

sive care units worldwide) we have seen a major shift toward infants from families of non-European origin. At the same time, the proportion of infants less than 1500 g at birth has risen dramatically. The use of pregnancy induction technology for infertility, which has been suggested as a cause for at least part of the increase in low-birth-weight live births, appears to be less of a factor in this population.

Information from Statistics Canada shows that, whereas before 1961 over 95% of new immigrants to Canada came from European countries, that proportion was down to 26.5% by the last period reported (from 1988 through the first 6 months of 1991).<sup>1</sup> Moreover, according to the most recent immigration data, more than half of the 208 791 immigrants to Canada in 1995–96 settled in Ontario,<sup>2</sup> the largest proportion of these in the

greater Metropolitan Toronto area.

Canada has an enviable record throughout the world for its immigration and refugee policy, a record of which we all should be proud. However, it would appear that in our health care and social systems we are not adequately identifying and addressing the needs of those groups who would most benefit from interventions described by Chance.

I echo the call of the authors of both articles for more accurate information but also call on our political decision-makers to acknowledge that there are identifiable communities at increased risk, particularly in our urban centres, and to develop community-based approaches through the current health care restructuring process in Ontario to address this very real issue. The benefits to the future health of the mothers and babies of this province, quite apart

from the benefits to the taxpayers, should be obvious.

**Andrew T. Shennan, MB, ChB**  
Associate Professor  
Departments of Paediatrics and of  
Obstetrics and Gynaecology  
University of Toronto  
Chief  
Department of Newborn  
and Developmental Paediatrics  
Women's College Hospital  
Toronto, Ont.

#### References

1. *Immigration and citizenship*. Statistics Canada: Ottawa; 1992. Cat no. 93-316.
2. CANSIM (Canadian Socio-Economic Information Management System): matrices 5772–5778 and 6367 to 6279. Ottawa: Statistics Canada. Available: [www.statcan.ca/english/CANSIM](http://www.statcan.ca/english/CANSIM)

#### [The authors respond:]

**D**r. Shennan describes the experience at a tertiary perinatal facil-

ity and argues that the proportion of low-birth-weight babies in Toronto has increased, inaccuracies in the reporting mechanism notwithstanding. As we mentioned in our paper, the truncation of birth weights does not fully address other findings suggestive of an increase in low-birth-weight live births in Ontario. In fact, correction of the erroneous birth weights only halves the documented increase between 1987 and 1994, from 22% to 11%;<sup>1</sup> the latter increase remains highly significant statistically. Clearly, the truncation error is only a partial explanation for the increase. Nevertheless, our experience with Ontario data leaves us uncertain as to whether the increase is real or artifactual.

Shennan further proposes increased immigration from non-European countries as a likely cause of the increase. We agree that this is a plausible explanation, although it and competing hypotheses need to be carefully examined. Whereas a few of the potential explanations for the increase in low-birth-weight live births could be tested with existing data, obtaining accurate and comprehensive answers to such questions necessitates an improved system of perinatal surveillance, such as that currently being set up by the Laboratory Centre for Disease Control, the provinces and territories, and other concerned parties.

#### **K.S. Joseph, MD, PhD**

Consultant Epidemiologist  
Bureau of Reproductive and Child Health  
Laboratory Centre for Disease Control  
Ottawa, Ont.

#### **Michael S. Kramer, MD**

Professor  
Department of Pediatrics and  
Epidemiology and Biostatistics  
Faculty of Medicine  
McGill University  
Montreal, Que.

#### **Reference**

1. Singh I, Hagey J. Error corrected, conclusions the same. *Can Med Assoc J* 1997;157[6]:646-7.

## **Licence plates for drugs**

In response to my earlier recommendations on drug ergonomics in the letter "Drug packaging" (*Can Med Assoc J* 1997;156[6]:764-5), Dr. Noel A. Rosen made some important comments about drug labelling problems in his letter "Action long overdue on drug labelling" (*Can Med Assoc J* 1997;156[10]:1383-4): "Perhaps the most useful recommendation is to include the generic name, perhaps in abbreviated form, as well as the strength, on each tablet or capsule." I write to further comment on this concept, which I sometimes lightly call "licence plates for drugs."

I recently examined a variety of solid and liquid dosage forms to determine how much information could be printed on tablets, ampules and the like. For some very small products, such as nitroglycerin and lorazepam tablets, labelling of this type appears impractical. However, many products apparently allow for a special labelling code (the "licence plate").

Consider first a 4-character code to identify products. If each character could be 1 of 36 letters or digits, there would be 1 679 616 possibilities. If, to save space, a smaller 3-character code were used instead, 46 656 combinations would still be possible. Even a 2-character code, for very small tablets, would generate 1296 different combinations. Larger numbers of unique codes could be achieved by allowing special typographic characters, such as & and \*.

Next, suppose that some agency were to be given responsibility for managing the system. The agency would accept code requests by email from manufacturers and maintain a computer system linked to the Internet to provide drug information. Physicians and other caregivers could go to a special Web site, where they would use the unique code to obtain information about the drug, such as generic and brand names, route of

administration, concentration and strength, and warnings, notes and precautions, perhaps even a photograph of the product.

I invite stakeholders to consider the advantages and disadvantages of such a system. Given that more and more health care providers are using the World Wide Web, this would appear to be a potentially invaluable service that could be used worldwide to get quick information on registered products.

#### **D. John Doyle, MD, PhD**

Department of Anesthesia  
The Toronto Hospital  
Toronto, Ont.

## **The best solutions may be the simplest**

On a trip through Africa it struck me that a simple but effective device is in wide use there but has yet to be "discovered" by our North American designers. This singular item, a foolproof ventilator for outdoor privies, consisted of a black stovepipe placed on the sunny side of the facility. Outdoor privies are still quite common in parklands and backwoods areas of Canada, yet almost all seem to ignore this ecologically friendly and noteworthy advance.

A patient of mine recently demonstrated great ingenuity in self-treating numerous strawberry nevi on his trunk. I had told him that the lesions weren't worth treating because they weren't symptomatic, were hidden by clothing and had no potential for malignancy or complications. I told him they would be best left alone. That didn't stop him from trying a simple, self-devised therapy. Using a magnifying glass, he focused sunlight on each nevus, burning it lightly. I don't know if he was being extra stoic, but he insisted that it hadn't been painful. He showed me the end result 6 weeks after the "treatment" ended. Almost