



ill-defined limitations makes the decision; in the second an ethics committee makes the decision. These models are, as he suggests, paternalistic, and within this framework paternalism seems to be the ultimate evil.

Even without their inherent logical contradictions these safeguards are practically unworkable. In practice all they will do is interpose a bureaucratic delay in the decision-making process, which is in itself not a bad thing, as sober reflection is a good idea when faced with a decision of this enormity. Both models would be totally unworkable if they include input from those opposed to killing. As a result the only people involved in either option will be either neutral to the idea or, more likely, promoters of it. It is highly unlikely that, for instance, Doctors for Life will be invited to send a representative to these ethics committees.

There is absolutely no reason why only physicians should be legally empowered to kill as the skills required are not great. There is every reason why as doctors we should not; for as Landman states, generally we are held in high esteem and we are usually trusted in South Africa. One of the main reasons for this is eloquently stated by the Editor<sup>2</sup> — every death is for us a loss and a cause for reflection. Patients should know that they can rely on us literally to fight for their lives. This proposed legislation and our participation has the potential to destroy that trust. We should confine ourselves to alleviating suffering as no illness should be intractable or unbearable with sufficient care and effort. For a physician to suggest death as a cure is nihilistic and the ultimate admission of incompetence. We should be concentrating our efforts in the areas of palliative and hospice care, and not seeking cheap and nasty alternatives.

As Professor Landman suggests, this debate should be civilised, but it should also be passionate because it strikes at the heart of who we are as a caring profession and what sort of society we want to live in. I can only agree with the Editor that PAS and VAE are inappropriate responses.<sup>2</sup>

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1. Landman WA. Legalising assistance with dying in South Africa. *S Afr Med J* 2000; 90: 113-116.
2. Ncayiyana DJ. Physician-assisted suicide — an oxymoron? (Editor's Choice). *S Afr Med J* 2000; 90: 75.

#### PHYSICIAN-ASSISTED SUICIDE — AN OXYMORON?

**To the Editor:** I read, with agreement, your comments on physician-assisted suicide (PAS) and voluntary active euthanasia (VAE).<sup>1</sup> However, your concluding statement lacked the lucidity of thought and argument that flowed through your earlier observations and comments.

Nowhere in his essay does Landman<sup>2</sup> suggest that PAS and/or VAE ought to be applied as appropriate responses to South Africa's 'eminently preventable and curable conditions . . . and diseases of social and economic deprivation and neglect. . .'. Surely, the irrational association with which you conclude is erroneous, an unintended slip of the pen based on a misunderstanding of Landman's article — or is it not?

If your comment was indeed carefully considered, then it must have been calculated to dismiss the relevance of First-World 'post-modern concepts' like PAS and VAE to the 'majority of South Africans', who succumb to predominantly Third-World (unarguably) disease patterns.

I am perturbed to find the Editor of the official scientific journal of the South African medical profession, which consists of 'some of the finest and best-trained doctors in the world',<sup>3</sup> propounding the sinister propaganda that we revere only intellectual discussion that is relevant to the 'majority of South Africans'!

Sir, as earthlings now living on an ever smaller rock in this information age, the local medical profession does, should, and will continue to immerse itself freely in both First- and Third-World intellectual medical debate, conjecture and practice. This is unavoidable, given the dual economic and social nature of the South Africa in which we coexist, and our irrevocable commitment to increasing the First-World component of our country, not the other way around!

Furthermore, while postmodern concepts have their origins in the eurocentric First World, they are definitely not inapplicable to Third-World communities. Are concepts such as subjectivity, particularity and the importance of context not relevant to the practice of postmodern medicine everywhere in the world?

Finally, the supreme authority in the hard-fought-for democratic South Africa is the Constitution, which confers rights, duties and obligations on *all* South Africans, not just the majority! Consequently, First-World medicine has a right to coexist with Third-World medicine in democratic South Africa. Most of us choose to remain here and spend every working day progressing towards the time when we can talk simply of medicine, which is non-racial and all-inclusive.

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1. Ncayiyana DJ. Physician-assisted suicide — an oxymoron? *S Afr Med J* 2000; 90: 75.
2. Landman WA. Legalising assistance with dying in South Africa. *S Afr Med J* 2000; 90: 113-116.
3. Ncayiyana DJ. South Africa's finest and best (Editorial). *S Afr Med J* 2000; 90: 73.