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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.