in the final days of life is either distressing or hastens death.[2]

Some of the assertions in the paper are contradictory. Hoffenberg suggests, for example, that many 'good and caring' doctors practice the principle of 'double-effect medicine' but the recent survey of BMA members – the largest organisation of doctors in the UK – quoted in the paper actually revealed no evidence of covert euthanasia.

Even if this Bill were to become practise in the UK, the training involved to ensure physicians are as well equipped as possible to make these decisions and the identification of appropriate facilities where euthanasia can take place undoubtedly have costly implications – surely this money would be better spent on educating those who care 'for the majority who die in acute hospitals or nursing homes' where the 'experience is bad'? Also, if specialist palliative care centres became involved in physician assisted dying is it not possible that this would undermine their public support and ultimately their funding? If, as stated by Richard Smith, 'for the minority who die under the care of palliative care teams [the experience] is probably good' then the solution is to provide greater palliative care services and promote palliative care education in medical schools.

Although today's society demands quick fixes to problems, the wider implications of physician assisted dying are enormous. Palliative care is a young specialty with much to offer patients. The common goal of palliative care professionals is to provide symptom relief, to encourage patients to live to the full and to be there for them at the end of life. We sincerely hope that given time, greater financial resources and increased public education it may be that this Bill is not necessary.

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1 Lasagna L. Hippocratic oath – modern version. 1964.

2 Vida RA, Wells GA, Peterson J. The effects of fluid status and fluid therapy on the dying; a systematic review. *J Palliat Care* 1997;13:41–52.

Writing to patients

Editor – O'Reilly, Cahill and Perry have analysed some effects of sending letters to patients following an outpatient consultation and have highlighted the benefits (*Clin Med* March/April 2006 pp 178–82).

I found over many years an added bonus from dictating and discussing the letter with the patient (and relatives) sitting with me. This improved my attitude to them and it was very rare indeed for me to have to send a separate message to the GP. Sometimes I felt that the harder it was to dictate, the more worthwhile it was!

I surveyed 118 GPs in North Bristol and 117 found the letter copied to them helpful. Recently, in Gloucester, 30 patients with diabetes were surveyed, 21 out of 23 patients responding and 24 out of 26 GPs surveyed very much liked the system.

It is important to ask the typist to use large print for patients with poor sight and, incidentally, it made the life of the secretary much more interesting even if the letters may have been a little longer than usual.

However can we think we are putting patients in the centre of our practice without writing to them?

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Editor – We much enjoyed reading the recently published results of the randomised controlled trial of the effects of post-consultation letters to patients (*Clin Med* March/April 2006 pp 178–82). The authors showed that following a consultation in a haematology clinic in Ireland, patients were very satisfied with a personal letter sent to them which summarised their outpatient consultation. The majority of referring doctors also apparently found the letter to be 'very useful' or 'useful' in lieu of the standard outpatient correspondence and were satisfied with the information provided.

As the authors stress, these studies need to be widened to include a variety of specialties. We have recently published a similar study in cardiorespiratory clinics comparing patients' and general practitioners' (GP) views regarding a specific letter written to patients and a letter sent to the GP.[1] Whilst we showed a number of other interesting points regarding the comprehensibility of the two types of letter, we cannot confirm from our study that a letter written specifically to a patient would be a substitute for a traditional consultant–GP letter. Fifty-eight per cent of our patients wanted to receive both the letter written to them and a copy of the letter written to their GP, whilst 21.6% would prefer the GP letter alone and 20% only their letter. The majority of GPs who received both letters during the period of this study (42 out of 45) wanted either the GP letter alone or the GP and the patient letter, not just the letter to patients. In our study, letters to GPs were significantly longer than letters to patients but significantly less comprehensible to patients. The GPs generally found the structure and lack of specific clinical detail in the letters to patients unacceptable.

What we now need to do is to combine results from all of these reports and if only one letter is going to be written, determine the optimal format in terms of structure, content and comprehensibility to serve the needs of both referring doctors and patients.

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Reference

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'Heaven's gate, built in Jerusalem's wall?'

Editor – All doctors admire the efforts of colleagues such as Sylvia Watkins who devote their talents to improving the standards of medical schools struggling in adverse conditions of the kind she encountered at the Al-Quds University in East Jerusalem. However, it is axiomatic that reports on such experiences in medical or