The Labeling of Medications

Although *Circulation* is primarily a repository for original papers, one's resolve to keep it pure is repeatedly eroded by the claim of mundane problems of practice to attention in its pages. In the terminology of Fox,1 one's goal is to have a pure "recorder" journal but, occasionally, "newspaper" objectives have claims to space that are difficult to deny. I wish to draw the attention of specialists in cardiovascular diseases to the positive recommendation by the Council on Drugs of the American Medical Association, that drugs be labeled. This was reaffirmed in a recent report, "To Label or Not To Label."2 The original resolution was *The Council resolves that it favors labeling of prescriptions as a general practice, and furthermore, it is recommended that prescription pads contain boxes for a yes or no on whether to label; if these boxes are not filled in by the physician, the prescription will be labeled.* The objections to such a standardized practice are fairly answered.

Because more than a few drugs utilized by cardiologists have occult toxic effects and because others cause severe reactions manifested by disorders of the circulation, cardiovascular specialists must know the nature of medications the patient has been taking, not only at the time of the examination but also in the previous months. The hazards related to the use by the patient of anticoagulants, corticosteroids, powerful new diuretics, anti-hypertensive agents, antidepressives, headache remedies, tranquilizers, and even nitrates, quinidine, and digitalis are, or should be, well known to physicians. The hazards increase in magnitude with the increasing travel by patients, the growth of group practices, and the increased propensity of injury and not infrequent need of surgical treatment. Particularly with the elderly whose memories may be failing and who may be using numerous nostrums, the physician may be especially frustrated.

It is trite to say that, only by being aware of the medications his patients are taking, can the physician be alerted to possible bizarre reactions from their long-term use in susceptible subjects. The potential nefarious effect of drugs, for example acetophenetidin (phenacetin), triparanol (MER-29), and hydralazine hydrochloride (Apresoline), was only accepted as valid, after gradual accumulation of rare cases. Can a contributory etiological role of methysergide maleate (Sansert) in valvular disease, as now suspected by me, or of contraceptive medications in thrombotic episodes perhaps be supported similarly by the collection of exceptional cases?

(It is obvious that labeling is without value unless it be read; for example preparations of potassium salts and of potassium penicillin G are available that if given *undiluted* and *rapidly* are capable of producing hyperkalemia and ventricular fibrillation. The knowledgeable physician who reads the label would not make such a mistake. In addition, labeling basically relates to the main drug being pur-
veyed, and it would be only the cavalier practitioner who, in the event of an accumulative untoward reaction, would not wonder about the carrier or an impurity.)

In a previous editorial, I made a plea for the labeling of drugs; in the nearly 10 years since that editorial was written, only modest progress in the adoption of the practice has been apparent. It is recognized that labeling will not solve all the problems related to unknown medication because patients will transfer medicines to other bottles, forget their medication entirely, or, in rare cases, even malinger, possibly as a "Munchausen's syndrome." Among the letters I received after the publication of my plea was one from the veteran cardiologist, Arthur Master, endorsing the recommendation and mentioning that it had been his mode of operation since he had first received his license to practice in 1921.

In what I have read on the controversy, the respondents are predominantly in favor of labeling. An example of a clear, concise opinion of a protagonist is that in the letter by G. M. Wilson to the Editor of Lancet. In Britain where possibly the patient may not as frequently have his disease and treatment explained in the same detail as in America, Wilson favors labeling. He states that he is unaware of any reliable evidence supporting objections to labeling and concludes "Good medicine cannot be practiced nowadays in ignorance of the drug patient has been taking."

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References

Albert Schweitzer 1875-1965

For there must indeed arise a philosophy profounder and more living than our own and endowed with greater spiritual and ethical force. In this terrible period through which mankind is passing, from the East and from the West we must all keep a look-out for the coming of this more perfect and more powerful form of thought which will conquer the hearts of individuals and compel whole peoples to acknowledge its sway. It is for this that we must strive.—ALBERT SCHWEITZER: Indian Thought and Its Development, New York, Henry Holt and Company, 1936, p. x.
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