Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Physicians' Role in Health Care Reform

To the Editor: Dr. Kirkegaard in the March-April issue of *JABFP* made several sensible observations regarding the need for physician activism in health care reform (Kirkegaard MA. The physician's role in health care reform. J Am Board Fam Pract 1993; 6:163-7). I was particularly impressed by her statement that "Physicians have the knowledge, capability, and opportunity to advocate for and to effect reform within the health care system." I agree that physicians do have the knowledge and the capability, but I do not believe we have the opportunity to participate in a meaningful way in our politics. Certainly, we have a multitude of medical societies, medical organizations, and other leadership units in various teaching centers and other institutions, but they all, in my opinion, have great difficulty and are quite ineffective in arriving at any consensus of what it is that is lacking and what is necessary to revitalize American medicine. Our leadership is not really a leadership at all; it is a bureaucratic establishment out of control.

But even worse there is no real way for the private physician to be heard. We have no effective methodology, no forum, no format to exert influence in the decision-making process. Our state and national societies are mostly driven by economic and academic forces, both of which ignore the basic philosophical principles that should guide us.

Until we have local forums, perhaps in our community hospitals, that encourage the participation of private physicians, we will not have any influential number of physicians participating in health care reform. The point is that participation requires a place that is convenient, a broad-based leadership, and a commitment to encouraging examination and debate of the great political issues facing us. One outstanding failure of American medicine is its oversight in not having instituted such forums 30 years ago, when medical technology was beginning to influence so greatly the way we practice.

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The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: I agree with Dr. Volpintesta's salient observation that local forums, which encourage the participation of private physicians, will greatly enhance the role of physicians in health care reform; however, I disagree that there is "no real way for the private physician to be heard."

Within the political arena, physicians have traditionally held a very powerful position. Health lobbying groups, such as the American Medical Association (AMA) and the Association of American Medical Colleges, have exerted a tremendous influence in the development of health care legislation. In the 1978 campaign the AMA Political Action Committee was the number one financial supporter, with $1.9 million in contributions.[1] These powerful lobbies supposedly comprise local physician representatives and derive much of their political support from the financial backing of private physicians. Unfortunately, the political role of physicians has been almost entirely reactive instead of proactive. Consider the AMA proposal, Health Access America, a 16-point proposal to facilitate access to care for uninsured Americans. The actual content of Health Access America is not as relevant to this discussion as the description of the proposal offered by C. John Tupper, MD, past president of the AMA. He writes, "There's nothing radical about this plan . . . freedom of choice for patients and freedom of practice for doctors are hallmarks of the plan, and there's *nothing new* (italics mine) at all about any of that."[2] There have been many new proposals and changes in health care in the last 30 years (and certainly there may be some radical changes proposed under the current administration). Why aren't physicians, not legislators, the ones to advocate for new changes in our health care system?

Finally, much of my original article focused on the changes that physicians can make in their daily practices to ensure cost-effective, high-quality medical care. Many of the changes are attitudinal and require no consensus, leadership, or forum but merely the personal conviction of the private physician. Physicians have a tremendous impact on their patients' personal lives, and with a little effort we can extend that impact beyond the examining room. We do have the potential to reform the health care delivery system in the United States while compassionately advocating for our patients.

Margaret Kirkegaard, MD
Hinsdale, IL

References

1. Jonas S, editor. Health care delivery in the United States. 3rd ed. New York: Springer, 1986:506.
2. Tupper CJ. Dreams, dollars and deeds: the sacred fire and Health Access America. JAMA 1990; 264:1150-2.

Effectiveness of Cough Syrups

To the Editor: The recent article dealing with the clinical effectiveness of three cough syrups[1] makes a conclusion that was not supported by the design of the study. Guaifenesin was compared with guaifenesin plus codeine and guaifenesin plus dextromethorphan for cough relief, adherence to treatment, and side effects. Guaifenesin was used as a control vehicle, although in the paper guaifenesin is implied as having antitussive properties in itself. With the exception of one treatment outcome for guaifenesin plus dextromethorphan at day 4 (ability to keep up with usual activities, which improved least for this group), there were no statistically significant differences for the three treatment groups in measured outcomes for days 2, 4, and 10. The authors' conclusion was that guaifenesin, codeine, and dextromethorphan are equally effective in relieving cough symptoms.

This is not the case, however. All the study could say is that codeine and dextromethorphan do not add anything to guaifenesin in relieving cough symptoms, because codeine and dextromethorphan were not themselves tested separately from guaifenesin. The only way they could be equally effective in this study is if guaifenesin is no better than placebo, and there are no convincing studies that guaifenesin is effective as an antitussive.[2,3] So the disturbing conclusion from this study is that guaifenesin, codeine, and dextromethorphan might be all equivalent in relieving acute cough symptoms, but equally ineffective.

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References

1. Croughan-Minihane MS, Petitti DB, Rodnick JE, Eliaser G. Clinical trial examining effectiveness of three cough syrups. J Am Board Fam Pract 1993; 6:109-15.
2. Drug facts and comparisons 1993. 47th ed. St. Louis: Facts and Comparisons, 1993:986.
3. Kuhn JJ, Hendley JO, Adams KF, Clark JW, Gwaltney JM. Antitussive effect of guaifenesin in young adults with natural colds. Chest 1982; 82:713-8.

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: Dr. Pisarik is correct in stating that our conclusion could be more accurately stated as "It appears that guaifenesin plus dextromethorphan or codeine is equally effective in relieving cough symptoms when compared with guaifenesin alone." Though the point is largely semantic, the three syrups can also be considered equally ineffective.

Considering either statement of our conclusion, the stage is set for a placebo-controlled randomized clinical trial of cough syrups. As stated in the methods section of our article, however, inclusion of a placebo syrup or "no treatment" group was unacceptable to the physicians participating in our study. After extensive conversations with practicing physicians, pharmacists, and patients, we determined that it would be quite difficult to select a true placebo syrup or to limit the intake of over-the-counter preparations among study participants. In addition, the most commonly used cough preparations all contain a guaifenesin-based syrup. Thus, we settled on using guaifenesin as a comparison cough syrup.

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Jonathan E. Rodnick, MD
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Family Physicians and Clinical Ethics

To the Editor: I have just read two works by Orr and colleagues[1,2] and an accompanying *JABFP* editorial by Pence[3] and find myself both excited and disappointed by their content.

I am disappointed not by the work by Orr, et al., which appears excellent, but by the authors' implication that family physicians must approach medical ethics the same way that other medical specialists do.

In their *JFP* article, Orr and Moon raise the question of whether a family practice perspective actually contributes to clinical medical ethics, but they do not clearly answer it. Not that they should have answered it, because the structure of their work — on paper anyway — is that of a traditional clinical ethicist who happens to be a family physician, not that of a family physician who does ethics. I could have missed something special about their management conferences, but I can't tell from the article.

The editorial by Pence was especially disturbing. His opinion is that really important clinical ethics happens only in very sick patients, usually at tertiary care centers, and most often in ICUs. This is certainly academic myopia. While a good deal of popular, "media-genic" ethics occurs in these settings, ethical questions arise everywhere — even at midsize community hospitals and physician offices. Dr. Pence refers to Howard Brody; has he read Dr. Brody's *The Healer's Power*?[4]

I am excited by many of the same issues that Orr and Moss discuss in their *JABFP* article, and I couldn't agree more that family physicians should have a naturally unique predisposition toward clinical ethics. Our approach to these issues, however, should build on our special expertise. We should approach clinical ethical problems with our communication skills, our understanding of the family, and our working knowledge of the biopsychosocial model as spe-