tation." I know of no clinical ethicists who bill. LaPuma has recently completed a national survey and found only 5 clinical ethicists who charge for their consultation services (personal communication). Perhaps Professor Pence knows something about third-party reimbursement that would be of benefit to others.

I also question Pence's characterization of the role of the ethicist as "more passive" than that of the family physician. While the advisory role of the ethicist is different from the decision-making role of the family physician, I would in no way describe it as passive. I, and I believe most clinical ethicists, play a very active role in the care of the patient. Perhaps his statement represents a difference between ethics consultants with a clinical background and those trained primarily in philosophy. I further disagree that ethicists must "keep private" their "strong feelings and beliefs about current ethical problems." While they must not impose minority views, they are individuals with moral standing who should feel free to express opinions tactfully when asked or when otherwise appropriate.

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Clinical Ethics in Family Practice

To the Editor: I am writing in reference to the recent editorial by Dr. Pence in *JABFP* entitled "Clinical Ethics and the Family Practitioner" (J Am Board Fam Pract 1993; 6:80-2). As a family physician who works with disabled persons and as a writer on bioethics, I am probably more aware than the average practitioner of what is being written in medical ethics and the societal changes that they involve.

As I am aware of what actually has been written by the ethicists that Pence cites[1-3] and of the trends that he mentions, I must sadly conclude that not only is Pence happy that modern ethicists are slowly pushing back the limits against taking human life but that he also wishes family physicians to "go forth and do likewise."

Modern ethicists (including Smith and Cranford[1]) teach us to judge a person's worth by marketplace values, by his or her economic usefulness, or by IQ,[4,5] so that we learn to see the marginal member of society as having "poor quality of life" or even as not meeting the criteria for personhood. As a result, we learn to see disabled persons as better off dead or merely as entities outside the moral and ethical boundaries of humanity, to be ignored, denied medical care,[6] destroyed ("out of respect for their lost personhood"[4,5]), or used for the betterment of the strong.[7]

In political literature many claim that we are in a "culture war."[8] Similarly, medical ethicists have questioned the very basic assumptions of traditional ethics.[9] But by insisting that tradition is irrelevant and that religious viewpoints have no place in discussion of public policy, they have left a moral vacuum that allows those more aggressive to push their ideological agenda to the forefront while those who try to stem the tide soon find that "it is the bold bioethicist who dares to say, and continues to say, 'No'. As he or she may quickly discover, the profession leaves such sensitive souls behind as the discussion leads to the next thing."[10]

We can easily see the results: cost analyses that limit medical care according to economic usefulness, arguments on why we should use anencephalic babies as organ donors, and articles in some of our leading medical journals that nod in approval when the sick, depressed, or useless seek "aid in dying."

In such a utilitarian world, arguing against such things by using the concepts of trust, human decency, or the importance of a transcendent meaning of life might sound like romantic nonsense.

But pragmatic sociologists[11] are the first to point out that our "communities of memory," i.e., the laws, customs, and religious traditions, are society's way of encoding thousands of years of human experience on what is helpful for a healthy society and what deeds are destructive to the human ecology. Almost universally such traditions teach us to see the marginal inhabitants of our world — the fetus, the infant, the sick, the elderly, the handicapped — not as "useless eaters," but as our brothers, persons to be loved and attended, because the deity insists that caring for the poor, the sick, and the orphan is important; because a just society is one that provides for its most vulnerable citizens; and because such values as compassion and caring and responsibility strengthen the "subtle ties of human beings" without which no society can survive.

Yes, Dr. Pence, we family physicians have many lessons to teach medical ethicists. But until medical ethicists such as Brody, Cranford, (and maybe even yourself[12]) are honest enough to recognize how ideas very similar to your own have corrupted the Netherlands,[13-18] or how such "politically correct" ideas have the capacity to destroy the civil rights of those who are vulnerable, our social ecology, and the physician-patient relationship, I doubt these lessons will be very welcome.

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The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: Dr. O'Connor takes me to be stating that "really important clinical ethics happens only in very sick patients, usually at tertiary care centers, and most often in ICUs." She obviously champions the view that family physicians face ethical issues in their daily practice, which are just as frequent and just as important as any other area of medicine. I agree. Nothing that I wrote disagrees with that view.

If I had read only the abstract by Orr and Moss, I could have read that they are addressing the different topic of family physicians as "future teachers, researchers, institutional leaders, and policy makers in clinical ethics." Moreover, the role of the clinical ethicist vis-à-vis ethics committees figures largely in their article. Given this orientation, I must ask whether family physicians are trained to fulfill these roles and to address these issues. When setting policy about whether to do liver transplants on alcoholics with end-stage liver disease who refuse to enter Alcoholics Anonymous, should the family physician ethicist be called? Second, most issues that come to the ethics committee do indeed involve ICUs and tertiary care centers, and if someone is going to be a consultant to such an ethics committee, that person must respond to its real needs. If the family wants a consultation before disconnecting the respirator of a patient supposedly in a persistent vegetative state, should the family physician be called? Of course, many ethical issues exist in family medicine that could come to such committees, and if Dr. O'Connor is correct that family physicians qua ethicists can be patient advocates, perhaps they will soon be raising such issues with such committees (or advising their patients of the existence of such committees if their patients experience ethical problems with physicians).

Dr. O'Connor falsely accuses me of embracing a slippery slope down the quality-of-life trail. While it is true that I have defended the Dutch system of physician-assisted suicide among terminally ill patients, unlike America, Holland has cradle-to-grave medical care and no families or patients who may decide to die to save money for their children or society. In other research I have concluded that competent, disabled patients such as Elizabeth Bouvia and Larry McAfee have a right to die, but I also believe that both struggled heroically against prejudiced systems. As American medicine begins now to embark on cost-saving schemes, I am cynical about our ability to create better systems for the disabled; I would rather see a great system, but until that comes, I want the competent disabled person to be empowered with a right to not suffer and to die. More generally, O'Connor does me injustice in that I have criticized the *Quinlan* decision in 1975 for lumping together incompetent with competent patients and the Baby Jane Doe case for biased, incompetent reporting that — amazingly! — was awarded a Pulitzer Prize.[1]

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Unsolicited Gifts from Pharmaceutical Companies

To the Editor: In the 10 years since my graduation from medical school, I have received innumerable gifts from pharmaceutical companies through the postal service, including puzzles, magnifying glasses, messages in plastic bottles, and nonmedical books, to name a few. These gifts have been unsolicited, have been of no value to me, and have made me less likely to use the product than otherwise might have been the case. Many of the items are nonbiodegradable, adding more problems to our troubled environment. The dollars invested in this advertising would be better spent on further research, lowering the cost of medication, or helping provide prescriptions to needy patients. I believe that this form of marketing is entirely inappropriate.