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The right to dignified death

To the editor: Let us be most grateful to David Cameron for opening up aspects of the care of dying patients.¹ Yes, the patient has the right to refuse treatment (though I am not sure where this right sits in current law). Yes, we must encourage more patients, but also our families and friends, to draw up advanced directives (Living Wills). But the standard format that I am familiar with (and have for myself, as a member of SAVES, The South African Living Wills Society) began some years ago very much in the context of brain death. Thinking about dying with dignity has intensified since then – as David's article shows. I think the many tensions that often arise in, and outside, the sick room between patient, family and doctor (indeed between doctors themselves) should be pre-empted at an earlier stage, by supported and open discussion of what *may* happen, what *might* be involved, and by helping the patient form his/her wishes as central to the process. This is taboo stuff within the culture of many of us, but now is catching up time. We must enrich our social understandings of dying as part of living. At present big brothers of different kinds look over the shoulders of doctors and family members so that it can be difficult to die with dignity! Therefore, as things are at present, I think it is best, *even when we are well*, to write, and share with significant others, a personalised and witnessed letter of wishes, which would go further than a standard advance directive or Living Will by expressing our personal view of these matters, and identifying, *in practical detail and circumstance*, the ways we do and don't want to die.

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1. Cameron D. Food and fluids in dying patients: some thoughts after the death of a patient. SA Fam Pract 2004;46(4):6-7.

Misconceptions about AIDS "Dissidents"

To the editor: Since my name is referred to in a letter under the title "Aids-dissident thinking" by David Whittaker in SA Family Practice,¹ I feel I ought to be given the right to respond. I am fully aware that the journal Family Practice may not be the right place to debate the issue of HIV/AIDS from my point of view. Dr. Whittaker writes "*How is possible to dismiss the death in misery from TB and diarrheal disease of a previously well-nourished urban middle-class man as yet another instance of under-development and social deprivation?*" Dr. Whittaker must know that we are now in the 3rd decade of HIV/AIDS and the hypothesis and assumption that HIV is the cause needs to be repeatedly examined and challenged if science is to move on. Surely Dr. Whittaker accepts that amongst other things, life style issues are involved in the causation of immunosuppression. My concern is that to most (Dr. Whittaker included) life style is reduced to one entity only i.e. sexual practice!!, particularly in mainstream pronouncements. The issue of recreational drugs, anal intercourse and homosexuality are not included in mainstream thinking. Family Physicians are acutely aware that the vast majority of patients they encounter need numerous consultation encounters before divulging their private life style histories. This is so regardless of social class.

Encountering and observing suffering and distress from whatever malady by patients is by no means the exclusive preserve of a few self-selected doctors or health professionals. Dr. David Whittaker in his criticisms of those he chooses to name-call dissidents gives the impression that only he and those like him care about suffering and distress. "Dissidents" do care but their caring is not driven and dominated by religious and sectarian beliefs.

Dr. Whittaker needs to read extensively before laying wild charges against "dissident" scientists and clinicians. In his references, there is nothing on the work of Peter Duesberg, David Rasnick, Val Turner, Eleni Papadopoulos-Eleopoulos, Christian Fiala and Roberto Giraldo to name but a few. Finally, I found the reference to Mckeown astounding. "*when it came to HIV/AIDS however, he (Mckeown) could not fail to note its horrific impact*". Noting an impact and asking questions are two different things. Mckeown in my view would have most likely asked why is the burden of this disease largely confined to the black poor and destitute who remain in a state of squalid distress and squalid dissipation.

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1. D Whittaker. Aids dissident thinking (letter). SA Fam Pract 2004;46(4):4