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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Molar dosage

SIR,—We are concerned that a major drug manufacturer has changed the labelling and the strengths of calcium chloride (BP) from weight/volume to millimoles. We understand that this has been done to conform with SI units in co-operation with several area pharmacists. This information about these changes has had to be elicited by an inquiry to the firm concerned.

Several serious issues arise here. (1) Who has instigated and taken responsibility for these changes without adequate consultation or assessment of the practical aspects? (2) The new solutions are not equivalent to the familiar standard 10% and 20% w/v solutions previously supplied. (3) Many clinicians prefer to use metric mass volume concentration for drug dosage, which is comprehensive, uniform, easier to understand, and fully conforms with SI. (4) The arbitrary introduction of new solutions and labels will cause confusion for the medical and nursing staff. (5) The mole is an SI derived unit and as such is not universally accepted in the UK or the USA in clinical practice.

Metric weight and volume measurements are universally used, easier to visualise, safer to apply, and dosage is widely expressed in them in textbooks and clinical practice. These trends to molar dosage are unnecessarily

confusing, dangerous, and uncontrolled and should be reversed. They also represent a further step in the erosion of clinical bedside responsibility.

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Slow euthanasia

SIR,—I have had considerable personal correspondence about this article (4 September, p 571) from elderly people, their relatives, and professional staff. There is general support for the concept that elderly dementing patients should remain within familiar surroundings, and services should be provided to them there. There are two points arising from the article, however, which I would like to comment upon.

Firstly, the patient quoted who died following a prolonged terminal phase, with many courses of antibiotics, was only under my care for a few days before her death. In the other hospital, as is not uncommon, she had been under the care of several doctors, each of whom no doubt had treated the particular episode of infection as he thought best. The end result to the patient, however, was merely

prolonged suffering. It is my own practice not to give antibiotics for the common bronchopneumonias in this kind of patient. They are always due to mixed infections which recur, usually with an increasing variety of drug-resistant organisms. Moreover, the key factor in recovery, if it occurs, seems to lie with nursing care rather than antibiotics. I also prescribe pain-killing drugs as necessary in these old people, including morphine when the pain is severe and not relieved by lesser medication. It must also be remembered that the dementing elderly may have great difficulty in expressing themselves. Some who have severe pain behave like a wounded animal and retreat from all contacts but without verbalising their symptoms.

Several correspondents pointed out that the relatives or neighbours may suffer considerable distress as a result of the patient's behaviour and suggest that this may reach a point where it is justifiable to put an old person into an institution even if it is against their express wishes and even if there is the risk of doing the elderly person more harm than good. I think one must query the ethics of such decisions. For example, there are other patients who create considerable distress and harm to those around them. The alcoholic may cause havoc to his family, in his career, with accidents at work and on the road. I do not think that the same attitude is adopted to the 20-stone (130-kg) male alcoholic that is frequently adopted to the frail little old lady.

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