



## RENDERING UNTO CAESAR?



Unless private gynaecologists take the initiative to create proper protocols for conducting caesarean sections, the government or the funding industry could step in and force these on them.

The current 'free for all' where specialists are able to conduct C-sections for no apparent medical reason (or fudge a reason to assist patients with medical aid claims) also places them at a significantly increased risk of patient litigation.

Many gynaecologists collude with insistent private patients in what one male funder cynically labelled the 'too posh to push brigade', thus loading the system with unnecessary expense and swelling the coffers of highly profitable private hospitals.

Some funders even claim that this comes at the long-term expense of specialists themselves as their share of the finite medical aid pie is eaten up by the private hospital sector.

At present, 65% of all private patients in South Africa undergo C-sections (for all indications) – almost double the percentages in the UK and the USA, a

cause for disquiet because of the inherent implication.

The equivalent South African public sector figure is estimated at between 10% and 20%, marginally higher than several leading first-world public health systems.

Confidential SAMJ interviews with seasoned gynaecologists from public hospitals that handle private patients reveal a telling common theme.

Unmanipulated normal deliveries are spread across the 24-hour clock, but C-sections have a distinct pattern of occurring at 'convenient' hours (very few after 17h00 and seldom on weekends).

The need for a protocol recently hit the public arena during a panel debate featuring a medico-legal expert and several leading gynaecologists at Stellenbosch University and posing the question, 'Once a pregnancy, always a C-section?'

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Dr Pulane Tlerebe, Acting Cluster Manager, Maternal and Child Health in the national Department of Health (DoH), said a C-section rate of 65% in the private sector was 'way above' the levels recommended by the WHO.

While no discussions about regulation had been held with the private sector, the DoH would be consulting stakeholders 'on the best approach to address the matter'.

'There is morbidity and mortality associated with the caesarean section

procedure, and C-section for non-medical reasons/indications is not supported by the national Department of Health.'

'Women's lives should not be put at risk for the convenience of the doctor, and patients should understand the risks they expose themselves to by requesting a C-section,' she added.

The SAMJ, however, reliably learnt that with the advent of prescribed minimum benefits and medical schemes choosing designated service providers, the DoH has just completed a joint feasibility study on its hospitals to cash in on this new system.

Guidelines for the most expensive and frequently occurring procedures are virtually complete – and C-sections top the list.

Asked about the lack of a C-section protocol, top MacRobert attorney Graham van der Spuy said the well-defined protocol for anaesthetists had significantly elevated practice standards and quality of service, and greatly reduced the risks of litigation.

He was 'astounded' to hear from the over 100 obstetricians and gynaecologists attending the Stellenbosch panel debate that no such protocol existed for them.

'C-section on demand is a very contentious issue. Basically it's virtually impossible to legally justify it for the convenience of the gynaecologist, and really difficult to justify on non-medical grounds for the convenience of the patient,' he warned.

He said medical grounds could include cephalo-pelvic disproportion, the baby suffering stress or the mother developing gestational hypertension.

Other justifiable indications included a particularly traumatic previous childbirth, painful episiotomy and lengthy labour with major distress and pain.

'I would have difficulty defending a practitioner who did a C-section on a whim or for the convenience of a patient, particularly when one bears in mind the risks of bleeding, leading perhaps to a full hysterectomy and things like an amniotic fluid embolism.'

He said any protocol should deal comprehensively with informed consent.

While the argument against normal vertex deliveries includes pelvic floor injuries, urinary incontinence and prolapse, the academic argument favours vaginal delivery.

Professor Jan van der Merwe, Chief Medical Advisor to the Council for Medical Schemes, said it was 'unbelievable' that a group of professionals was prepared to 'sit back'.

'They must absolutely come up with guidelines and then, furthermore, discipline their own members.'

Van der Merwe said good clinical and ethical practice should prevail, 'namely that there must be an indication and the patient should give informed consent'.

As for all procedures, the indication should be so sound that if complications arose (at worst, death), the physician would still be able to justify the decision to operate.

Van der Merwe said it would be 'fantastic if gynaes themselves would come up with an evidence-based protocol and drive it into the market'.

South Africa's private sector was 'way out' in its numbers of C-sections compared with Europe, the UK and the USA, he added.

Professor Hein Odendaal, a former O&G Head at Stellenbosch University, noted that a C-section could be potentially damaging to the intra-uterine brain development of a child.

Van der Spuy said the risks of not having developed a C-section protocol ranged from the obvious professional conduct enquiry to criminal proceedings in the event of death, and

civil claims for damages from both parents and child.

The largest quantum he could remember being awarded to a patient when a C-section was not indicated was R102 million in Kimberley.

The mother had died and the child had survived with brain damage.

Van der Spuy said the average claim for a brain-damaged child was R4 - R6 million, but depended on the extent of brain damage.

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The biggest claims involved future medical treatment and loss of earnings, he said.

The lawyer said doctors felt 'very vulnerable because of the way medicine

has evolved in this country', and tended to practise defensive medicine.

He said doctors were more regularly taken to task for not doing C-sections when indicated.

However, the Stellenbosch debate had not encompassed this, he stressed.

Dr Jacqui Searl, a gynaecologist at Vincent Pallotti Hospital in Cape Town, said that some kind of audit in the private sector was long overdue.

As long as doctors are not honest, 'we'll never really know where we are - we need honesty about our C-section rate and why we're doing it'.

'If I'm satisfied that I've counselled the pros and cons, I can sleep at night - but I draw the line at kidding the patient,' she said.

Van der Spuy said rare legal cases existed where practitioners 'invented' medical grounds to persuade a patient to have a C-section.

'The scope for emotional blackmail is enormous. The patient thinks that if she doesn't have a C-section her kid could be damaged - this is utterly unacceptable,' he added.

Some medical aids insist on an indication being recorded before





considering payment. Others, like Discovery Health, simply pay.

Dr Maurice Goodman, clinical communications chief for Discovery Health, said that Discovery tried unsuccessfully to enforce a pre-authorisation protocol several years ago.

'You had a doctor on this side of the phone asking whether it's really necessary, and another in front of the patient saying yes it is – it wasn't worth the antagonism and tension.'

Discovery chose to 'leave it up to the professional integrity and judgment' of individual doctors.

Discovery's C-section percentage of total deliveries stood at 63%, with the global cost of a C-section typically about 30% higher than that of a normal vertex delivery.

It's not a trivial expense, probably close to 4% of our total deliveries payout which last year was R250

million – any savings would have a significant impact on the spend of medical schemes,' Goodman said.

Dr Johan Dippenaar, another medical aid advisor, said it was time private gynaecologists came into line with other specialties and audited themselves or had some kind of peer review and protocol.

'Everyone does what they want, and we pay in full because we don't know what the reason (for the C-section) is,' he said.

Dippenaar said the funding industry was witnessing soaring hospital costs in comparison to all other stakeholders, with the slice for GPs and some specialists shrinking every year.

'The gynaecologists seem to have no long-term vision – they're doing themselves out of market share and just making the slice for the hospital industry bigger,' he claimed.

He quoted a R4 000 difference in costs between a normal vertex delivery and an elective C-section.

Searl tempered this, saying planned vaginal deliveries could develop complications and result in C-sections after hours, pushing costs up. Theatre costs also had to be compared with labour ward costs.

The Stellenbosch panellists agreed that unless gynaecologists took the initiative around a protocol, one could be forced on them.

With C-sections on the rise internationally, private insurers are beginning to balk at the costs. Quoted in *Time* magazine this April, Dr David Costain, the medical director of the UK's AXA PPP Healthcare, said they no longer covered even emergency C-sections.

Added Costain, 'The number of C-sections we were being asked to pay for was rising so rapidly, and it showed no signs of leveling off. It just wasn't plausible that they were all medically necessary'.

Dr Igno Siebert, the Tygerberg Hospital consultant who organised the local debate, said no gynaecologist present could remember having lost a patient owing to a C-section. This was in spite of international statistics showing a 5 - 8 times higher incidence of morbidity and mortality for C-sections versus normal vertex deliveries.

He said it was clear that emergency C-sections were more risky than elective ones, which suggested favouring elective C-sections over vaginal deliveries to begin with.

Siebert intimated that he was aware of the DoH's silent move to create protocols, 'so we want to be pro-active rather than reactive'.

**Chris Bateman**