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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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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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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-

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