lent outcomes, and most women are likely to place a higher value on the benefits of planning a vaginal birth than on the risks. However, my plea is that we also respect and honour the views of the women who place a higher value on the risks, preferring instead to plan a cesarean procedure. I agree with Michael Klein that most of the research concerning risk of urinary incontinence has examined such risks over the short term and that an elective planned cesarean does not prevent all incontinence. However, overall, the current evidence indicates that elective cesarean is associated with a lower risk of incontinence than vaginal delivery. Klein infers that the benefits of interventions during labour and delivery, such as induction, are not sufficiently adequate to justify their widespread use. Surely this is a judgement for the woman and her physician or midwife to make. Also, research suggests that most women are extremely "fetal risk averse" and would choose cesarean section if this could prevent even a very small increased risk of stillbirth or neonatal death.[4] I find it surprising that Klein estimates it would take up to an hour to inform a woman about her options for delivery. However, if this is true, consideration should be given to developing a patient information sheet detailing the options, along with their risks and benefits.

Selon Catherine Gerbelli, l'accouchement vaginal spontané à la maison serait peut-être plus physiologique que l'accouchement vaginal spontané à l'hôpital. J'en conviens, il faudrait signaler cet avantage éventuel, en même temps que les risques éventuels, aux femmes qui envisagent d'accoucher à la maison.

It is quite likely that only a small minority of women will choose a planned cesarean, but those who do so make the choice for reasons that are important to them. According to them, the opportunity to exercise that choice is consistent with the ethical principle of patient autonomy, which has largely replaced the paternalism so long associated with the provision of obstetric care.

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## New letters submission process

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## Corrections

Due to a clerical error, a death notice for Douglas H. Graham[1] was published in error in the May 25, 2004, issue. Dr. Graham continues to practise at St. Paul's Hospital in Vancouver. We regret this error and offer our sincere apologies.

**Reference**

1. Deaths. *CMAJ* 2004;170(11):1759.

DOI:10.1503/cmaj.1040864

The DOI prefix printed in *CMAJ* issues between March 2, 2004, and May 25, 2004, was mistakenly printed as 10.1053 rather than 10.1503. For example, the DOI "10.1053/cmaj.1040594" should have been printed as "10.1503/cmaj.1040594."

DOI:10.1503/cmaj.1040948

In a Clinical Vistas article describing a man with mesothelioma and neck swelling,[1] a statement about Virchow's triad should have referred to endothelial (rather than epithelial) injury as a predisposing factor to intravascular thrombosis.

**Reference**

1. Schattner A, Kozack N. A 47-year-old man with mesothelioma and neck swelling. *CMAJ* 2004;170(4):465.

DOI:10.1503/cmaj.1040949