



Female autonomy and elective abdominal delivery

To the Editor: I congratulate the Editor¹ and Dr Hugo-Hamman² on recognising the significance of respect for female autonomy in this debate. This was overlooked at the high-profile meeting held at Tygerberg Hospital last year, where a diverse body of speakers took critical positions.³ Several issues concern me about that meeting: the presence of funders, the fact that medico-legal experts were required to pronounce on moral issues, but mostly, the absence of a bioethicist. The issue of respect for female autonomy was consequently not even raised.

The medico-legal expert suggested that elective abdominal delivery without a clear medical indication might be construed as an unnecessary operation, with the possibility of judicial repercussions should complications arise. If this were true, how can we even contemplate elective cosmetic, and many other forms of equivocally indicated surgery? If it were indisputable that vaginal delivery produces better outcomes for all the anti-choice group might have a case, but this does not seem to be the case (not that I am an expert in this field!).

The essence is that the woman has an autonomous right to informed choice on her body. Isaiah Berlin stated the principle of personal autonomy in the most beautiful prose: 'I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not other men's act of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes which are my own, not by causes which affect me, as it were, from outside. I wish to be somebody, not nobody – a doer, deciding, not being decided for, self-directed and not acted upon by external nature or by other men.'⁴

Personal autonomy should be limited only in so far as my choices might affect others without their express consent. Before birth, the fetus has no legal status. I would argue that it has moral status, although others, particularly utilitarian philosophers, would disagree. The (competent) woman is nevertheless its only spokesperson. Of course the concerned clinician will, in a way, act as advocate for the fetus, but the choice remains that of the woman. The question is whether we are expected to comply with her request. As long as treatment is medically acceptable, not particularly hazardous, and within our expertise, the answer is yes, although in a non-emergency case I presume a doctor who was strongly opposed might refer the patient.

The issue of funding is obviously a different matter, but forcing vaginal delivery on a woman is an act of unacceptable and perhaps even cruel paternalism.

I urge that bioethicists be included in discussions of this nature. We often confuse morality with rules and laws; the

latter is the domain of the medico-legal expert. Clinicians might be pleasantly surprised at the depth of the contributions of bioethicists.

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1. Ncayiyana DJ. Elective abdominal delivery – should mothers have the right to choose? (Editorial). *S Afr Med J* 2005; **95**: 192.
2. Hugo-Hamman C. Caesarean section – claims and concerns (Letter). *S Afr Med J* 2005; **95**: 200.
3. Bateman C. Rendering unto Caesar? *S Afr Med J* 2004; **94**: 800-802.
4. Berlin J. *Two Concepts on Liberty*. Oxford: Oxford University Press, 1969.

The possible 'tsunami effect' of the 2-year internship – an early warning

To the Editor: We would like to bring to the attention of your readers the implications for junior doctors and their managers over the next few years of the new 2-year internship as promulgated by the Health Professions Council of South Africa (HPCSA).

Curricular reform in South Africa resulted in some, but not all universities embarking on a 5-year MB ChB degree. The need for an extended and more encompassing internship training programme, which included exposure to all domains relevant to the South African situation and addressing the need for doctors and services in South Africa was planned long before the wave of curricular reform reached South Africa. The first 134 graduates who complete their degrees from Unisa and Free State universities in the revised curricula, are currently in their first year of the 2-year internship at selected hospitals around the country. The university of KwaZulu-Natal will produce a total of about 334 graduates at the end of this year, comprising 170 on the 5-year track and 160 on the old 6-year curriculum. The implementation of the 2-year internship has been pragmatically staggered, after extensive negotiations with all stakeholders, to allow successive groups of new graduates to enter the community service (CS) pool and wider market, in the least disruptive way possible. However, there will still be radical shifts – a 'tsunami effect' of doubling the number of interns can be anticipated in terms of its effect on posts, teaching and CS. This includes the radical withdrawal of CS doctors in 2008, analogous to the recession of water from the beaches before the tidal wave.

Seeing the horizon move from the top of a coconut tree, we would like to alert the medical community to the wave that is on its way. If managed proactively with proper human resource and financial planning and transparent negotiations between all stakeholders including the universities, the