

## Vaginal deliveries – is there a need for documented consent?

**To the Editor:** We thank Anthony *et al.*<sup>1</sup> for responding to our article,<sup>2</sup> which was not meant to be prescriptive but to prompt thought, initiate discussion and exchange ideas about the issues raised. We feel we have been successful in raising interesting points that need to be considered. We do not intend responding to every point but highlight some essentials that were missed in their commentary.

Our central tenet is that vaginal delivery is not without its risks, and these hazards may include concerns about intrapartum care and non-medical risks **with potential for medical complications**. As we perceive these risks as 'material', we argue that they warrant discussion with the patient and that it would be prudent to document the conversation. This view is not inconsistent with the law, the regulator or ethics. Obtaining informed consent for a vaginal delivery does not equate to us favouring caesarean section over vaginal delivery, and we do not recommend that people in training should be taught this.

We feel that a weak justification is given as to why our legal arguments do not merit discussion. Medical practice is already regulated by laws that govern the conduct of business either directly or indirectly, The Medical Schemes Act (131 of 1998), Health Professions Act (56 of 1974) which has sections dealing with fees, and The National Health Act (61 of 2003), which also requires a health professional to disclose cost of treatment and management in Section 6 on informed consent. Private practitioners expect that reasonable fees will be paid to them by the patient for appropriate services rendered. This is legal and, where the fees are reasonable, not unethical. Doctors do not lose their professional ethical standards because of charges for services rendered. Public sector professionals are paid a global salary for services rendered. Business ethics exist alongside the doctor's professional ethics and, should the ethical component of either be lost, it is common knowledge that the Health Professions Council can and does punish that person for unethical and unprofessional conduct.

Our paper is not an attack on the public sector nor does it attempt to create an obligation on the State to provide resources for all women to deliver by caesarean section. If anything, the resulting discourse as pertaining to the State should focus on its obligation to provide an environment that allows for safe vaginal deliveries and well-informed patients. We agree with Anthony *et al.* that, where a choice exists, this does not mean that a choice can be made. However, we do not agree that, based on this argument, women should not be given all material information and neither do we agree that the 'therapeutic privilege' should be invoked to justify this approach which, in our opinion, dangerously borders on paternalism.

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## Decriminalisation of drugs

**To the Editor:** The progressive opinion expressed in your February editorial<sup>1</sup> in the traditionally conservative *SAMJ* is to be lauded. The decriminalisation of drugs debate is usually such a political hot potato that no one wants to touch it. However, the war on drug users remains one of society's long-standing civil wars, now being played out on an international stage in Afghanistan, where the quibble is largely over who controls the world's opium supply, 92% of which comes from the poppy fields of that country.<sup>2</sup>

My work in the field of substance dependence treatment for the past 20 years has convinced me that declaring drugs illegal does not in the slightest act as a deterrent for the 10% of drug-dependent users who cause 90% of the drug-related problems. Many problems arising from drug use result from the fact that the substances are illegal, and not from the drugs themselves. Even the very act of being a non-problematic drug user is in itself a criminal event.

The big fear most people harbour is that decriminalising, regulating or even legalising drugs will increase the prevalence of substance use behaviour. While this might be true to an extent, the perception that liberalisation will overwhelm and result in a nation of drug users is unfounded.

The legalisation of commercial gambling in South Africa in 1996 provides useful empirical evidence. Similarly the fear then was that legalisation of this previously prohibited industry would create a nation of problem gamblers. Yet prevalence studies<sup>3</sup> show that the incidence of problem gambling in this country has not increased since its legalisation, despite the dramatic increase in the commercial size of the industry.

The likely increase in the prevalence of substance use that will result from decriminalisation of the activity must be carefully weighed against an inevitable decrease in the massive worldwide morbidity and mortality that currently arises from an illegal industry.

Prohibition of drugs simply creates an underground economy that cannot be taxed, controlled or regulated. It causes corruption and fills the prisons with people found guilty of a victimless crime. It creates extremely lucrative monopolies for those prepared to take the risk, but does very little to deter those intent on drug use, which was the purpose of the prohibition.

Professor Hamid Ghodse, professor of psychiatry and drug policy and several times head of the International Narcotics Control Board and a long-standing drug war warrior, recently stated: 'Legalization arguments don't withstand critical evaluation and run contrary to general expectations. Proponents have yet to produce viable proposals. Liberalisation would irrevocably impact public health, social well-being and international stability.'<sup>4</sup> Our challenge is to manage the problems arising from liberalisation of drug laws rather than bury our heads deeper in the sand, believing that we can legislate the problem away.

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2. United Nations Office on Drugs and Crime. World Drug Report. UNODC, June 2007.

3. Collins P, Barr G. Gambling and problem gambling in South Africa. June 2009. <http://www.responsiblegambling.co.za/media/user/documents/NRGP%20Prevalence%20Study%202006.pdf> (accessed 31 May 2011).

4. Ghodse H, ed. International Drug Control into the 21st Century. Aldershot: Ashgate, 2008.

1. Anthony J, Stewart CJM, Patel B. Commentary on the need to obtain informed consent for vaginal delivery. *S Afr Med J* 2011;101(5):310-312.

2. Dhai A, Gardner J, Guidozzi Y, Howarth G, Vorster M. Vaginal deliveries – is there a need for documented consent? *S Afr Med J* 2011;101(1):20-22.