to assist their own death. The law needs to reflect this.

Such individuals have already demonstrated their willingness to travel and go through with assisted suicide in spite of the law, and it seems absurd that these people should be breaking the law, be fined or end up in prison. We should not be debating whether euthanasia should be legal as there will always be people for and against this question. This is no different from arguing that capital punishment should remain illegal despite the majority of the current public being in favour of it. Similarly, medical abortion is still a controversial area where people are strongly divided, but whether one accepts the moral arguments in either direction, legalisation of medical abortion allowed a marked reduction in deaths in women. Instead of debating whether assisted dying should be made legal or not (a matter of opinion), the real question is whether it can be strictly regulated. The easiest way to regulate it would be to dictate that a court order is mandatory. That way the difficult task of ensuring that assisted death is never misused can be left up to judges who take full responsibility for the decision.

The palliative care doctors are understandably concerned that they may be forced, or at least pressured, into performing the procedure of assisted dying if it becomes law. The law must state clearly that doctors can always refuse to perform assisted death, in order to reassure doctors that they will never be forced to perform this procedure (some gynaecologists refuse to perform terminations of pregnancy). If an individual patient wishes it, if judges are prepared to accept responsibility for the decision that a particular assisted death should be legal, and if there exist doctors and healthcare staff prepared to perform it, then I think assisted dying should be made legal. Those who do not wish to carry out such procedures must not stand in the way of lawmakers simply because of personal choice, as it should not affect them. To do this, the law must ensure that doctors are never discriminated against on the basis of their views on this matter. However, the choices of the very few who want to be assisted in dying must also be respected. For our part, we should not poll who is in favour or against euthanasia, but find out how many doctors are actually prepared to perform it.

The question of resources is a poor excuse in an important ethical debate. I would argue that resources simply should be made available – this is a drop in the ocean in terms of quality of life/death compared to numerous much more expensive interventions already widely in use.

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Hippocratic oaths: medicine and its discontents

Editor – Professor Gordon points out (*Clin Med* January/February 2005 pp 83–4) that the pessimistic expectation that applications for medical school would fall has not turned out to be the case. In *Hippocratic oaths: medicine and its discontents*, I was quoting Chris McManus' paper, 'Medical school application – critical situation'.[1] However, I added a note of caution as follows: 'It is perhaps important not to read too much into short-term trends. In 2004, there was an overall increase in application to medical school of about 20%'.[2]

Whether or not medicine will remain attractive and whether those who have been attracted to medicine will stay is another matter altogether.

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Chasing ideas: clinical research in the NHS

Editor – We read with great interest the editorial in the most recent issue of Clinical Medicine that bemoaned the lack of clinical research within today's NHS and asked, 'Is there any hope?' (*Clin Med* January/February 2005 pp 5–6). Whilst we agree that escalating demands on consultant time are made from an increasing variety of directions, we would argue that this does not preclude interested physicians from developing an active programme of clinical research, even within a busy district general hospital. Practising both as a physician and as a specialist allows exposure to a wider variety of conditions than might otherwise be encountered within a single discipline such as rheumatology (our area of special interest).

New observations on the natural history of chronic diseases continue to be made during the course of routine clinical practice. Over the last 10 years we have developed a range of clinical research projects leading to the development of a unit, which attract collaborative research from a range of other medical and paramedical specialties, academic departments and hospitals.[1,2,3] The move towards a consultant-led service and expanded roles of allied health professionals provide the opportunity to investigate and teach these findings to both junior doctors and other professional groups. These offer tremendous opportunities for generic training of junior doctors which fits well with the requirements of the Foundation Program and the Hospital at Night initiative, as well as the recent recognition that opportunities for training in general internal medicine are waning in the face of increasing specialisation.

Our programme has attracted enough funding to permit the expansion of the unit to include a research fellow and to allow consultant sessions to be dedicated to research and teaching. We feel that far from inhibiting clinical research, the rapid evolutionary changes we are witnessing within the NHS may offer new opportunities for exploring disease processes, which are still often incompletely understood. But we agree that it is vital that some consultant time is protected to allow clinical research initiatives to continue to be pursued.

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European Residents Exchange Scheme – new centres needed

Editor – We would like to take the opportunity to remind readers of *Clinical Medicine* about the European Residents Exchange Scheme, which has been running a highly successful exchange programme since 1977. The programme has enabled trainee doctors, who are usually within their first four years of registration, to undertake a period of 6–12 months of their training in other European centres. By the end of 2004, approximately 120 trainees had taken part in this successful scheme. The scheme works on a two-way basis, giving an opportunity to European doctors to come and work in the UK, as well as British doctors to work in a European country, and thereby allows young doctors to develop a critical knowledge of other healthcare systems and different ways of working.

The ongoing success of the scheme has resulted in it being adopted as the official exchange programme of the European Federation of Internal Medicine (EFIM), and the scheme has been described in a number of articles in the medical literature.[1–5] Currently, only a limited number of centres take part in the scheme and potential exchanges have to be nominated by the scheme representative at their local centre.

The Steering Committee is chaired by Professor Jurg Schifferli, Universitatsspital Basle, and meets on an annual basis, in order to plan partnerships for future exchanges. The Steering Committee is keen to consider new centres in the UK as potential points of exchange and interested parties should contact Professor Schifferli directly (j.schifferli@unibas.ch). We appreciate that training in the UK is becoming more formalised, but still consider this opportunity to be a very positive part of the trainees' educational experience and look forward to it continuing in the future.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Survey of flexible working amongst specialist registrars and consultants in respiratory medicine in the UK

There is currently a rapid and progressive change in the sex distribution within the medical workforce at all levels.[1] In addition, there is an increased tendency for senior consultants to consider early retirement.[2] In 2002 the British Thoracic Society formed a working party to examine issues around flexible training for specialist registrars and flexible working for consultants (defined as working less than full time or maximum part time), and between January and March 2003, three separate cross-sectional questionnaire surveys were performed of work patterns in all specialist registrars, consultants <50 years, and consultants ≥50 years in respiratory medicine in the UK.

Specialist registrar survey

The response rate, age, sex and working pattern are shown in Table 1. All those training flexibly (all female) had started in full-time training and 10/18 (55%) intended to continue to train flexibly, whereas 8/18 (44%) reported an intention to return to training full time. Of those training full time, 178/215 (82.7%) (M = 135, F = 43) reported having no intentions to train flexibly, 2/215 (1%) (M = 2, F = 0) made no comment and 35/215 (16.3%) were considering training flexibly in the future (3 (M = 1, F = 2)) declaring this as possible, 20 (M = 4, F = 16) probable and 12 (M = 1, F = 11) definite).