Female autonomy and elective abdominal delivery

To the Editor: I congratulate the Editor[1] and Dr Hugo-Hamman[2] 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 Unitra 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

Department of Health, the Health Professions Council of South Africa and junior doctors, this 'tsunami effect' can and should be prevented.

Medical students who graduate successfully after 1 July 2006, regardless of their university of origin or duration of undergraduate curriculum, will have to undergo the 2-year internship comprising 4 months each of medicine, surgery, obstetrics and gynecology, paediatrics, and family practice/primary health care with exposure to mental health. There is also a 2-month rotation through orthopaedics and orthopaedic trauma and 2 months through anaesthetics. The laudable aim of this change is to make our graduates more competent doctors, so that by 2009 we should have CS doctors who are better prepared for the challenges of the public health system. The provincial departments of health, the HPCSA, the Junior Doctors Association of South Africa (JUDASA) and the human resource managers from central government are currently jointly addressing the implementation of the 2-year programme.

Table I gives an idea of the numbers that can anticipated and the issues that need to be managed.

Firstly, a doubling of the total number of interns has major implications for the post allocations and budget requirements of regional and central hospitals. For those peripheral hospitals unable to offer the full 6 domains, the option of forming complexes with other institutions is being negotiated. In most

Table I. Anticipated effects of the 2-year internship

Year	Total intern posts	1-year interns	2-year interns		Community service
			Year 1	Year 2	
2004	1 399	1 399	0	0	
2005	1 510	1 376	134	0	1 399
2006	1 765	1 275	356	134	1 376
2007	1 965	0	1 609	356	1 409
2008	3 176	0	1 567	1 609	356
2009	3 072	0	1 505	1 567	1 609

instances the effect of the new system will be to concentrate interns in the cities, and utilise the more peripheral hospitals for CS. Some of the provinces, however, have taken up the challenge to re-look at the staff establishments of their more peripheral hospitals and to strengthen their supervisory support for interns. In those institutions that will not be able to offer all 6 rotations, the substitutions of CS doctors will be the solution in that they will be better prepared after 2 years of supervised practice in all domains.

The year 2008 presents particular challenges, with a maximum of only 356 potential CS applicants countrywide, less than one-third of the usual number. This figure is likely to be even less owing to failure and dropouts along the way. Since CS was introduced in 1999, most public service hospitals have become very dependent on CS to provide a constant source of medical staff. This has been a largely positive experience for all concerned, and the temporary withdrawal of these young doctors could be disastrous for the health services, particularly in the 'difficult-to-staff' institutions in rural and under-served areas.

However, every threat is also an opportunity. All stakeholders involved in the change process need to put differences aside, tackle the challenge and show that good planning, transparent negotiations and commitment to a common goal can succeed. The common goal in this instance is the production of young doctors who can meet the challenges of the health needs of the entire South African community.

The HPCSA will ensure that only institutions adhering to the standards and regulations with regard to internship training will be accredited. This remains a continuous process and is not a once-off occurrence.

As employer, the Department of Health must help identify the most suitable institutions within their human resource plan that will offer sustainable supervision and quality of care as required for internship training.

Interns must realise that internship is an apprenticeship and that they also have a responsibility towards their employer, their patients and themselves to develop into responsible professionals who will honour our profession and its values.

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Changes in reimbursement for anaesthetic valid from January 2005

To the Editor: Having recently returned from a holiday I was extremely dismayed to read in the 11 February issue of *Medigram* that from 1 January general practitioners may charge the same as specialist anaesthesiologists for the first hour of an anaesthetic.

Such authorisation indicates nothing less than an appallingly ill-considered decision, definitely not in the best interests of patients. Any action by any properly caring medical practitioner should always be directed towards the best interests of his/her patient, and consequently whenever anaesthesia is required the most skilful practitioners available at that time should not be precluded form rendering the necessary service by this recent senseless decision. Some surgeons will inevitably feel constrained to accede to the demands of certain general practitioner anaesthetists, especially those who are the source of referral to the surgeon.

The 60-minute time limitation is utterly ridiculous because although stable tranquillity is the usual objective in anaesthesia and numerous general practitioners have experience in the achievement of such a state, life-threatening crises may suddenly occur at almost any stage during surgery, and when these serious problems do arise surely the more extensive experience of a specialist anaesthesiologist may be clearly decisive in affecting a favourable outcome.

Furthermore, bearing in mind the steady increase in population in our country, we should ensure that no regulation exists with the potential to discourage specialisation in any discipline. This will be an inevitability if this new change in reimbursement is not revoked. Specialist numbers in every discipline, and I include the discipline of general practice, should be allowed to grow *pari passu* with the population.

The subject of equal payment for anaesthetics was raised and discussed more than once during my many years of service on both the Federal Council of the Medical Association of South Africa (as it was then known) and the National Executive Council of the South African Society of Anaesthesiologists. Fortunately, sanity prevailed at that time. One is now left wondering which specialty general practitioners will next have in their sights.

What also seriously bothers me is that this recent alteration in fee structure for anaesthetics is also obviously motivated for the wrong reason of financial gain, with no thought for patient safety, which is indisputably the most vital of all considerations.

The sooner this decision is revoked the better for the specialist anaesthesiologist, those contemplating specialising in