Correspondence

Letters to the Editor should not exceed 500 words.

"Doctors' Orders"

SIR,—Like so many other doctors I have been appalled by the presentation and content of *Doctors' Orders*. It is based on the myth of the magical omniscience of the doctor in matters of "health" which belongs to the pre-scientific era of medicine. The advice given on diet implies acceptance of over-nutrition as normal rather than as being one of the commonest diseases of modern civilization. Nonsense such as "from the health point of view, clothes should be warm, loose, and comfortable, allowing the body to breathe and sweat" recur on almost every page, indicating homely ignorance of physiology. This sort of stuff could be ignored if there was any attempt to distinguish untutored opinion from conclusions based on scientific study, but there is no such attempt.

My personal objections are unimportant, but the pamphlet carries on its front page "Published by the British Medical Association." If this statement is based on official acceptance by the Association of the contents of *Doctors' Orders* those who feel as I do will have to consider resignation. If, however, the Association has given the pamphlet no official sanction a public apology should be made as soon as possible with an announcement that the Association gives no support to "health education" such as this, which, since it has little foundation in scientific study, is largely irrelevant to the prevention of disease.

I hope that this apology and announcement will be made before subscriptions to the Association fall due for renewal next year.—I am, etc.,

Richmond, Surrey.

C. M. FLETCHER.

SIR,—The first objection that can be taken to this unfortunate document is that there are no such things as doctors' orders, but only doctors' advice, the patient being free to accept or reject advice at his discretion and at his risk. As an illustration of the inaccuracy with which this publication has been put together, it mentions, under the heading of "Fluoridation," that Kilmarnock are still fluoridating their water supplies whereas, in fact, they ceased doing so over 18 months ago.—I am, etc.,

A. E. JOLL,
Chairman of Executive,
Liss, Hants. National Pure Water Association.

Expensive Isolationism of London's Teaching Hospitals

SIR,—There are 12 undergraduate teaching hospitals in London with a haphazard location—for instance, in the North-West Metropolitan Region there are four hospitals and the distance between the nearest two can be covered in a walk of less than 10 minutes. Hospitals and medical schools duplicate and

compete for staff, equipment, and clinical material. One hospital recently acquired a computer and now another on the North Bank will be having similar apparatus in its new building. Is every school to have a computer? Is every hospital to have a unit for cardiovascular surgery; a department for organ grafting; a division for some new super-specialty? No teaching hospital can remain aloof from the sophisticated techniques and methods that are now developing. We are all caught up in this rat race, intent on the maintenance of status and privilege. With the national penury and the astronomical cost of medical care and research has not the time come for rationalization and the integration of some departments?

Why should the students of one school be restricted in their outlook to a postal district? When Professor X is lecturing at St. Etheldred's or Dr. Y is taking a ward-round at St. Anthony's—both men with an international reputation in their specialty—it should be possible with modern communication for students to share this pedagogic experience. Programmed learning and a new curriculum have been introduced at Newcastle. Are we "with it" in London where half the medical students of the country have their education? The injection of new ideas should be accelerated. Given good will and determination, London could set the pattern of a multiversity of medicine in which resources would be pooled; this would help to sustain the viability and virility of the teaching hospitals.—I am, etc.,

London W.C.1.

W. C. W. NIXON.

Code for Drugs

SIR,—Dr. C. Douglas Needham writing from Aberdeen is lucky. From his letter (12 December, p. 1527) it appears that if he traces a container of a drug to the pharmacist who dispensed it he can discover the nature of the drug dispensed. In my part of the country this is often not the case, there appearing on the container nothing but the name and address of the pharmacy and a simple signature, no date, no reference number. I usually add the letters N.P. on my prescriptions; it is seldom that my directive is complied with by the dispenser.

In the same issue of the *Journal* Dr. S. Bradshaw (p. 1527) refers to the Co-Tab code of imprints on tablets. This system is a big advance in imprinting: several pharmaceutical firms have used similar imprints, in the sense of providing identification of the producers linked with an indexable identification of the drug, but these have always applied to relatively small numbers of products, and almost invariably to proprietary specialities. Co-Tabs cover almost the whole range of non-proprietary drugs which are used in tablet form.

For the very reason that this is such a great step forward it calls for very detailed

criticism. I would have liked to see a much more modest collection of Co-Tab imprints as a pilot venture, say 20 or 30; this would have made it easy for relatively major changes to have been made in the "code" and kept the position fluid till it was discovered what dispensing doctors preferred. As it is it will be very difficult to introduce improvements without burdening retail pharmacists with a multiplicity of pharmacologically similar products.

For the moment there is only one aspect of the Co-Tab code to which I want to draw critical attention. There are some drugs which for all intents and purposes are only used in one strength—in the Co-Tab list this applies to acetarsol, amphetamine, atropine, butobarbitone, and 32 others. In these cases the initial letter followed by a number is a logical coding; so far so good. In the case of stilboestrol, however, there are listed six different strengths: 0.1 mg., 0.25, 0.5, 1, 5, and 25 mg., the coding number for these is 3, 5, 17, 18, 19, and 20, respectively, so there is no common factor in the codings for the different strengths of stilboestrol except the initial letter S which they share with the codings for sodium bicarbonate C. B.P., sodium chloride, sodium citrate, sodium salicylate, stramonium, and five sulphonamides. There is also no common differentiation between preparations containing a single drug and those with more than one active ingredient. Merely as an example I suggest that S J 2, S J 3, S J 4, S J 5, S J 6, and S J 7 is more useful than S 3, S 5, S 17, S 18, S 19, and S 20 for the six strengths of stilboestrol, S J being unique to stilboestrol.

For more than a hundred years chemists have used a system of abbreviations for the elements; there is no reason why a different system of abbreviations should not be available for established drugs, which could form the logical basis for imprinting of solid dose forms.—I am, etc.,

Halstead, Essex.

W. A. L. COLLIER.

Alkaline Diuresis for Aspirin Poisoning

SIR,—Dr. I. G. Graber states (28 November, p. 1395) "that normal saline is acid (pH 5.5–5.8)." This is not necessarily true. My experience is that solutions both of commercial and hospital manufacture vary from 5.5 to as much as 9.2. The glass from which M.R.C. transfusion bottles are made appears to vary considerably in the amount of alkali it contains, and I have found that random samples of normal saline from a single batch are likely, after autoclaving, to give solutions of very different pH. These are almost always on the alkaline side. Very rarely are they within the range mentioned by your correspondent.

The *British Pharmacopoeia* does not lay down pH limits for normal saline, although I understand that such a control is being considered.—I am, etc.,

A. F. MARSTON.

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Birmingham 15.