nize that proportionate medical treatment can be withheld or withdrawn under certain circumstances, such as at an advanced stage of a terminal illness.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death*, this constitutes passive euthanasia because the patient will die as a result of the treatment being withheld or withdrawn.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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