Identification of tablets

SIR,—I read with interest Dr Anthony Kaiser's letter (16 February, p 485) suggesting the colour coding of tablets to assist in their identification by both the patient and his doctor. On the surface this appears a good idea. There must be over 2000 different preparations currently listed in *MIMS*, not including the various strengths of each one; and if one employs a policy of assigning each tablet a colour and three different coloured bands then, if we assume the use of eight colours, 4096 (8⁴) different combinations are possible.

I doubt, however, whether such an upheaval would be justified. It would probably be more difficult for a patient to remember "a blue capsule with yellow, red, and black bands" as opposed to "red and black capsules." I can foresee many mistakes being made in identification of tablets, by the patients and by hospital staff alike.

If one wishes to improve the identification of tablets, then one should adopt the general medical principle of applying the simple things first. I suggest: (1) All prescribed drugs should have clear labels with the name and strength of the bottle contents *printed* upon them, as opposed to illegibly scribbled. (2) Every bottle should have a sticker stating the use of the tablets—for example, arthritis, water pills, diarrhoea, etc—so that the patient remembers why he is taking them. (3) Manufacturers should be encouraged to christen new products with easily remembered names—this helps the doctor too. (4) One should encourage the use of identification boards. For instance in this hospital the rheumatology clinic has a plastic tray encased in which is a specimen of each of the currently available anti-inflammatory drugs. It is assumed that the forgetful patient recognises the tablets that he has ingested *x* hundred times!

R M ANTRUM

Department of Surgery,
Leicester Royal Infirmary,
Leicester LE1 5WW

SIR,—I read Dr Anthony Kaiser's letter (16 February, p 485) with considerable interest and sympathy.

Between 15 and 20 years ago I made the same *cri de coeur* and published some suggestions that a combination of letters and figures should be imprinted on tablets, so that by consulting a list one could identify a tablet, the drug, the dose, and the manufacturer.¹ At that time there was difficulty in imprinting characters on pan-coated and press-coated tablets, and capsules presented a separate problem.

After much discussion between the BMA and the Association of the British Pharmaceutical Industry (ABPI) it was felt that it would be difficult to implement this idea comprehensively on all tablets because of the expense factor (despite the fact that polo mints can be produced with their name on, apparently at such little cost).²⁻⁴ Foreign-produced tablets had also caused complications.

Despite these difficulties the situation is now very much better, and the ABPI compendium includes a description of each fixed dosage form for each product. Many more manufacturers infallibly identify their products, and I suggest that Dr Kaiser should

only prescribe drugs that can be instantly identified on looking at the tablet itself.

It took the profession a long time to accept the principle of *nomen proprium*—that is, putting the name of the drug on the bottle.⁵⁻⁷ When in difficulty I ask patients to bring in their bottles for confirmation of the tablets, but it should also be borne in mind that patients can swap tablets between bottles.

Attempts were also made in the early 1960s to identify tablets and capsules on the basis of colour, but three problems were found: (i) the difference of colour between the tablet and the reproduced colour on a chart; (ii) the difference of colour (albeit slight) between different tablet batches; and (iii) the difference in colour between successive printings of tablet identification charts—for example, by *Chemist and Druggist*. Eight per cent of males are colour blind, and patients can never be relied on to describe a colour accurately.

In order to keep this letter to an acceptable length for publication, I have only briefly touched on a few of the problems that were found. In no way do I consider the present situation ideal, but in fact it is much better than it was.

JOHN D W WHITNEY

Lichfield, Staffs WS14 0NJ

- ¹ Whitney JDW. *Br Med J* 1960;i:50-1.
- ² BMA Council. *Br Med J* 1961;iii:69.
- ³ BMA Council. *Br Med J* 1962;iii:36.
- ⁴ BMA Council. *Br Med J* 1965;iii:98.
- ⁵ BMA Council. *Br Med J* 1962;iii:36.
- ⁶ BMA Council. *Br Med J* 1964;iii:99.
- ⁷ BMA Council. *Br Med J* 1965;iii:98.

Bladder cancer as a prescribed industrial disease

SIR,—We wrote our recent paper (23 February, p 540) believing that there is serious under-claiming for PD 39 benefits (including those under the Old Cases Act). Unpublished DHSS tables give annual numbers of new awards of benefit by region, and during 1970-5 awards to Royal Marsden Hospital patients (excluding occupational referrals) appear to have accounted for a third to a half of all those in the South-east region. Yet only about 5% of bladder cancer patients in the region attend the Royal Marsden Hospital; several London teaching hospitals treat as many cases, and various hospitals draw more of their patients from relevant industrial areas.

The Royal Marsden Hospital has long operated a PD 39 claims service, with full occupational histories taken from all patients with bladder cancer, and help given with the claiming procedure—without which we believe that some claims would not be completed successfully. Currently a part-time service is funded mainly by industry, with contributions from some trade unions, since the hospital can no longer finance it. We believe that this service has ensured that virtually all Royal Marsden Hospital patients eligible under the PD 39 prescription have been identified and helped to obtain benefit. The fact that Royal Marsden Hospital patients have proportionately 10 to 20 times as many awards as other patients in the South-east surely suggests that there is serious under-claiming elsewhere in the region where this service is not available.

Our general experience supports this suggestion. Most Royal Marsden Hospital patients are referred from other hospitals; often those with exposure to bladder carcino-

gens have not had this feature of their illness noted, particularly when exposure occurred decades earlier in a job long since left, and this suggests that patients have not been questioned about past occupations. Moreover, when urologists in the London area have identified suspected occupational cases they have often called on our experience and help to evaluate these and assist in the claiming procedure; inclusion of such cases increases the proportion of regional awards in which the Royal Marsden Hospital has been involved to between a half and three-quarters. The degree of under-claiming probably varies in different industries and regions; we note that the West Midlands region had only about nine awards during 1970-5 although it is a centre of the rubber industry.

Doubtless many reasons contribute to the present unsatisfactory position in respect of PD 39 claims, but basically insufficient manpower and expertise are available. Identifying and checking possible exposures to carcinogens after long latent periods can be a complex task requiring time and expertise, and effective help for patients with these uncommon and technical claims demands experience. We hope that our recent paper will be of some help, but it does not provide a solution. How can the present state of affairs be improved?

SHEENA M SOMERVILLE

Department of Community Medicine,
St Thomas's Hospital,
London SE1 7EH

JOAN M DAVIES

Division of Epidemiology,
Institute of Cancer Research,
Sutton, Surrey SM2 5PX

W F HENDRY
GRANT WILLIAMS

Department of Urology,
Royal Marsden Hospital,
London SW3 6JJ

SIR,—The article by Sheena M Somerville and others (23 February, p 540) is admirable. There is, however, an omission in the paragraph "What other compensation may be obtained?"

It should be known among clinicians that a financial compensatory scheme known as the "papilloma scheme" was introduced by a number of firms in the dyestuff manufacturing industry many years ago. Clinicians who encounter patients with confirmed diagnosis of papilloma or carcinoma of the urothelium and in whom there is a suspicion of exposure to a bladder carcinogen would do well to advise them to contact the employer with whom they worked at the time of exposure.

J S GARDINER

Organics Division,
Imperial Chemical Industries Limited,
Manchester M9 3DA

Postgraduate education and the doctor

SIR,—It would be unfortunate if your readers were to deduce from Dr David C Evered and Hilary D Williams's paper (1 March, p 626) that continuing medical education using electronic aids such as videotape recorders was not worth pursuing. The "unacceptability" of such aids, as demonstrated in the limited selection of papers analysed, must surely depend at least partly on the nature of the material available through the medium. It is our experience,

obtained through contact with most of the postgraduate centres in the country, that one group of doctors at least—general practitioners—are aware of the potential benefits of audiovisual training programmes. In our own limited survey carried out early last year, of 123 course organisers for vocational training replying to a questionnaire, 81% had access to video recording equipment and 65% of them used the equipment sometimes or often. Since then we have evidence of an increase in interest in this type of teaching as shown by the purchase of videotape equipment, monitors, and cameras by individual course organisers or postgraduate centres. One area in particular where these techniques are being used is in the recording and study of general practice consultations, which many trainee groups use as an aid to study of many different general practice topics.

One point which seems clear from observations we have made of the use of audiovisual equipment is that the more frequently the equipment is used the more frequently it *will* be used, since familiarity breeds competence. Admittedly, there are still postgraduate centres like the one I visited where a missing videocassette recorder, needed in an hour's time, was eventually tracked down to a cupboard in the pathology museum, but these are becoming rarer as audiovisual programme material becomes available.

The authors' recommendation that "new techniques should be introduced only after rigorous evaluation in a pilot study" ignores the possibility of a learning effect associated with the use of such techniques, an effect which is likely to be significant only after considerable consistent use of audiovisual materials. The message that does emerge from the survey is the inadequacy of current evaluation of teaching methods. Often the only measure offered is whether the particular technique is preferred by the users rather than whether it had any teaching effect. Until more time and money are put into true evaluation many of the questions raised by the variety of current teaching methods will remain unanswered.

KARL SABBAGH

MSD Foundation,
London WC1 9JZ

Gonorrhoea—a question of tactics and logistics

SIR,—During my searches of the medical literature I look for communications on venereal diseases, if only because I have become somewhat specialised in the behaviour of the spirochaetes. However, combination of medical history and gonorrhoea (22-29 December, p 1631) attracted my attention for another reason. Probably there are pathologists and medical technologists still alive who would dispute the accuracy of my tale, but they might forgive my imaginative excursion or confirm my memory.

In 1943 I was a very junior trainee technician in a military general hospital in Malta. I had but recently been promoted from washing up to the bacteriology bench, and I still wonder whether I was being honoured or whether it was that the other technicians had found adequate excuses to avoid the job. I was required to collect specimens at 6 o'clock every morning from soldiers who had, I was told, acquired gonococci resistant to German sulphonamides, which, it seemed, had

been prescribed for prostitutes in Sicily. (Maybe it was North Africa.) I was to make cultures, which I would then test against British and American sulphonamides. That was the gist of the first medical research in which I participated. I did my best, even to making Oxford cups from old glass tubing—nobody under the age of 50 seems to remember what those were. My "chocolate agar" produced the required colonies and the work proceeded successfully up to the assays.

Then one morning the chief technician came into the laboratory. "Right. Pack it all up and go back to the routine bench." I must have looked as though suffering from shock. "Oh, it's all right. You've done nothing wrong. They've flown a new drug in and it'll be pumped into these blokes and they can go back to Sicily." I dared to ask the obvious question. "What's it called?" "Ah. It's something called penicillin. Very expensive. But it'll cure them."

During my activities for 30 years in medical and veterinary research I have told often this story as a moral tale to illustrate several things. Told with a touch of bawdiness, it relieves stress or tedium. Told with emphasis on status, it provides comment on our concern for professional one-upmanship in the community of science. With technical embellishments, it may help trainees to think about what they are doing. As a tale of fortunes and misfortunes, it may help to put into proper perspective our concern for our contemporary problems.

GERALD FOWLER

Wellington, 2 New Zealand

Pleural aspiration and biopsy

SIR,—In the article "Pleural aspiration and biopsy" (8 March, p 693) Drs P B Iles and Colin Ogilvie quite rightly open with the statement that the patient should be "as comfortable and relaxed as possible." Later on they say that "he may be either seated facing the side of the bed . . . or in bed with a bed table as a support for his arms." I submit that it is impossible for a patient to be relaxed and comfortable while leaning forward in bed with his legs outstretched. I cannot recall an occasion when it was not possible for a patient to sit beside the bed for aspiration.

It is equally important for the aspirator to be comfortable. To achieve this he should sit at a higher level than the patient so that the syringe is approximately level with his waist.

A O ROBSON

Chest Department,
Wycombe General Hospital,
High Wycombe, Bucks HP11 2TT

Rotating lights on doctors' cars

SIR,—Trinity House has been made aware that the Department of Transport is to permit the use of rotating green lights on doctors' cars when answering emergency calls in an attempt to help them reach such emergency cases more quickly.

While Trinity House fully supports any action that is likely to assist in the saving of lives, we are concerned over the possibility of the meaning of this light being misconstrued in coastal areas. As an example, a doctor could be called to a ship anchored at a pier and on arrival leave his rotating green light switched on. In periods of poor visibility

a mariner to seaward of the pier may mistake the light for an aid to navigation as green lights are used for starboard hand marks under the provisions of the IALA Buoyage System "A" recently introduced throughout the waters of North-west Europe.

While it is appreciated that the likelihood of this occurring is remote the consequences could be very serious and Trinity House has asked the Secretary of State to consider adding a suitable note to the relevant instructions, when they are issued, that the light should be used with caution in the vicinity of navigable waterways.

L N POTTER

Trinity House Lighthouse Service,
London EC3N 4DH

Disputes between branches of the profession

SIR,—The East Sussex Local Medical Committee has noted the letter by Mr Nigel Harris, the London surgeon, to the *Daily Telegraph* concerning communication problems between hospital doctors and general practitioners in the metropolis.

We regret publication in the lay press of letters by medical practitioners of one branch of the profession criticising those in another. This can, we feel, only serve to bring the profession as a whole into disrepute—these matters of difference within the profession should surely best be considered in the medical press.

E J KING

Vice Chairman, East Sussex
Local Medical Committee

Brighton, Sussex BN1 5LE

¹ Harris N. *Daily Telegraph* 15 February 1980:16.

Doctors and compulsory procedures

SIR,—The review of the use of Section 47 of the National Assistance Act 1948 by Drs D P Forster and P Tiplady (8 March, p 739) leads them to question its justifiability in present times. On the basis of my national survey, which will be published this year, I share their conclusion that Section 47, in its present form, is inappropriate and should be amended. This is a matter for the Central Ethical Committee to debate. However, I do not believe that it should be repealed.

As the DHSS does not record the number of removals, I sent a questionnaire to all responsible community physicians in England, 90.8% of whom responded giving data on 830 cases. In 94% of cases the powers of immediate removal of the 1951 Amendment Act¹ were used; in 97% of cases the individual was over the age of 65 and in two-thirds of cases admission was to a hospital, most of the remainder being to old people's homes. On the assumption that those who did not reply used their powers at a similar rate, about 225 people are removed using these powers each year in England, compared with 240 a year in the years 1949-55, during which time the numbers were recorded in the annual reports of the Minister of Health. (It is an interesting example of bureaucratic wish fulfilment that the 1955 report stated that "it is to be hoped that . . . the need to invoke this Section will gradually diminish"—following which no further reference to Section 47 was made.)

The range is considerable. Thirty-five out of 141 community physicians made no use