we believe that the trial is worthwhile. We have also found that many parents starting subcutaneous infusion at home have acquired new hope and a greater personal involvement in the care of their children. The main obstacle to routine home treatment, apart from the psychological difficulties, is the cost of a subcutaneous infusion apparatus (including the syringe driver, still half the price of a colour TV set, and a scalp vein needle for each infusion).

In conclusion, our short-term experience is encouraging: if its efficacy is confirmed by long-term trials, subcutaneous infusion therapy promises to be a reliable, convenient method of preventing or reducing iron overload in transfusion-dependent patients.

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Naming of drugs

SIR,—The explosion of drugs on to the market is disturbing, and the dangers were emphasised by Sir Richard Doll in Oxford six years ago. Not only do drugs have chemical and proprietary names, but the same preparations are often marketed under different names. The prescriber finds it difficult to remember these and to distinguish one drug from another. When the names of the drugs are very similar errors are likely to occur. For this reason the name Molivate was changed to Eumovate. Other drugs, such as Movelat and Motival, are easily confused. The biochemical effects of Sinthrome and Sintisone or of Optimax and Optimine are very different, but again the names are very close. Can many of these names not be simplified before more accidents occur?

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*. *Since all the names mentioned by Dr MacGregor are those of proprietary preparations his letter provides one more good argument in favour of using BPC approved names. These are carefully devised not only to avoid confusion with other names but also to indicate, wherever possible, the pharmacological group to which the drug belongs.—Ed, *BMJ*.

How to appear on television

SIR,—May I comment on the article about appearing on television by Mr Karl Sabbagh (21 October, p 1145)? His thesis is that a doctor who is approached to appear on TV should "trust" the producer in deciding whether or not he should appear on TV. What Mr Sabbagh fails to say is what the position of the doctor is if the producer misuses that trust.

Several years ago I was asked to contribute to an article in a national newspaper on a medical theme currently of public interest. I placed my "trust" in the journalist involved—much to my subsequent chagrin. The article was not in the form that the journalist informed me that it would be; and it contained material that I specifically wished to be excluded. The result of my willingness to give my services "as a person who does have something to contribute" (to use Mr Sabbagh's

phrase) was that I received the inevitable letter from the GMC, paid over £160 for a legal opinion on whether I had a case to sue for libel, and had several weeks of letter writing—and throughout all this time very much aggravation.

During the past year I have been approached twice to appear on TV for the purpose of contributing to a discussion on a subject of current public interest. My immediate reaction was a very definite "no," and I strongly recommend any doctor similarly approached to think twice about the proposition, despite Mr Sabbagh's comments. The question the doctor should ask himself is whether he can envisage medical colleagues who were not invited to appear on the TV programme watching their television sets with notebook in hand, having already looked up the GMC's address in Hallam Street, and just waiting to send off the letter of complaint. If such a scene can be imagined, then I suggest that he forget the invitation—the decision not to appear may not be "particularly good for medicine," but it will definitely be very good for one's own peace of mind.

J SLOME

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SIR,—Mr Karl Sabbagh in his interesting piece on appearing on television (21 October, p 1145), while offering some useful hints, omits some of the unexpected hazards.

The person who phones has, in my experience, rarely been the producer but a research assistant. Well-informed, courteous, and seductively persuasive she briefs you well, tells you of an eminent colleague who may be participating and what line she thinks you ought to take. She omits to say that there will be at least five others on the panel and that if you are lucky you may have 20 seconds of talking time. And that's after you have rearranged, with great difficulty, all your other commitments and suffered the concern and the anxiety that appearing on television entails.

Or what's worse is when you accept, at very short notice, a pressing invitation to be on the programme the following evening which you consider worth while, only to be told half an hour before the car arrives that "owing to unforeseen circumstances" this part of the programme has had to be postponed. Fair enough, but what of the indignity when they put the programme on a week later with another colleague in your place and neither explanation nor apology?

Even worse is to be invited to take part in a programme in a few hours' time, and because it is all so rushed nobody in the studio has time to talk about it and before you realise it either you are in the studio about to appear in somebody else's slot or, what happened to me, somebody else was about to do your bit.

But there are innumerable well-timed, carefully thought out programmes in which it is a privilege to participate and which enable you to "say something important about your own specialty in minutes."

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Day hospitals

SIR,—Having had a research interest in geriatric day hospitals for the last three years, I was very interested to read of the work of a Nuffield-funded day hospital mainly for pre-

terminal cancer patients (14 October, p 1053). Though not documented, some geriatric day hospitals have carried out similar supportive work in elderly cancer patients, with benefit both to patients and to relatives (if any).

Professor E Wilkes's day hospital also caters for those with "chronic disease" and here there is even more overlap with geriatric day hospitals since the conditions treated are very similar (strokes, arthritis, Parkinsonism), as are the therapy and diversions used. Although geriatric day hospitals cater mainly for those in their 70s and 80s, about 13% of their work is with younger disabled patients with strokes, multiple sclerosis, etc; and this group is similar to those treated in the Sheffield unit.

It would seem very desirable, as Professor Wilkes suggests, that any new day hospital function should be grafted on to existing units, to avoid duplication of staff and skills and to avoid worsening of transport difficulties. If the physicians and surgeons who first care for these cancer patients will continue their care in the day hospitals, enlarging and sharing the facilities with geriatric physicians, this would be a further and desirable move in the integration of general and geriatric medicine.

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Drug treatment of psychiatric patients in general practice

SIR,—I am disappointed that your correspondents look on my survey (7 October, p 1008) as destructive academic research. I had hoped that the "practical help and advice on how to help our patients" asked for by Dr D C Hogg (28 October, p 1228) would be detected in the article. If, as a result of reading it, doctors now prescribe benzodiazepines singly, for short periods at a time, and in flexible rather than fixed dose schedules, and recognise that low dosage of antidepressants is adequate for sedation but inadequate to produce antidepressant activity, they will help their patients a great deal.

Dr I H McKee (4 November, p 1296) claims that my conclusions cannot be justified as I was a participant in the consultative process, and as my sample was a psychiatric outpatient one the results are not applicable to general practice. He is right in assuming that general practitioners did receive feedback about their prescribing habits—I hope this was recognised as much from the clinical response of their patients as from any ex cathedra pronouncements I may have made—and in the last two years of the study there was less incorrect prescribing than in the first. This is likely to reduce errors in prescribing in those patients referred to an outpatient clinic, but Dr McKee nevertheless suggests that those who are treated by general practitioners alone might show fewer prescribing errors. This cannot be answered from the study, which, as its title indicated, was concerned with patients seeing a psychiatrist. However, as the survey was concerned with prescribing habits rather than response to treatment I have no reason to believe that the practitioner's general prescribing principles differed for other patients. Of course not all general practitioners refer patients to psychiatric outpatient clinics, but from my experience of the generally high quality of care given to the patients I saw I doubt whether the doctors who did not refer