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Perhaps the rather loosely applied term "self-determination" should have been replaced by the more straightforward designation "self-termination."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

major national priority. However, we doubt that even the best palliative care would eliminate all requests for euthanasia or assisted suicide.

Kreyes' appeal to "common sense," no matter how attractive, is unlikely to provide a solution to the complex and pressing social problems of euthanasia and assisted suicide. This is an issue on which people of common sense disagree.

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Reference

1. *Special Senate Committee on Euthanasia and Assisted Suicide. Of life and death. Report of the* Ottawa: Supply and Services Canada; 1995:A80-3. Cat no YC2-351/1-OIE.

Gender sensitivity a sensitive issue

One of the excellent reviews concerning gender sensitivity, "Gender sensitivity in medical curricula" (*Can Med Assoc J* 1997;156: 1297-1300), by Barbara Zelek and associates, neglected very important terminology that has been used in the US but was not included in this article.

The term "seminar" should be reserved for teaching presentations involving male faculty members, with "ovular" being used for presentations by female faculty members.

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Received via email

I read the article by Zelek and colleagues with what I felt was genuine sensitivity. I have been educating young women and men to become physicians for the past 30 years and have been conscious for most of that time of the problems facing both sexes. I do not believe the problem to be as complex as the authors suggest. It is real but it is also simple: it is a matter of choosing the right words. In health care we are notorious for creating new words and giving old ones new meanings. A lot of our problems would be solved if instead of creating new words we made use of well-established ones. The article asks us to be sensitive to "genderizing" medical curricula. Gender is defined in this paper as "both the real relations between the sexes and the cultural renderings of those relations." I do not agree. The word gender refers to a grammatical classification of objects roughly corresponding to the two sexes and sexlessness (for example, masculine, feminine, neuter). Ships are a good example: for eons they have been of the feminine gender.

Gender has nothing to do with real relations between the sexes or their cultural renderings. Two simple words are enough to define this: respect and equality. And what this requires is the right attitude. The creation of new words and the misunderstandings of old ones are not the answer.

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I read this article with dismay, and I am concerned that there is a tendency for our prestigious journal to be involved in subject matter best reserved for newspapers. I am also concerned that the article was classified as educational. I hesitate to open a can of nonmedical worms but hasten to state that I am entirely sympathetic to the concerns of the authors, but not to their methodology. Simply stated, both genders should be treated equally, fairly and with respect in every way. However, promotion of the misuse of words and syntax destroys much of what is good by levelling everything in reaction to a history of gender inequality, which a decreasing minority of both sexes perceives to still exist.

If we need to alternate "men and women" with "women and men," we will need to do a count to ensure equal use. We will then be unable to concentrate on the merit of a medical article. What education! What syntax!

The principle of equality of the genders is unquestioned, and some suggestions in the article have merit. For example, if only the title Mr. is to be used for men, then Ms. should be used for women. Age and marital status are personal and irrelevant.

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I believe this is a timely and valuable article and particularly appreciate the advice for medical educators that will help us to avoid creating difficulties unwittingly. That one can easily be gender insensitive during a medical communication is exemplified in the last paragraph of the section on guidelines relating to language. The authors suggest changing "a 23-year-old woman who works as a medical secretary" to "a 23-year-old medical secretary." While this change might place equal emphasis on this person's occupation, compared with the previous example of a "40-year-old professional man," it has become totally insensitive to gender. The authors are presuming that all medical secretaries are women. If this was the only mention of the secretary's sex in this med-