A novel method for reducing confusion in hospital corridors

Hugh Malcolm

The similar appearance of physicians wearing white lab coats as they walk down hospital corridors often leads to cases of mistaken identities. Although surgeons are readily identifiable by their scrubs, it is much more difficult to distinguish other specialists. This often leads to confusion among nurses and other doctors who might be wondering if the nearby group of physicians are, for instance, internists, radiologists or obstetricians. The end result may be erroneous questions, embarrassed cases of mistaken identities and inappropriate usage of time.

To solve this problem, I propose that physicians be assigned a specific lab-coat colour on the basis of their specialty. This would make them easily distinguishable. To wit:

- cardiologists and hematologists: red
- gastroenterologists: brown
- obstetricians: pink (or blue, depending)
- radiologists: black and white
- nephrologists: pale yellow
- hepatologists: bright yellow
- infectious disease specialists: mouldy green

And so on.

Using this simple, low-cost method, much of the confusion that currently exists could be eliminated, allowing physicians to be correctly identified even from far away. Further studies need to be done to demonstrate the cost-effectiveness of this approach, to choose appropriate accessories for each lab-coat colour and to determine how colour-blind people might be affected. I await prospective validation of this suggestion in a randomized, but not blinded, controlled trial.

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[A hospital administrator responds:]

Jeffrey Silverman brings timely attention to the problem that hospital patients have in identifying the multitude of people they encounter in a hospital. A recent study at the Vancouver Hospital and Health Sciences Centre revealed that during a stay of average length, a patient will be looked after by 50 to 60 people in a wide variety of professional disciplines and staff categories. Silverman's suggestion of colour coding lab coats should certainly be taken seriously and widely discussed, but there are some major stumbling blocks.

He acknowledges the difficulties colour-blind patients would face, but even those with normal vision would require a very keen eye indeed to distinguish the multiple shades that would be necessary to represent the 13 major specialty departments and 41 subspecialty divisions found in a large hospital. The colour decoder that would need to be posted on the walls of all units and corridors would be extremely difficult to interpret. It would need many nuances to differentiate all of them: perhaps misty rose pink for female obstetricians, with shocking pink reserved for psychiatrists who perform ECT, black for pathologists, and so on.

However, a logical extension of Silverman's proposal would solve the problem perfectly. Rather than having distinctively coloured coats, it would be much more declarative and easily understood by patients to have the white coat clearly marked with appropriate emblems of the wearer's specialty. An exhaustive list would require the Medical Advisory Committee to put forward recommendations, but the typical surgical personality would go for this sort of branding big time and the mind boggles over the wide range of anatomical options available. For the cardiologist, it would be tastefully stylized hearts in bright red. Radiologists should have an x-rated design of one kind or another. For the pathologist, a skull-and-crossbones motif would immediately convey the proper message. In this age of political correctness gynecologists and the urologists would present a serious problem, but I have no doubt that their fertile medical minds could come up with a bottomless list of possibilities.

An analysis of the cost of bringing these changes about in Canada's hospitals could easily be designed by Silverman and me, probably at a cost of no more than a million dollars or so. I am certain that Human Resources Development Canada would fund the project without asking too many questions.

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Authorship of articles in *CMAJ*: Who goes first?

Although the Vancouver Group should be congratulated for refining the definition of authorship,[1] might not the task have been easier and more complete had the group consulted a linguist? Granted, the revised criteria effectively distinguish the denotations of authorship from its connotations and

advance the limits of its lexicon beyond the classical set of performative functions, such as writing the paper, to the condition of being bound to take responsibility for the utterance. These accomplishments are meaningful and serve to reconstruct the container "authorship." As a result we now know who belongs in the box. But from a linguistic perspective, the contents of that box remain jumbled and messy because the revised definition, devoid as it is of philological sensibility, fails to account for the relational components within authorship.

The components are, of course, names: epithets (Miller), toponyms (Atwood), patronyms (Johnson) and sobriquets (Smiley). So once we have decided who is an author, how do we then decide in which order to arrange the names? Criteria need to be set for this unfinished task. In undertaking to complete it, I suggest that the Vancouver group appeal to linguistic principles such as those of onomastics, the study of the origins of names. With onomastic awareness, a meaningful order among authors' names often simply declares itself. Take, for example, Julia Twigg's landmark 1983 paper, "Vegetarianism and the meaning of meat,"[2] or Dale Speedy's recent contributions to articles on marathon running.[3,4] There's also D.P. Speach's work on stroke rehabilitation.[5]

Are the observed references between the meanings of the authors' names and the contents of the articles mere coincidence? No. Onomastics tells us that these are historical derivatives, sobriquets. A more convincing example lies in experimentation. The epithet "weir" means a dam across a stream to back it up. When we run a MEDLINE search on the author name "Weir" and the keyword "urology," it's not mere coincidence that we discover Julie Weir has authored in this field.[6]

It's noteworthy that under the current definition of authorship, Weir is listed as author 7. Since many medical journals by convention list only the first 6 authors, the onomastic coherence between this author's name and the substance of the paper is pretty much lost. Were the Vancouver group to incorporate onomastic criteria in the definition of authorship, more than likely Weir would be acknowledged as one of the primary authors, history would be preserved and redundant MEDLINE searches that combine author names with keywords could be avoided.

Of course, the potential of involving a linguist in redefining authorship goes well beyond onomastics. Additional branches of linguistics that could also assist with the task of establishing order among author names include: genetic relationships, etymology and perhaps phonology. (Although I would be cautious about the latter. For example, to establish linguistic coherency between Dr. Achenbach and his article on pain,[7] one runs the risk of reducing the authors to a set of phonemes and the criteria for authorship to a bunch of idioms. I believe this is what the Vancouver Group was trying to avoid in the first place.)

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[Editor's note:]

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