

'brown–yellow dot inhaler' regularly.

Colour has always been used to aid recognition, this convention is not new in medicine. A standardised colour code for user-applied syringe labels for anaesthetic drugs exist in the US, Australia, New Zealand, South Africa, and Canada.² A single standard system for syringe labelling in critical care areas has been adopted in the UK as well.³

There is always a problem in reading the labels as instructions are often written at a level too complex for low literacy patients.^{4,5,6} Inadequate literacy, without any doubt, is a barrier to asthma knowledge and proper self-care.^{6,7} Moreover, patients who have a different first language than the healthcare provider can raise additional issues.

So there will be a large group of patients who can identify their inhalers only by the colour. Older people who have difficulty identifying colours will have difficulty reading fine print as well and will need assistance. People who are colour blind should continue to read the labels or identify their inhalers by the design or size. We, therefore, believe that adding universal colour dots to the current system will only do good in creating uniformity without causing any additional limitations.

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REFERENCES

- Jayakrishnan B, Al-Rawas OA. Asthma inhalers and colour coding: universal dots. *Br J Gen Pract* 2010; **60(578)**: 690–691.
- Christie IW, Hill MR. Standardized colour coding for syringe drug labels: a national survey. *Anaesthesia* 2002; **57(8)**: 793–798.
- Carter JA. Syringe labelling in critical care areas. June 2004 Update. *RCOA Bulletin* 2004; **27**: 1370–1373.
- Davis TC, Crouch MA, Wills G, *et al.* The gap between patient reading comprehension and the readability of patient education materials. *J Fam Pract* 1990; **31(5)**: 533–538.
- Goodyer L, Savage I, Dikmen Z. Inhaler technique in Turkish people with poor English: a case of information discrimination? *Pharm World Sci* 2006; **28(2)**: 107–114.
- Williams MV, Baker DW, Honig EG, *et al.* Inadequate

literacy is a barrier to asthma knowledge and self-care. *Chest* 1998; **114(4)**: 1008–1015.

- Sestini P, Cappiello V, Aliani M, *et al.* Prescription bias and factors associated with improper use of inhalers. *J Aerosol Med* 2006; **19(2)**: 127–136.

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Visual loss

We would like to highlight the problems that patients with significant visual loss have in detecting clinically important signs. Two male patients aged 71 and 75 years, who were registered blind due to retinitis pigmentosa, were late presentations with bladder carcinoma. It was clear that these patients had haematuria for some time prior to presentation but were unable to detect this due to severe visual loss.

The purpose of this letter is to draw attention to the difficulty that patients with visual loss have in detecting signs that are easily apparent to patients without visual loss.

It is difficult to see how these problems can be avoided. One suggestion would be a protocol in place where patients who are placed on the Blind Register and their relatives are advised on their inability to detect clinical signs such as haematuria, malaena, and haemoptysis and therefore need regular assessment by a third party to detect such signs.

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The physician assistant

In answer to Olumide Elegbe's question 'is there a role for physician assistants (PAs) in routine care?' my answer, currently, would be no. I would much prefer an experienced nurse or even, dare I suggest

it, another doctor. Mr Elegbe obviously has confidence in the evidence he has referenced, however, the majority of this is from the US and given the differences between our two healthcare systems and respective primary care, I would not rush to apply the same conclusions from the data collected there, to here.

A pilot of PAs has already been undertaken in Scotland² and this highlighted some important points. The PAs involved felt that they were unable to demonstrate their full capacity within primary care and this was attributed to the fact that there was no identifiable gap in the care of patients for them to fill, presumably this was because the pre-existing primary care team was already sufficient and as the PAs put it 'family medicine/general practice differed from the US to Scotland'.

Any issue regarding the cost-effectiveness of PAs was also underlined by the study, reporting that within the primary care setting, an individual PA would cost approximately £15 000 more to employ than a practice nurse (PA salary defined as Agenda for Change Band 7, £29 091–£38 353).

I remain unconvinced that a science graduate with 2 years training would complement the current primary care team, at least not for that price.

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REFERENCES

- Elegbe O. GP commissioning consortia: is there a role for physician assistants in routine care? *Br J Gen Pract* 2010; **60(578)**: 704–705.
- Farmer J, Currie M, West C, *et al.* Evaluation of physician assistants to NHS Scotland. Final report. UHI Millennium Institute, 2009. <http://www.abdn.ac.uk/crh/uploads/files/PA%20Final%20report%20Jan%2009%20version%205.pdf> (accessed 8 Oct 2010).

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Antidepressant prescribing

The appropriateness of antidepressant