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.

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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.

### 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.