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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.

Paul Pisarik, MD
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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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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-

cial assets, not just with the management team at provider-only conferences, but with patients and families themselves.

We should address the ethical questions in the clinical situations we face daily, not to the exclusion of tertiary care ICU cases, but not to dwell on them either. Let the neurologists deal with the neurologic aspects of the comatose patient's ethical dilemma; let us deal with the primary care clinical ethical issues — including overall case management — and help with the family in a comprehensive way. Orr and Moss demonstrate this approach with the *JABFP* case report of the man with amyotrophic lateral sclerosis, but what about exploring the ethical questions in more common cases?

Dr. Pence is concerned that physicians will be challenged by antiphysician sentiment as we fulfill the patient advocate role inherent in clinical ethics. We may be challenged, though I think Dr. Pence is creating a false sense of conflict. As family physicians, we are dedicated not to any specific medical ideology, but to using our skills, both professional and personal, to provide the best care for our patients.

According to the American Academy of Family Physicians,

> The family physician is educated and trained to develop and bring to bear in practice unique attitudes and skills which qualify him or her to provide continuing, comprehensive health maintenance and medical care to the entire family regardless of sex, age or type of problem, be it biological, behavioral or social. This physician serves as the patient's or family's advocate in all health-related matters, including the appropriate use of consultants and community resources.[5]

Finally, I agree with Drs. Orr and Moss that there is a great need for the participation of family physicians in the teaching and practice of clinical ethics. Christie and Hoffmaster said as much in their book *Ethical Issues in Family Medicine*.[6] Still, we shouldn't need to become who we're not; we should develop who we are.

Marc Tunzi, MD
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3. Pence G. Clinical ethics and the family physician. J Am Board Fam Pract 1993; 6:80-2.
4. Brody H. The healer's power. New Haven: Yale University Press, 1992.
5. American Academy of Family Physicians. Definition of family physician. Adopted by the Congress of Delegates of the American Academy of Family Physicians, 1975.
6. Christie RJ, Hoffmaster CB. Ethical issues in family medicine. New York: Oxford University Press, 1986.

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

To the Editor: I would like to thank Dr. Tunzi for his thoughtful comments on my recent articles on ethics consultation in family medicine.

In the *JFP* article,[1] Dr. Moon and I were describing an ethics consultation service, developed in the department of family medicine, which offers service to all departments in a tertiary care medical center, because that is who recruited and hired me and that is where I have most of my experience. We did not mean to imply that "family physicians must approach medical ethics the same way that other medical specialists do." In that article, we referred to the forthcoming *JABFP* article,[2] which had the thesis that family physicians are uniquely qualified to do ethics consultations.

Dr. Tunzi characterizes my work as "that of a traditional clinical ethicist who happens to be a family physician, not a family physician who does ethics." I am a family physician first, and I use those skills when I do an ethics consultation. I trained in a program in traditional clinical ethics, and I use much of the knowledge that I gained there when I do an ethics consultation. I do not consciously try, nor do I think I should or could, to separate these personae. I believe that the management and family conferences that I facilitate are different from those held by other clinical ethicists because of the family medicine perspective as outlined in the *JABFP* article. We did not make it clear in the article that patient and family members are present at most of our management conferences.

I agree with the author that "We should address the ethical questions in the clinical situations we face daily." I teach family medicine residents in their outpatient clinic, and I try to do just that. There is, unfortunately, a dearth of literature on outpatient ethical dilemmas.

I agree with Dr. Tunzi's concern about Professor Pence's perception that ". . . most of the problematic cases . . . involve patients who are comatose"[3] and his conclusion that neurologists are therefore most suited to do ethics consultations. His observation does not match my experience. In the *JFP* series, 35 percent of the adults had decision-making capacity, and many others without such capacity were not comatose. I am currently analyzing a series of 64 ethics consultations in children and find that ventilators and pulmonary status are more frequent determinants than coma. Careful reading of reports of other series of ethics consultations clearly shows a wide variety of issues raised in a wide variety of patients. Although many neurologists are sensitive to ethical issues, and some serve as clinical ethicists, I believe that the neurologist's perspective is neither as broad nor as applicable as is that of a family physician.

I am also curious about Dr. Pence's statement that there is ". . . a growing trend . . . to bill for consul-