to conform to their beliefs. A substantial majority of people favour assisted dying; should their views be subordinated to the views of a minority?

4 I did not claim that autonomy was the sole ethical principle; I said it was of 'paramount importance', which means it ranks above other principles in importance, not that it displaces them. I do not know how old Dr Trimble is but those of us of mature age will remember with some embarrassment the days when patients had no say at all in what was done or not done to them. The ascendancy of autonomy is the most significant change in medical ethics of the last half-century. I believe most medical ethicists would agree with this.

5 I used the analogy with abortion simply to emphasise that in the face of legal prohibition many covert abortions were carried out. I believe – and there is evidence to substantiate this – that the same thing is happening on quite a large scale within our profession with regard to assisted dying, usually under the guise of the double-effect principle. Dr Trimble's citation of the vast number of abortions now being carried out is another irrelevancy. I do not believe legalisation of the process of assisted dying will unleash an orgy of medical killing; it has not done so in countries that have legalised it.

6 It is Dr Trimble's final paragraph that persuaded me to reply. His dismissal of the public view in favour of assisted dying on the grounds of their inability to understand the complexities or dangers of assisted dying is an example of the sort of arrogant paternalistic medicine that I thought we had eradicated. Are we going back to 'leave it to doctor; he knows best?'

RAYMOND HOFFENBERG
Past President
Royal College of Physicians

Assisted dying

Editor – Raymond Hoffenberg's account of the arguments he gave to the Select Committee concerning the Assisted Dying for the Terminally Ill Bill coincided with a fascinating debate on the same subject, organised by the Christian Medical Foundation (CMF), that took place at Guy's Hospital on 16 February.

Dr Margaret Branthwaite, doctor and barrister, explained with forensic clarity why the Bill should be passed in terms of medical need and public demand, before pre-empting the factual and duty-based, or deontological, reasons that are often presented in opposition. Dr Jeff Stephenson, a palliative care consultant, countered passionately and offered differing interpretations of data available from the Netherlands, Oregon and oft-quoted public surveys in the UK. He won the debate, increasing the proportion of the 152-strong audience who would vote against the Bill from 32% to 44%, gaining the majority (given the number of 'don't knows').

Attendees found pamphlets printed by the CMF on their seats. These argued strongly against assisted dying and euthanasia from a heavily religious perspective.[1,2] In stark contrast, the debate itself contained very little reference to religion. Dr Stephenson, who has written about his own Christianity in relation to palliative care,[3] made no mention of it at all. Dr Branthwaite argued that religious beliefs should not be allowed to influence what is a secular issue.

This relegation of religious argument is paralleled in Sir Hoffenberg's article. In a very brief paragraph at the end of the section titled 'Doctors and patients', he finds that religious objections can be accommodated by the Bill because 'no doctor should be obliged to carry out any measure that is contrary to a firmly held belief or principle.' I wonder if sufficient attention is being paid to the concerns of those for whom the termination of life represents a spiritual and religious contravention.

As a doctor without strong religious beliefs, why should I be concerned about the scant mention of religion in these two contributions to the public debate? Surely an overwhelmingly factual approach is preferable, and least likely to irk atheists like myself. My concern is that in evading religious matters we are underestimating the importance of spiritual reflection as individuals struggle with the question 'Could I ever kill a fellow human?' When the conventional arguments – medical, emotional, statistical, deontological – have been heard and mulled over, it is to their perception of life and its relation to God (or their personal philosophical construct if atheist) that each doctor will have to look.

Religious belief is relevant to our society's approach to the subject of assisted dying. By concentrating solely on 'solid' arguments, and delicately skirting politically sensitive issues of faith, proponents and opponents of the Joffe Bill risk failing to engage with the fundamental concerns of many.

PHILIP BERRY
Specialist Registrar in Gastroenterology
King's College Hospital, London

References

1 Maugham T. Euthanasia. *CMF Files* 2003;**22**.
2 Myers K. Physician assisted suicide. *CMF Files* 2000;**9**.
3 Stephenson J. Being a Christian in palliative care. *Nucleus* July 2004:11–7. www.cmf.org.uk/literature/content.asp?context=article&id=726

Assisted dying

Editor – The paper by Sir Raymond Hoffenberg was certainly provocative and I could take serious issue with many of his arguments in what would be a much longer letter. Let me, however, make five brief but necessary points.

1 Sir Raymond states that the objective of legislation to permit assisted dying is to provide a lawful way to alleviate intolerable suffering in terminally ill patients despite appropriate medical treatment. He then goes on to say that the majority of patients do not have access to optimal terminal care. The point is that many of the patients in question do not receive 'appropriate treatment'. It is wholly inappropriate to legislate in favour of assisted dying on that basis when the responsible approach is to optimise treatment and increase the availability of the appropriate care he correctly espouses. In any case, the Joffe Bill[1] does not specify the need for failure of treatment.

2 I strongly refute the statement that palliative care specialists believe they can 'always relieve physical pain'. We are only too aware that we cannot relieve all suffering, but that must inspire further investment and research into symptom management rather than the legalisation of assisted dying.

3 Public opinion is not necessarily reliable or right, and nor is it a robust basis on which to base legislation. Informed public opinion is better, and the public need to be better advised about the enormous and widespread implications of legislation for assisted dying.
4 Sir Raymond speculates about what 'might' happen if assisted dying were legal, and states that there is no evidence from elsewhere to support some of the contentions of those opposed to such legislation. Having read many reports of procedure elsewhere, I am confident that there is indeed such evidence and participants in the recent House of Lords debate[2] on the Joffe Bill were certainly not unanimously reassured by supposed safeguards. Interestingly he states that 'in a civilised society it is highly unlikely that a doctor . . . would acquiesce to the involuntary killing of individuals'. That is precisely what we now do to vast numbers of unborn children.
5 Lastly, I do object to the description of a dying human being as 'an incipient corpse'. Our patients are still people, loved and valued, even though they are dying and it is our responsibility to care lovingly for them, not to discard them.

STEPHEN MW HUTCHISON
Consultant Physician in Palliative Medicine
Highland Hospice, Inverness

References

1 House of Lords. Assisted Dying for the Terminally Ill Bill 2005. Norwich: Stationery Office, 2005.
2 Hansard, House of Lords Debate, 10 October 2005.

In response

Having replied in some detail to the letter from Dr Trimble, I feel it would be discourteous to ignore these two additional letters. Let me assure readers that I have no intention of continuing the correspondence indefinitely.

In response to Dr Berry: In limiting my reference to religion I did not intend to diminish its importance. Like most proponents of the Joffe Bill, I sincerely respect the views of those who oppose it on religious grounds. The Bill does make an effort to accommodate them. What I question is the appropriateness of this sector of society imposing its will on those who feel differently.

Dr Hutchison's letter contains many of the points covered by Dr Trimble. Let me repeat that I am in favour of more and better palliative care and of improving public awareness of the issues involved in the debate about assisted dying.

Like Dr Trimble, Dr Hutchison misconstrues or distorts what I said in my article. I said there was no evidence of a decline in the patient–doctor relationship in the countries that have legalised assisted dying. Has he evidence to the contrary?

Finally, when I used the phrase 'incipient corpse' I was referring specifically to patients in a vegetative state, like Bland, once it had been decided to withdraw food and water and everyone was aware that death would soon follow. I was not generalising about all dying patients, and I used the phrase deliberately to emphasise my disapproval of the decision that allows a slow death by attrition rather than a more humane and speedy end.

I should add that I have had many letters from UK doctors supporting the views I expressed in my article. I do not stand alone.

RAYMOND HOFFENBERG
Past President
Royal College of Physicians

Re-training refugee and other overseas doctors

Editor – With regards to Eastwood *et al*'s article (*Clin Med* January/February 2006, pp 51–6) I appreciate that there were posts for only 70 refugee doctors out of probably 1,000. I think part of the refugee doctor problem is their initial interaction within society here. This could be helped by improving their English language and approach to initial contact with hospitals, and with regard to dealing confidently with staff and patients when embarking on Professional and Linguistic Assessments Board examinations. The initial period here is a very stressful time, particularly for doctors with difficult psychological or financial situations, to whom I advise the following:

1 Doctors who cannot find their way to training programmes could attend a nursing course for short periods of training or complete a prescribing course or therapist mini-course.
2 Doctors could be employed initially, for example, as nurses, pharmacy dispensers, endoscopy assistants or cardiology technicians to gain financial security. They will be able to proceed and train in their profession, gain experience, fill the shortage in these jobs, cease to be a burden on social benefits, and may also proceed into management jobs.

During their non-medical career they will be allowed to enter medical professional teaching sessions to make them safe doctors in the future.

L AL-DHAHIR
Physician and Geriatrician
St George's Hospital

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.

Doctor's knowledge of driving regulations: an interview-based survey

In August 2001, the Drivers Medical Group (Driver and Vehicle Licensing Agency (DVLA)) distributed guidelines on medical standards of fitness to drive to all UK-based medical practitioners. Since then, they have updated their guidelines biannually,[1] following working group meetings.

The survey reported here used a structured questionnaire, incorporating common medical scenarios, to examine the accessibility of the DVLA guidelines and of doctors' knowledge of their fundamental points.