamansvarlig David Linker, har han hatt Mariannes utvikling og behandling under full kontroll i mange uker, og det var et lykkelig løslat som «litasid» ettermiddag kunne ta imot sin «pasient», som

Ø GERD ISERN
LEIF KNUTSETH (foto)

Kvart over fire tirsdag var gjeden stor. Fosteret med hjertesvikt ble til slutt født på helt normalt vis — det var en sprell levende liten jente som kom til verden og laget medisinsk historie ved fødsel. Hertebehandling i mors liv hadde vært vellykket i Marianne, ble født med normalt hjerte.

Gleden og takknemligheten over å ha fått en frisk liten jente uten hjertesvikt er ubeskrivelig. Jeg har vært så redd — Jeg fikk vite gjennom rutinekontroll at jeg var seks-ått uker på vei til hjertelegene til barnet mitt var uregelmessig. Hjertet slo 270 slag i minuttet, forteller Marianne mamma, Grete Tveite fra Moholt.

Takknemlig

Jeg var redd det skulle gå som for fire år siden — da mistet jeg et fullblutt barn. Min takknemlighet er stor overfor legene ved RIT og jordmor Eva Tegmøller som har hatt Marianne og meg som pasient tre ganger i uken i 12 uker. Tenk at det går an å behandle et foster i mors liv, sier Grete Tveite (30), som i går fikk vite frem til fosteret Marianne til storester Elisabeth på tre år.

Vi har simpelthen brukt moren som transportsele for det hjerte- og kretsløpsmedisinske teamet. Det var det som var viktig, sier Marianne som i 12 uker har gått Marianne som professor, overlege Sturla Eik-Nes ved Kvinneklinikken. — Da fosteret var syv uker gammel, ble det oppdaget at hjertelegene periodevis var ute på ferie. Det slo så raskt at det ikke klarte å pumpe unna blod — det ble en stuvning av blod i hjertet som gjorde at blodet ikke fikk komme ut. Dette kunne vi lett se med ultralyd. Vi så også at fosterhertets forkant og navlevene



Stor glede i samlet som har hatt Marianne under behandling og full kontroll med ultralyd i 12 uker. Professor Sturla Eik-Nes (t.h.) og barnekardeolog David Linker. — Marianne har gjennomgående fremtidsutsikter, sier de. I går på barselvisitt på Barneavdelingen sammen med Grete Tveite, som nå leder seg til Å. Marianne ut av kuvosen.

Foto: LEIF KNUTSETH

Heldig pasient

Lille Marianne var heldig som få andre gammel ble pasient akkurat i Trondheim. Samarbeidet RIT har med NTH/SINTEF gir helt spesielle overvåkningsmuligheter av blant annet blodstrømning hos foster. Den spesielle apparatur som er brukt for å overvåke Mariannes hjerte er et ultralyddiagnostisk utrustet ved NTH/SINTEF som følger blodstrømmen i farver. Dette instrumentet ble for et år siden presentert i Adresseavisen da det var på utviklingsstadiet, og det er først nå tatt i bruk. Marianne er derfor den første pasient

Marianne hvile svane igjen på belgen «Skibladner» kastet seg tirsdag ut på belgene igjen. Dermed åpner en ny sesong for den 150 år gamle hvaldamperen på Mjøsa. Flere charterturer er allerede fulltegnet.

Ferie og fritid!



Presentation of professor Sturla Eik-Nes and his team, and Marianne, successfully treated for heart problems.

"Adresseavisen" 05.06.1986.

Ultralyd kan avsløre foster-misdannelser

Ultralydundersøkelse av fosteret åpner nye muligheter innen nyfødtmedisinen og kan bidra til at barn med medfødte handicap får en bedre start, mener ekspertene.

ANNE LISE STAFNE

— Det er tidligere oppnådd enighet om at alle norske kvinner bør få tilbud om én ultralydundersøkelse i 18. uke av svangerskapet. Lønning-utvalget har så vidt jeg forstår ikke rørt ved dette, men har gitt lav prioritet til ytterligere rutineundersøkelser. Det er en fornuftig vurdering når en ser på landet som helhet, sier overlege, professor dr.med. Sturla Eik-Nes ved Regionsykehuset i Trondheim.

— Vil man gå videre med flere undersøkelser, må det være av medisinske årsaker. Ved første gangs ultralydundersøkelse, oppdager man 30–40 prosent av utviklingsavvik hos fosteret. Det er en viktig forskningsoppgave å finne ut om gevinsten vil være stor nok til å rettferdiggjøre en rutineundersøkelse også i 32. eller 33. uke av svangerskapet. Her, ved Kvinnekliviken i Trondheim er vi nå i gang med dette, men svaret vil vi ikke ha før om et par år, sier professor Eik-Nes.

— Ved å legge inn en undersøkelse nr. to, vil man kanskje, hvis den utføres av trenet personale, oppdage f.eks. vekstsvik eller misdannelser i hjerte eller nyre- og urinveier som ikke er oppdaget ved første undersøkelse. Nyfødtmedisinen er gledelig høyt prioritert av Lønning-utvalget, og vi mener at ultralydundersøkelse må sees som en viktig del, som en «bro» fra svangerskapskontroll til behandling av den nyfødte. Det vi finner ved slike undersøkelser kan tilsi at man etterhvert vil komme til å utføre korrigerende inngrep allerede i fostertiden. Slike operasjoner har vi utført flere ganger ved misdannelser i urinveiene.



Professor dr.med. Sturla Eik-Nes ved Regionsykehuset i Trondheim har vært en banebryter for ultralydundersøkelse i svangerskapet. Han er enig med Regjeringsprioriteringsutvalg i at metoden må brukes mer kritisk enn idag, og er nå i gang med et forskningsprosjekt som skal vise om en rutineundersøkelse nr. to har nytteverdi. (Foto: Morten Antonsson)

Denne tilstand kan føre til opphopning av urin som, hvis det ikke blir oppdaget, kan gi livstruende infeksjoner etter fødselen. Her ved Kvinnekliviken, har vi akkurat åpnet et nytt laboratorium for å kunne gi effektiv hjelp i slike tilfeller.

De funn man gjør gjennom

ultralydundersøkelse, kan også tilsi at man endrer tidspunktet for forelesningen, eventuelt foreleser ved kelseersnitt og øker graden av overvåking. I noen tilfeller vil eksperter i barnekirurgi være til stede ved fødselen, sier professor Eik-Nes. Han understreker at ultralydundersøkelser, ennå er en ny metode, og den er krevende å bruke fordi bildene er så detaljrike og vanskelige å tolke. Det er derfor viktig at de som skal utføre slike undersøkelser rundt om i landet, får opplæring ved de sentra som idag ligger lengst fremme.

Den siste tsar, Nikolai, hans familie, fikk et endeligt. Men hun av tsaren, tsarina Alexandra Fjodorovna og de barn i Jekaterinburg, 1918 var ikke et resondskap fra bolsjide. Det er helle grunn til å gråte av skjebne.



Russlands siste tsar, fotografert i høyre. Lenin visting om familiens 1918, hevder den historikeren Genri

Nyt fam

Bolsjevik-leder genting om dragder en sovjetisk

KJELL DRAGNES

Moskva, 16. juli. Den siste tsar, Nikolai, hans familie, fikk et endeligt. Men hun av tsaren, tsarina Alexandra Fjodorovna og de barn i Jekaterinburg, 1918 var ikke et resondskap fra bolsjide. Det er helle grunn til å gråte av skjebne.

Det slår historikere rikk Ioffe fast i en artikkel om tsaren. Sovjetskaja Rossija tikkelt som fyller ut mange «hvite flekker» i historien som opphav til både lege ikke minst mange om den siste tsars ger. Artikkelforfatter det selv klart at spør har vært mange, og nærmere inn på de heter som bidro til a abdiserte etter februsjonen året før.

Poin ilko

B

SYLV

Voksen farlig ligg utsatt brent nyere for al brent, er, jo besky

Professor Eik-Nes with a baby in his arms.

"Aftenposten" 16.07.1987.

Spesilt foreldre rilig lys

reft har år. Det igste av en. Den i kjenne pen, mer Blir den den spre r lymfe-

**PHILIP
WILLOCH
SYSEs
MAMMA:**

GLAD hun slapp ABORT- valget

**LEON:
LEI
SEG
etter
bruddet**

● RAMPELYS

**GRAVID
JORDAN
ROMIE**

■ USA-politiet jakter på
Cindy Garcia (10). ● SIDE 8

CECILIE LEGANGER:

• Bærer
**IKKE
NAG**
til Marit

● SPORTEM

■ ■ Sjarmtrollet Philip Willoch Syse er født med Downs syndrom. Mamma Cecilie Willoch er sjeleglad for at hun aldri fikk valget om å ta abort. Da vet hun ikke hva hun ville gjort. Nå kaster hun seg inn i sen-aboridebatten. ● SIDE 6 og 7