

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.

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#### **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.

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## **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

all of the lesions had disappeared, and there was no evidence of scarring or inflammation.

One item that is sadly lacking in our state-of-the-art hospital system is a user-friendly lid for sealed fluid, margarine, jam and food containers. Many of these sealed units defy dexterous patients and utterly defeat weak, uncoordinated or arthritic ones. We aim for patient independence and self-sufficiency, but the seal-tight lids force patients to either get help or go hungry. Surely we could design pull-off lids with large tabs with a hole for a finger. Not only would this improve patient care, but it would also decrease demands on staff.

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## Where does our duty lie?

In his recent letter "Foreign specialists need not apply" (*Can Med Assoc J* 1997;157[7]:869-70), Dr. Shabbir Alibhai discusses the decision by the Royal College of Physicians and Surgeons of Canada to recognize only training taken in accredited residency programs in Canada and the US and raises some important questions about this decision.

The college's accreditation process is very different from that applied in most countries. Although it is un-Canadian to consider anything from Canada the best in the world, in the case of accreditation of postgraduate training it happens to be true. Indeed, most countries do not accredit residency programs. Some, such as the United Kingdom and Saudi Arabia, are developing systems modelled to some degree on ours.

As long as there is no generally accepted measure of competency to test physicians from around the world, no study to demonstrate differences between countries can be undertaken. However, the relative performance of

trainees of different origin on examinations *has* been studied. At one time the college allowed a broad spectrum of candidates to take its examinations. Failure rates in certain groups exceeded 90%, and we were criticized for "exploiting" candidates who went to great expense with little chance of success. The college then decided that examinations should be limited to those expecting to practise here and those who would likely succeed because of previous evaluations in accredited programs. This is another distinguishing characteristic of the Canadian system: success in examinations does not in itself confer certification. Evaluation during training plays an increasingly important role.

For more than a decade, only candidates trained in Canada, the US, the UK, Ireland, South Africa, Australia and New Zealand have been allowed to take Royal College examinations. Our recent change has decreased the number of foreign exemptions to 1: the US. The college does hope to see increasing reciprocity in accreditation. A formal offer has been made to sister colleges in many of the countries noted above. As well, the Royal College sponsored an October symposium that brought together key players in an attempt to find a way to evaluate and recognize offshore specialists recruited to remote areas.

But I have some questions of my own. Why do we, as Canadians, collectively throw up our hands and presume that we can never overcome the inadequate distribution of medical specialists? With all of our advantages, why should Canada not be a net exporter of highly trained specialists instead of an importer? And what of young Canadians and their desire to pursue a career in medicine? There is less than 1 first-year place in medical school available for every 20 000 Canadians. The only other country with such a low number is Albania! In BC the ratio of first-year positions to population is 1:26 000. In

the UK, a commission has determined that the ratio there should be increased to 1:13 500.

I fully agree that as citizens of the world we have moral obligations to specialists everywhere, but surely our first duty is to Canadians.

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## Is it ethical to forgo treatment?

In their article "The 'Supremes' decide on assisted suicide: What should a doctor do?" (*Can Med Assoc J* 1997;157[4]:405-6), James Lavery and Dr. Peter Singer write: "There are 3 practices along the spectrum of end-of-life care: palliative care, decisions to forgo treatment, and euthanasia and assisted suicide. The first 2 are ethically uncontroversial, legally permissible and part of quality medical care."

The second half of this statement is incorrect, for although palliative care is undeniably and always "ethically uncontroversial," the same cannot be said about decisions to forgo treatment. The ethical character of these decisions depends largely on what is meant by "treatment." Is it "medical treatment" or is it "treatment" that involves not only the administration of remedies by a physician but also the provision of minimal care such as nutrition?

Furthermore, it makes a considerable difference whether the medical treatment being withheld or withdrawn is considered ordinary (proportionate) or extraordinary (disproportionate). A medical treatment is disproportionate if its complexity, cost or risk or the degree of suffering it entails is out of proportion with the potential benefits.

Even committed pro-lifers recog-