Patient or client? If in doubt, ask

The simple answer to Dr. Peter Wing's question (Patient or client? If in doubt, ask. *Can Med Assoc J* 1997;157:287-9) was provided by a senior consultant in medical school. "Doctors treat patients; clients are found in lawyers' offices and brothels."

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A message for the "human medical community"

The brief article "Veterinarians' suggested fees may leave physicians feeling ill" (*Can Med Assoc J* 1997:156:1689) deserves comment. Because we acknowledge the media's appetite for controversy, real or perceived, we ignored the original article, written for the *Ottawa Citizen*. However, when an excerpt from this article, with commentary, is printed in a human medical journal, we take serious exception.

Veterinarians are health care professionals and businesspeople who administer our own hospitals while maintaining standards required by the College of Veterinarians of Ontario: there are no publicly funded facilities. We provide complete anesthetic, radiologic, laboratory, dental and surgical services, and many of us provide specialized care such as endoscopy or diagnostic ultrasonography. We must maintain an inventory of all supplies that may be required for a procedure. How many physicians know the cost of an 8-mm endotracheal tube or a bottle of isoflurane? Our fees must reflect these overhead costs and pay for nursing, technical and other support staff while ensuring an adequate standard of living for ourselves. The Ontario Veterinary Medical Association employs an economist to examine the real costs of veterinary medicine. Our suggested fee schedule is based on this work.

When we perform a double-contrast urinary-tract study (usually a cystogram), we must cover the cost of tranquillizing agents, contrast media and delivery instruments, rare-earth screen radiographic plates, processing chemicals and equipment, radiologic equipment, a designated room for performing the procedure, dosimeters, view boxes and technical staff to assist. The animal must also be kept in hospital for the day. After these costs are covered, our fee pays us for performing the procedure, interpreting the film and advising the client. What does the fee paid to a physician cover? If it merely reimburses the physician for performing a procedure and interpreting film at a publicly funded facility, comparison of the 2 fees is impossible.

We can empathize with the human medical community's frustration with health care funding. However, to take that frustration out on another group of comparably educated health care professionals without examination of the facts is inappropriate. That such statements appeared in a national medical journal verges on the unprofessional.

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I was dismayed to see once again another apples-and-oranges comparison of fees charged by veterinarians and physicians, which seems to imply that veterinarians' fees are excessive when compared with those charged by physicians who deal with the human species. These across-the-board comparisons fail to mention that most veterinarians must cover substantially higher overhead costs than any general practitioner and many specialists. Our professional education and training is perhaps even more comprehensive and arduous than a medical student's, for we are trained to be the GP, internist, surgeon, radiologist, anesthetist, pathologist, dentist, pharmacologist and psychiatrist, and not just for one species! This means that most of our practices must stock a full dispensary, have a surgical suite with instruments, anesthesia and monitoring equipment, an x-ray machine with automatic developer, blood-chemistry analysers and a staff of certified animal-health technologists.

Each veterinary practice is a hospital unto itself, and running a hospital is not cheap. How many Canadian radiologists have their own x-ray machines, own their own facility and employ the staff needed to run it? How many GPs have a full surgical suite in their little, 2-exam-room office?

It would have been more appropriate for *CMAJ* to compare the amount veterinarians keep after paying overhead costs with the payments physicians receive for providing a specific service. Try examining the fee breakdown for a specific procedure, such as an oophorohysterectomy, performed on a large dog versus the same procedures performed on a woman. The average fee for this operation at a veterinary clinic, which would include a pre-anesthetic examination, anesthesia, surgery, surgical materials, nursing care and an overnight stay in the hospital, is approximately $120. Do physicians honestly believe the same procedure

on a human would fit within this meagre budget? I suspect the cost would be at least 10 times more.

In Canada, human medical and surgical care is subsidized by tax dollars, and physicians' fees appear to be "free." Our colleagues south of the border do not seem to take as much flak over their fees, no doubt because the owners of the pets they treat are only too aware of the real costs of health care.

As vets, we can console ourselves because we do not have to listen to patients complain about their piles, bowel movements and assorted aches and pains. Animals seem to put up with mild discomforts with grace and dignity. And, oddly enough, it is often human health care professionals who gripe the most about vet bills. Go figure.

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Relief from pain, not from life

At first sight the article "Bioethics for clinicians: 11. Euthanasia and assisted suicide," by James V. Lavery and associates (*Can Med Assoc J* 1997;156:1405-8), impresses one as a well-researched and scientifically and logically sound paper.

On closer scrutiny, however, it raises more questions than it answers. A lapse in logic appears immediately with the use of "assisted suicide" in the headline. If suicide is the consequence of an act of self-destruction — something carried out by the person — then any persons rendering assistance in this act of destruction automatically become murderers, regardless of whether the "assisted" victim had agreed or not. The heading alone reflects strongly the ambivalence pervading the article. It is, of course, our society's ambivalence that is being shared by the authors.

Perhaps the rather loosely applied term "self-determination" should have been replaced by the more straightforward designation "self-termination." I can only determine with certainty that I have travelled from A to B if I know everything I have to know about both points. Do we know — scientifically — where we are going after death? Of course not. How then can I determine where I am going by ending my life?

Someone suffering extreme pain does not wish to go into possible oblivion. These people scream to be relieved from pain and not from life. Have you ever witnessed patients who first "demanded euthanasia" and then changed their mind? I did in my younger years. How many patients had changed or may have changed their minds but may have been unable to say so and were accidentally put to death because of their inability to communicate?

Pain-relieving medication may as a side effect shorten a patient's life span, but this has nothing to do with euthanasia. The intent is to relieve the pain, not terminate a life. In my younger years as a general practitioner I used to visit terminally ill patients as often as necessary to soothe at least their pain. A bond would develop between patient and physician and nobody ever thought of "assisted suicide." Obviously there was no need for it then, so why should there be a need for it today? Let's be honest and use common sense.

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[Two of the authors respond:]

Dr. Kreyes' comments reveal his strong personal views regarding euthanasia and assisted suicide. We applaud him for contributing to the public debate by sharing these views.

Contrary to his assertion that our paper reflects our ambivalence toward euthanasia and assisted suicide, we were asked to collaborate in the writing of the article precisely because we all share a strong professional interest in these issues. The article was meant to outline key concepts associated with euthanasia and assisted suicide and to help clinicians integrate these concepts into daily practice. The paper was not intended as a forum for us to expound our own views.

Kreyes offers 2 specific criticisms, both objections to our choice of language. First, far from revealing a "lapse in logic," we used the term "assisted suicide" to be consistent with the vast majority of commentators around the world, including the report of the Special Senate Committee on Euthanasia and Assisted Suicide.[1] As well, the term accurately conveys the spirit and substance of Section 241(b) of the Criminal Code of Canada, which prohibits aiding or abetting a person to commit suicide.

Second, Kreyes objects to our use of the term "self-determination," suggesting instead a "more straightforward" term, "self-termination." We used "self-determination" in our summary of the arguments in favour of euthanasia and assisted suicide because it is this concept, more than any other, that has underpinned this set of arguments. "Self-termination," though precise with respect to the specific act of suicide, does not convey anything of the broader social, legal and political context that frames these arguments and gives them force.

Kreyes suggests that appropriate pain control and compassionate, attentive care would obviate the need for euthanasia and assisted suicide. Based on our clinical experience, we agree with him that better palliative care would reduce the need for euthanasia and assisted suicide; in fact, we think improving end-of-life care, including palliative care, should be a