

# Changing the culture?

The report into the removal of organs from children at Alder Hey makes harrowing reading, and doctors should not be surprised to find themselves once more under the public spotlight.<sup>1</sup> It states that removal of organs was taking place on 'a large scale', effectively without the knowledge — and therefore of necessity without the consent — of the bereaved parents. Through all the public debate that has followed publication of the report the lack of proper consent procedures emerges as a scandal, even while some members of the public have wondered how difficult it would be to engage in the appropriate discussion at the time of bereavement. What is equally scandalous, but has attracted less public attention, is that organs were retained in the name of research, but that no research was being done even as more organs were being stored.

The affair has brought other questions into the public domain. Do we owe the same duty of care to dead bodies as to the living? What is our attitude to death and the treatment of bodies in an increasingly secular age? Or, as the *New Statesman* put it less delicately, why, in a godless age, are we so obsessed with corpses? 'The conduct of Dick van Velzen seems ghoulish to many; but equally macabre has been the reaction of some of the bereaved parents, who raided hospitals to scoop up the bits and pieces of long-dead children and carry them home in plastic shopping bags, so as to go through the ritual of burying the remains for a third or fourth time.'<sup>2</sup> Some of us have found it hard to understand the need of some families to repeat the pain of a funeral in order to bury the recovered organs. However, with small children, whose personalities are as yet unformed, the bodies may for their parents represent the essence of their selves. The experience of such parents sets them apart and others cannot guess at the extent of their grief.

One of those who has been keen to express his outrage was the Secretary of State for Health, Alan Milburn. Both before and after the release of the report, he was to be heard and quoted in the public media lambasting not only those who were responsible at Alder Hey but also, by extrapolation, the whole medical profession. 'The whole medical culture has to change' was one such comment.

That successive Secretaries of State regard doctors in the UK as a nuisance, a collection of backsliding, idle, good-for-not-very-much barriers to progress, to be whipped into line, has become all too dreadfully familiar. The notion that no large organisation can afford to treat its most valuable resource with such contempt has not yet penetrated into the councils of the Department of Health. That other divisions of government, most obviously the Department of Education, treat their staff with equal disdain makes it more, not less, depressing. At a time when public service needs to survive in a buoyant national economy, when graduates can earn a quicker buck by dabbling on the fringes of an information economy, such myopia risks the foundations of a publicly funded health care system, which still depends on a certain degree of altruism among its workforce.

However, it is the notion that the whole culture must be changed that needs challenging. The central issues are the related matters of informed consent in general and how it operates in the more specific field of medical research. There can be very few doctors working in the NHS who both do not understand the principles of informed consent and how it comes directly from the fundamental principle of respecting patient autonomy, and who have not had to apply it, most obviously in getting patients to sign consent forms for surgery. When it comes to research, application of the principle is not left to clinicians remembering. All research projects have

to be passed by ethical committees. Research ethical committees scrutinise with great care the information provided to participants, so that they can make an informed decision and ensure that pressure is not applied to influence their choice. Indeed, research ethics committees have become so zealous in discharging their duties that anecdotal reports from researchers complaining about the difficulties of obtaining ethical committee approval abound. The final protection comes from editors insisting that all papers reporting research involving patients include details of ethical committee approval.<sup>3</sup> The application of the principles may be much more patchy. Often, consent to surgical operations may be left to the most junior doctor on the ward, and be rushed. It should be possible to ensure that consent is always obtained by the doctor carrying out the procedure and that patients are given plenty of time to reflect and ask questions. We need to be much more careful about procedures where the consensus has been not to do so — the grey area of implied consent. Our handling of patient records often leaves much to be desired. We also need to distinguish between informing the patient and their understanding. However, the profession's acceptance of the principles should not be at issue. As in so many other aspects of medicine, the pace of change is slow and gradual — much slower that politicians would wish, but the *culture* has, over the past 20 years, been transformed. The shock that many doctors have expressed over the Alder Hey inquiry (and the finding that the practice was not unique to Alder Hey) is testament to that.

What, then, are we to make of a Secretary of State apparently unaware of such changes? He may be genuinely ignorant, but if so he should know better, or take the trouble to inform himself, or at the very least find civil servants and Chief Medical Officers who know enough to correct his misconceptions. If he is knowingly using the opportunity for easy, short-term, political advantage we can only despair that the political system encourages such behaviour.

However, the real irony here is that, while calling for informed consent, the Secretary of State is simultaneously steering through parliament the widely reported Clause 59 of the NHS Bill that gives him and his successors sweeping powers over the disclosure of personal information held on patients within the NHS. The apparent reason for this is that cancer registries had found themselves outside the provisions of the Data Protection Act. In this case, the decision implies that cancer registries are so important that they are not to be left to the vagaries of individual patients giving (or withholding) their consent. The profession can support the Secretary of State in seeking to promote much better practice with informed consent, even if we find the language intemperate. However, we also feel that he has to be completely consistent in the standard to be achieved throughout the NHS.

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# Patients with alcohol problems — simple questioning is the key to effective identification and management

ALCOHOL misuse causes a massive burden of health and social problems across all sections of the community and is responsible for a great deal of morbidity in patients presenting in general practice.<sup>1</sup> There is good evidence that eliciting a good history of alcohol intake, followed by simple intervention, can result in important reductions in consumption.<sup>2</sup> Despite this, the majority of general practitioners (GPs) have generally failed to engage in the systematic detection and management of patients with alcohol problems, either on a screening or case-finding basis and most still largely rely on unstructured questioning about alcohol consumption and the use of blood tests. Both have been shown repeatedly to be unreliable,<sup>3</sup> and the paper by Aertgeerts *et al* in this month's *BJGP* that reports a large study carried out in general practice in Belgium adds considerable additional evidence to support this.<sup>4</sup> This rigorous and well-designed study shows that only one-third of patients identified at interview as alcohol abusers or having alcohol dependence were already known to their GPs. It demonstrates clearly that conventional laboratory tests (liver function tests and mean cell volume) perform very poorly in screening in a general practice setting and it also found, disappointingly, that carbohydrate deficient transferrin, the more recently developed marker, is not much better. While blood tests cannot be relied upon to identify heavy drinkers in general practice, they may nonetheless be useful in follow-up, particularly if initial results are abnormal. However, there must now be considerable doubt about the appropriateness of their continued use by the Department of Transport to decide whether drivers should be entitled to have their licences back after convictions for drink-driving.

The study examined the performance of five questionnaires: the CAGE, the AUDIT, the AUDIT-C, the five-shot questionnaire, and the AUDIT Piccinelli. The study showed that, except for the CAGE questionnaire, all performed much better than laboratory tests. The CAGE questionnaire — perhaps the best known of the questionnaires and popular because of its simplicity — was shown to have unacceptably low sensitivity and specificity when used in general practice. Though some will mourn its passing, there can be little doubt that GPs should now abandon it as a routine screening instrument. The other questionnaires all performed remarkably well against the detailed interview that was appropriately used as the 'gold standard'. They are all strikingly similar, consisting of a combination of simple measures of quantity and frequency of alcohol consumption, one or more questions designed to identify bouts of heavy (binge) drinking, and a few short questions designed to elicit evidence of dependence and/or harmful effects from drinking. The AUDIT-C questionnaire, that consists of only three questions, combines brevity with high performance. Though the authors point out that it performed significantly less well

with female patients, it nonetheless compared very well with the other questionnaires. Its simplicity means that clinicians should have no difficulty in memorising both the combination of screening questions and the simple coding system. However, although the systematic use of a questionnaire such as AUDIT-C should lead to the identification of some 75% of patients with alcohol abuse or dependence, GPs should be aware that a patient's score on a screening test cannot provide definitive information about their actual risk from alcohol consumption nor whether they are abusing or addicted to alcohol. Once the subject of drinking has been broached and there is an indication of a possible problem, there is no substitute for taking a more detailed history to explore the role of alcohol in the patient's personal, social, and professional life, accompanied by a proper physical examination. Given the extent of the impact of alcohol on health and the evidence that identification is the key to successful management of heavy drinkers, those responsible for undergraduate teaching, specialist training, and higher professional development should give careful consideration to the inclusion of all of this in their educational programmes.<sup>5</sup>

What are the chances that primary care professionals will do something about this? Not very high, according to most of the evidence. Last year, the findings of the United Kingdom (UK) arm of Phase III (Strand 3) of the World Health Organisation's collaborative study on dissemination and implementation of brief alcohol intervention in primary care were reported in this *BJGP*.<sup>6</sup> The study showed rather disappointing results for three training and support strategies used to encourage GPs to get involved in screening or case-finding and intervention. A more recent study showed that GPs are generally reluctant to take a population approach to lifestyle advice and remain unconvinced about the effectiveness of their intervention.<sup>7</sup> In the case of alcohol, some of this is no doubt owing to a lack of familiarity with the now substantial evidence base but it probably also results from repeated negative experiences with disruptive and uncooperative problem drinkers. The brief report by Webster-Harrison *et al*, published in this month's *BJGP*,<sup>8</sup> suggests that GPs and practice nurses are often unsure about the recommended limits for 'sensible drinking' and that many are unable to calculate the alcohol content of a range of commonly consumed alcoholic beverages.

What would help to encourage a more active participation in screening and intervention? Different approaches are likely to be needed for heavy drinkers without current harm, alcohol abusers, and patients dependent on alcohol. In any event, although the clear message about the effectiveness of simple questionnaires may make a difference, better support for general practice is also needed. Community and hospital alcohol services need to implement systems to

ensure prompt and appropriate information exchange with general practices in their locality. Alcohol outreach workers operating in a general practice setting can be effective and GPs need ready availability of proper facilities for alcohol 'detox', either in residential facilities (including hospital wards) or in the community. However, many GPs may still hold back from getting involved in the detection and management of these patients, unless they can include drug treatment as part of their management programme. For heavy smokers, the prescription of nicotine replacement therapy has been shown to have a real and important effect on smoking cessation rates, and GPs have been keen to be able to prescribe this treatment as an adjunct to giving advice. More recently, bupropion has been licenced for use with heavy smokers. This drug appears to have an effect by raising the concentration of dopamine in the nucleus accumbens, a process that is also involved in nicotine addiction.<sup>9</sup> The evidence for its effectiveness in general practice patients is still weak, though the reports of two studies carried out in the USA showed promise. If a similar range of effective therapeutic agents were available for patients suffering from alcohol abuse or dependence, this might provide GPs with an important aid to intervention and thus enhance their readiness to become involved in this work. There is some evidence that naltrexone, which appears to stimulate the same receptors as alcohol, might be suitable in alcohol withdrawal and possibly as an aid to reduction in alcohol consumption. A number of studies have been performed in hospital settings, but good evidence is still required for patients presenting in primary care.<sup>10</sup> Finally, evidence about effective targeting of interventions might be particularly helpful. Although numerous studies have suggested that success rates may be as high as 40% in patients counselled to reduce their alcohol consumption, this still means that a substantial majority of patients will not respond. If GPs are to respond to the challenge to take a more active role in the management of alcohol problems, they will want to be able to maximise their success rates. More evidence is still needed from trials of intervention about the characteristics of patients likely to make significant reductions to their alcohol consumption. The recent advances in deciphering the human genome may eventually offer further opportunities, for there is now a real possibility that genetic markers may be developed to enable the early identification of patients who are most likely develop cirrhosis or alcohol dependence.

However, this is probably several years off and should not allow deviation from the goal of better policies for dealing with the UK's most damaging drug. The Department of Health has regrettably delayed publication of its much awaited Strategy document on drugs and alcohol, but there are strong indications that the paper will recommend support for early identification and brief intervention, hopefully with provision of financial incentives for general practice involvement in this work. GPs can now feel confident that the use of a simple tool, such as the AUDIT-C questionnaire will enable them to increase markedly the detection of alcohol abuse and dependence in their patients. Coupled with the more widespread adoption of simple brief interventions, GPs now have a real opportunity to make a significant impact on the

growing problems of alcohol abuse and dependence. This goal is surely well worth pursuing.

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# Diagnosis and prognosis of lower respiratory tract infections: a cough is not enough

**E**VEN though it is the most frequent complaint in general practice there is much uncertainty over the diagnosis and treatment of patients with an acute cough. Surprisingly little evidence is available to support decisions concerning these patients in daily practice.

A major problem is that an acute cough can be caused by a variety of different aetiological factors. Usually, a distinction is made between acute cough related to upper respiratory tract infections (URTIs) and to lower respiratory tract infections (LRTIs). In URTIs, postnasal drip is often mentioned as an important cause of an acute cough. Apart from the fact that all patients with acute viral rhinitis have some sort of postnasal drip and only a fraction of these people are also coughing, the evidence on the relationship between postnasal drip and acute cough is based on only a few studies containing serious methodological flaws and carried out mainly in referred patients with prolonged symptoms.<sup>1</sup> There is an undoubted causal link between URTIs and LRTIs; however, there is no reason to believe that the vast majority of patients with an URTI and an acute cough do not have inflammation of the lower respiratory tract as well.

Additionally, inflammation of the mucosal lining can have different causes within the lower respiratory tract. The recently published study by Macfarlane and co-workers shows interesting new data on the possible microbiological pathogens in adult patients with an acute cough and at least one other sign of involvement of the lower respiratory tract.<sup>2</sup> With the benefit of complete follow-up and using modern techniques, including the polymerase chain reaction (PCR) technique, they found possible pathogens in 55% of their patients. Assuming that PCR did not give a substantial number of false-positive results, viral pathogens or *Mycoplasma* that are usually absent in healthy people were found in at least 25% of the patients. When a bacterial pathogen is found in a coughing patient, possible carrier effects make it difficult to draw conclusions about the relationship between the clinical picture and the microbiological findings. The work of Macfarlane *et al* showed that there is some correlation between the presence of bacteria and other indirect evidence for infection, such as positive chest X-rays and an elevated plasma level of C-reactive protein; however, the vast majority of patients with a positive bacterial specimen did not have this indirect evidence. The conclusion is that, particularly when using new and sensitive techniques, no microbiological aetiology can be detected in around 50% to 70% of adult patients with an acute cough.

Another possible reason for bronchial inflammation causing an acute cough can be undetected asthma or chronic obstructive pulmonary disease (COPD). Among others, Thiadens *et al* showed that, in patients with an acute cough and known to have a chronic lung disease, over 40% did in fact have asthma or COPD.<sup>3</sup> The presence of wheezing, dyspnoea, allergy induced complaints, prolonged expiration, pack years of smoking (the product of years of smoking and

mean number of cigarettes per day, divided by 20) and female sex could enable the general practitioner (GP) to recognise those patients with a previously undetected chronic lung disease and treat them accordingly.

In short, making a correct diagnosis in a patient with an acute cough is not always easy in general practice. It is therefore not surprising that diagnostic labels, such as acute bronchitis, are used inconsistently in general practice and are in fact suggesting a microbiological aetiology that is uncertain. To avoid misclassification and false notions of its aetiology, Holmes *et al* in this issue of the *BJGP* again use the rather broad definition 'lower respiratory tract illness' in patients with an acute cough.<sup>4</sup> However, when using this label in daily practice GPs should realise that they have to differentiate within this clinical syndrome to give rational treatment.

Before discussing diagnostic problems in this field it is important to determine what rational treatment is. First, in patients with an acute cough in whom asthma or COPD can be diagnosed, bronchodilators or corticosteroids can be regarded as useful. Antibiotic treatment will not have clinically relevant effects in the vast majority of patients. There are, however, some subgroups of coughing patients that have pneumonia — or are at risk for a similar complication, hospitalisation, and death — for whom antimicrobial treatment is indicated.

Macfarlane *et al* diagnosed pneumonia in 6% of their patients and could not identify signs or symptoms to detect this small subgroup of patients. Others have also shown that signs and symptoms alone are poor guidance for diagnosing pneumonia.<sup>5</sup> In other words, clearly positive signs such as localised dull percussion certainly have diagnostic value; however, such severe signs are almost always absent in patients with community-acquired pneumonia. It seems that, until further notice, uncertainty about differentiating between acute bronchitis and pneumonia must be accepted in daily practice. Perhaps it is more fruitful to assess the prognosis of a coughing patient. Some patient characteristics have shown to be risk factors for pneumonia and hospitalisation; for example, old age, alcoholism, and comorbidity (e.g. COPD and heart failure).<sup>6,7</sup> These factors should therefore be taken into account when deciding whether to prescribe antibiotics for an acute cough or not. The precise indications for antibiotic treatment in patients at risk for complications are yet unknown. Further diagnostic and prognostic studies in this field to help the GP to identify those coughing patients who need treatment is urgently needed.

Nevertheless, even with the little evidence that we have at the present time, Holmes *et al* rightfully conclude that antibiotic prescription rates are much too high in coughing patients. The majority of syndromes with an acute cough are mild and self-limiting. Currently, much attention is being given to strategies aiming at rationalising antibiotic prescription in general practice. In this respect, Holmes's remarks

about the need for patient education on the natural course of LRTIs are very important. Several studies have pointed out that, for patients, understanding the nature of their illness and sufficient attention from their physician are more important than the prescription of antibiotics.<sup>8,9</sup> Adequate patient education is only possible if GPs are well informed about the important issues of the disease involved, including its aetiology, diagnostic possibilities (and impossibilities), and its prognosis. For this purpose, the facts supplied by Holmes, Macfarlane and co-workers are a valuable contribution to the body of knowledge concerning the management of LRTIs (or lower respiratory tract illness). As said before, further extension of that body of knowledge is necessary, particularly focusing on the diagnosis and prognosis of this very frequent group of diseases. It is clear that knowing about a simple cough is simply not enough.

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