all of the lesions had disappeared, and there was no evidence of scarring or inflammation.

One item that is sadly lacking in our state-of-the-art hospital system is a user-friendly lid for sealed fluid, margarine, jam and food containers. Many of these sealed units defy dexterous patients and utterly defeat weak, uncoordinated or arthritic ones. We aim for patient independence and self-sufficiency, but the seal-tight lids force patients to either get help or go hungry. Surely we could design pull-off lids with large tabs with a hole for a finger. Not only would this improve patient care, but it would also decrease demands on staff.

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Where does our duty lie?

In his recent letter "Foreign specialists need not apply" (*Can Med Assoc J* 1997;157[7]:869-70), Dr. Shabbir Alibhai discusses the decision by the Royal College of Physicians and Surgeons of Canada to recognize only training taken in accredited residency programs in Canada and the US and raises some important questions about this decision.

The college's accreditation process is very different from that applied in most countries. Although it is un-Canadian to consider anything from Canada the best in the world, in the case of accreditation of postgraduate training it happens to be true. Indeed, most countries do not accredit residency programs. Some, such as the United Kingdom and Saudi Arabia, are developing systems modelled to some degree on ours.

As long as there is no generally accepted measure of competency to test physicians from around the world, no study to demonstrate differences between countries can be undertaken. However, the relative performance of trainees of different origin on examinations *has* been studied. At one time the college allowed a broad spectrum of candidates to take its examinations. Failure rates in certain groups exceeded 90%, and we were criticized for "exploiting" candidates who went to great expense with little chance of success. The college then decided that examinations should be limited to those expecting to practise here and those who would likely succeed because of previous evaluations in accredited programs. This is another distinguishing characteristic of the Canadian system: success in examinations does not in itself confer certification. Evaluation during training plays an increasingly important role.

For more than a decade, only candidates trained in Canada, the US, the UK, Ireland, South Africa, Australia and New Zealand have been allowed to take Royal College examinations. Our recent change has decreased the number of foreign exemptions to 1: the US. The college does hope to see increasing reciprocity in accreditation. A formal offer has been made to sister colleges in many of the countries noted above. As well, the Royal College sponsored an October symposium that brought together key players in an attempt to find a way to evaluate and recognize offshore specialists recruited to remote areas.

But I have some questions of my own. Why do we, as Canadians, collectively throw up our hands and presume that we can never overcome the inadequate distribution of medical specialists? With all of our advantages, why should Canada not be a net exporter of highly trained specialists instead of an importer? And what of young Canadians and their desire to pursue a career in medicine? There is less than 1 first-year place in medical school available for every 20 000 Canadians. The only other country with such a low number is Albania! In BC the ratio of first-year positions to population is 1:26 000. In the UK, a commission has determined that the ratio there should be increased to 1:13 500.

I fully agree that as citizens of the world we have moral obligations to specialists everywhere, but surely our first duty is to Canadians.

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Is it ethical to forgo treatment?

In their article "The 'Supremes' decide on assisted suicide: What should a doctor do?" (*Can Med Assoc J* 1997;157[4]:405-6), James Lavery and Dr. Peter Singer write: "There are 3 practices along the spectrum of end-of-life care: palliative care, decisions to forgo treatment, and euthanasia and assisted suicide. The first 2 are ethically uncontroversial, legally permissible and part of quality medical care."

The second half of this statement is incorrect, for although palliative care is undeniably and always "ethically uncontroversial," the same cannot be said about decisions to forgo treatment. The ethical character of these decisions depends largely on what is meant by "treatment." Is it "medical treatment" or is it "treatment" that involves not only the administration of remedies by a physician but also the provision of minimal care such as nutrition?

Furthermore, it makes a considerable difference whether the medical treatment being withheld or withdrawn is considered ordinary (proportionate) or extraordinary (disproportionate). A medical treatment is disproportionate if its complexity, cost or risk or the degree of suffering it entails is out of proportion with the potential benefits.

Even committed pro-lifers recog-

nize that proportionate medical treatment can be withheld or withdrawn under certain circumstances, such as at an advanced stage of a terminal illness. In their view this does not constitute passive euthanasia but simply good medical practice.

As for disproportionate treatment, it should never be imposed upon a patient, and it can be legally discontinued at any time. There can be disagreement, of course, as to whether a medical treatment is disproportionate.

It is generally held that if "treatment" includes basic (or minimal) care and if such treatment is stopped at any time in a patient's illness *other than in the phase of imminent death*, this constitutes passive euthanasia because the patient will die as a result of the treatment being withheld or withdrawn.

If they are to make a meaningful and useful contribution to the euthanasia debate, physicians who talk or write about "decisions to forgo treatment" should be very clear about what they mean.

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[One of the authors responds:]

Dr. Lafrance is correct that in a detailed discussion of consent to treatment (which was not the purpose of our "Supremes" article) "treatment" should be defined, as it is in consent legislation in some jurisdictions.

In terms of nutrition and hydration, "treatment" includes feedings administered by a nurse through a tube, but not chicken soup lovingly administered by a family member. Although I acknowledge that there is a longstanding ethical and legal debate on nutrition and hydration, most courts and commentators have concluded that tube feeding constitutes medical treatment.

Regarding the distinction between terminally and nonterminally ill people, these terms can be arbitrary, prognostication is sometimes inaccurate, and even nonterminally ill people have the legal right to refuse medical treatment.

The extraordinary–ordinary distinction has deep religious roots that deserve respect but may not resonate sufficiently across cultures to serve as a basis for public policy in our multicultural society. Nevertheless, one of our greatest ethical challenges is to ensure that health care providers and institutions treat the cultural and religious values of patients, family and staff with the utmost care and respect. My colleagues and I have argued, for instance, that health care facility missions, including those based on religion, should be protected and respected.[1]

At the heart of our article was the notion that Canada still has too many patients dying in pain or connected to life-support machines they do not want. We must draw clear distinctions between palliative care and decisions to forgo treatment, which are ethical and legal under appropriate circumstances, and euthanasia and assisted suicide, which are ethically controversial but clearly illegal. Any muddying of these waters will lead to another patient dying in pain or hooked up to unwanted life-support equipment. With palliative care and decisions to forgo treatment, it is time to move beyond ethical and legal hair-splitting to focus on improving Canadians' quality of life as they approach death.

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