A morally irrelevant distinction on euthanasia

I have tremendous respect for people like Peter Lovrics, who frequently treats severely ill patients in the last stages of life. However, his argument against euthanasia[1] — both active and passive — is founded on a misunderstanding of passive euthanasia as it relates to palliative care. He states that the "distinction between good palliative care and euthanasia (active or passive) … is clear and important." He then argues that "good palliative care makes euthanasia … unnecessary." Thus, he presents palliative care as a preferred third option that is inconsistent with passive as well as active euthanasia.

No humane person could be against the provision of good palliative care. All patients who are suffering deserve the highest standard of palliative care possible, and they should never be deprived of this when it has been decided to withhold or withdraw curative or supportive treatment. But palliative care and passive euthanasia are not mutually exclusive alternatives. Lovrics writes that he has been in the "difficult situation of withholding or withdrawing care to allow death on numerous occasions." This, of course, is the very definition of passive euthanasia. Palliative care is care that helps minimize pain and suffering, and it is especially important in the context of passive euthanasia.

Many people do not like the term passive euthanasia, probably because they associate the word euthanasia with active euthanasia, which they do not support. The argument I presented in my essay[2] is that virtually everyone already supports passive euthanasia — regardless of what they prefer to call it — and that, in certain circumstances, the distinction between passive and active euthanasia is morally irrelevant. When our efforts to relieve suffering with palliative care fail, active euthanasia may be morally permissible and even preferred over passive euthanasia, for it ends the suffering more quickly.

Lovrics believes that the cases I mentioned in my essay "show the importance of continued medical education, awareness and proper training [in palliative care]." I agree. I also think that these cases remind us that palliative care is not only "hard to do well" but also sometimes impossible to do well. When we cannot, despite our best efforts, adequately control the suffering of terminally ill patients who want to die, active euthanasia may be a means to respect their autonomy and relieve their distress.

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References
1. Lovrics P. Euthanasia's never an answer [letter]. *CMAJ* 1999;161(1):18-20.
2. Gorman D. Active and passive euthanasia: the cases of Drs. Claudio Alberto de la Rocha and Nancy Morrison. *CMAJ* 1999;160(6):857-60.

Following the rules in marketing

I am glad that Joel Lexchin is looking after the moral well-being of the CMA and the Pharmaceutical Manufacturers Association of Canada.[1]

Without his careful scrutiny I have no doubt we would all descend into a veritable trough of corruption and lose what little self-respect we still have.

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Reference
1. Lexchin J. PMAC Code of Marketing Practices [letter]. *CMAJ* 1999;160(11):1556.

In his recent letter to the editor[1] Joel Lexchin alludes to the mechanism by which Canada's Research-Based Pharmaceutical Companies (CRBPC), formerly the Pharmaceutical Manufacturers Association of Canada, enforces its Code of Marketing Practices, and he provides "2 recent examples" of ways in which "physicians and drug companies sometimes break the guidelines of their respective organizations."

Through his familiarity with our code, Lexchin is well aware of Section 12 (Enforcement), which provides for the adjudication, by our Marketing Practices Review Committee, of allegations of infractions of the code. Such allegations, supported by documented evidence, can be brought forward by an individual or organization encountering what they believe to be inappropriate behaviour in terms of our marketing code. In his letter Lexchin implies that he is in possession of such evidence, yet he did not see fit to bring the matters to the attention of the CRBPC.

One can understand why he did not bring the evidence to the attention of the CMA, since that organization's policy summary on physicians and the pharmaceutical industry[2] does not provide for an enforcement mechanism. However, Lexchin's concern about the possible loss of the trust of the public and professions should have at least motivated him to bring the "examples" to our attention, particularly in view of the fact that our Marketing Practices Review Committee includes representation from the medical community, a fact of which Lexchin is also aware. Had he done so, he would have been helping to serve the best interests of his own constituency and would not have fallen into the category of those "health professionals [who did not bother] to complain."

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References
1. Lexchin J. PMAC Code of Marketing Practices [letter]. *CMAJ* 1999;160(11):1556.
2. Canadian Medical Association. Physicians and the pharmaceutical industry (update 1994) [policy summary]. *CMAJ* 1994;150(2):256A-C.

[The author responds:]

Murray Elston asks why I did not submit a complaint about the alleged violations that I reported in my