

are unaware of simple measurers of exacerbation severity which could have been applied in this study.

Their main criticism concerns the possible occurrence of a metabolic acidosis and the lack of significant difference in CO₂ tension between those receiving FiO₂ >0.28 and FiO₂ <0.28. In the group receiving an FiO₂ >0.28, only one patient had a predominantly metabolic acidosis (H⁺ 56 nmol/l). A further five patients had a predominantly respiratory acidosis with a metabolic component (two severe and three mild acidosis). None of the patients receiving controlled oxygen had a metabolic component to their acidosis. Table 1 shows that in patients receiving an FiO₂ >0.28 at any stage during their presentation to hospital with AECOPD, the average carbon dioxide tension rose as the acidosis worsened; further, patients with acidosis had a higher mean oxygen tension than those without.

We note that Singer and Bellingan attend the A&E department to treat hypercapnoeic patients and frequently use high inspired FiO₂ with mechanical ventilation (invasive or non-invasive) to treat AECOPD as the major problems are fatigue, atelectasis, sputum retention, poor respiratory effort and cough. In the circumstances this course is perfectly correct, but as respiratory physicians we would seek to avoid this situation arising in the first place by careful titration of FiO₂ to achieve 85–90% if possible. The mechanism by which flow oxygen causes hypercapnoea (whether by altered ventilation perfusion, by the Haldane effect or by depressing hypoxic drive) is not at issue here. The fact is that we and others observe this phenomenon and believe it to be detrimental and potentially avoidable.

We are not alone in our concerns about the use of HFO. Murphy *et al* review the dangers of HFO in AECOPD showing evidence that the resultant hypercapnoea was associated with coma and death,² and their concerns are reflected in the guidelines produced by North West Oxygen Group (NWOG).³ Howard and Harrison report similar findings in their prospective study in East Anglia (personal communication) identifying 27 episodes of hypercapnoea associated with HFO and hypoxia out of 175 admissions with AECOPD. The

practice of liberal and unlimited oxygen administration to patients in the period leading to hospital admission in those with AECOPD is widespread and may cause additional morbidity and mortality. In some regions, ambulance services and A&E departments concur that there is a problem with COPD patients and have agreed to address it by a credit card type of self-identification as being at risk from high oxygen concentrations.

Slowranski's letter points out that we do not state how the FiO₂ of the patients was determined. This is a difficult area as oxygen prescription in hospitals is often in disarray.⁴ We assumed that nasal oxygen at >2 litres/min by mask or nasal prongs was FiO₂ 0.28 or greater. In many, however, 'asthma levels' of 6–10 l/min was administered and ambulance crew recorded percentages based on mask instructions whilst Lifecare masks suggests gradation from 2 l/min = 29% and 8 l/min = 60% oxygen.

We acknowledge that our prospective audit has shortcomings but it has served to further highlight a serious dichotomy between the approaches of different specialists to the problem of oxygen therapy in AECOPD. We suggest that this needs to be resolved by an adequately powered cooperative controlled trial of controlled oxygen so that guidelines can be agreed by all concerned.

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Cultural differences: practising medicine in an Islamic country

Editor – I read with pleasure Professor Al-Kassimi's article (*Clin Med* January/February 2003, pp52–3). However, an urgent correction is required in that the vaccine recommended for the Hajj is now the Meningitis ACWY not the AC. This is endorsed by both the Saudi government and the Department of Health. In the last two years many have died in the UK and abroad of Meningitis W135. Protection from this strain is given by the ACWY vaccine but not by the AC.

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Conversations with Charles

Editor – I have always enjoyed the wisdom and wit of Charles, but his latest offering (*Clin Med* November/December 2002, pp 595–6) makes me fear that the old boy is losing touch with reality. He advocates keeping information from patients and secrecy. He advances the argument that information feeds distrust. He fears that revealing the differential diagnosis may cause alarm. He worries that audit figures may be misinterpreted.

All these things are true but the cost of secrecy is far worse. Errors accumulate uncorrected. Patients understand that information is being withheld from them and find sinister explanations for this behaviour. The media smell something is being hidden and find grounds for wild conspiracy plots. Communication between patient and doctor is damaged. The patient is denied their right to develop greater understanding. The doctor denies himself or herself the opportunity to work with the patient as a co-producer of health.

Down with paternalism, long live openness and trust.

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In response

I asked Charles for his comments. He replied: 'I echo "Long live trust and openness", but openness should not be confused with unconsidered total disclosure. Trust allows discretion in disclosure and

unthinking demand to be told everything breeds mistrust.

The press protects its sources so why should not the employer protect the victim of chance? To do otherwise also encourages cover-up. Misinformation does not only arise from malice on the part of the originator but also from premature enforced disclosure of what are literally half-truths. Any consequent lack of clarity sows seeds for misinterpretation by the recipient.

Too much information can overwhelm. Knowledge is often best gained from an appropriately controlled flow through a good teacher. Paternalism implies advising whilst withholding some information for the benefit of the recipient. I can imagine situations where I would welcome this. Paternalism may not be for Dr Kemm, but he cannot deny that trust is essential for a successful paternalistic relationship. It is perhaps because the modern cult of the individual encourages neither trust nor humility that paternalism now has such a bad name.'

His reply led to an animated conversation about paternalism. Perhaps the editor will agree to publish it one day.

Coemgenus

Driving restrictions after stroke: doctors' awareness of DVLA guidelines and advice given to patients

Editor – The recent letter by Goodyear and Roseveare (*Clin Med* January/February 2003, pp86–7) highlights the poor standard of advice given about fitness to drive by many clinicians. (Incidentally, the stroke and TIA standards quoted are for car drivers: they are more stringent for the drivers of large vehicles.) A parallel study of psychiatric patients, showing similar results, was published recently.¹ The widespread failure to provide appropriate advice about driving and other safety critical tasks reflects the low priority this issue is currently given within the clinical consultation. In turn, this prevents both patients and society from achieving a sound balance between personal mobility and public safety. Those working in transport and occupational medicine are very

familiar with this common shortcoming.

There are several initiatives underway to address this.

- A considerable programme of research to improve the evidence base on certain common safety critical conditions such as diabetes, cognitive impairment and visual defects is in progress. This will provide a clearer rationale for advice to patients and may even enable some of those now restricted to be considered fit to drive.
- Funding has been allocated to produce better guidance for health professionals. This will cover acute conditions, recovery from surgery and the use of medication, as well as medical licensing standards. A series of complementary patient information leaflets, downloadable from the Internet, is also envisaged.
- Studies of the attitudes of health professionals to advice on driving safety are proposed to identify the barriers to its provision and how they can best be overcome.

There is already close cooperation with clinical specialists on driving standards through the Secretary of State's six Honorary Medical Advisory Panels on Fitness to Drive. The provision of a clearer understanding of safety critical fitness throughout clinical training, coupled with improved information and raised awareness should, it is to be hoped, make sound advice on preventing accident risk to self and others an integral, and even perhaps an auditable, part of good medical practice.

Reference

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Editor – The audit by Goodyear and Roseveare (*Clin Med* January/February 2003, pp86–7) was very interesting. However, the authors failed to differentiate between Group 1 (Ordinary) and Group 2

(Vocational) driving requirements. They have only mentioned about the requirements for Group 1/Ordinary driving licence holders. People with Group 2 entitlement cannot drive for 12 months following a stroke/TIA. They can be considered for licensing after this period if there is a full recovery, provided there is a satisfactory medical report including an exercise ECG testing. This is to identify any significant underlying coronary artery disease in a patient who has already had a stroke/TIA.

We are currently doing the same audit because we too felt that this information is very scanty in the case notes. We have incorporated in our 'stroke care pathway checklist' the driving status and the advice given, in order to remind doctors to establish the driving status and give appropriate advice.

Reference

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Consent with understanding: a movement towards informed decisions

Editor – In the recent paper by Mayberry and Mayberry (*Clin Med* November/December 2002, pp 523–6), the authors rightly affirm that the basis of informed consent is 'the need to understand the information ... and an ability to retain that information for a period'.

A gynaecologist colleague recently informed me that, in view of the recent drive for full information for informed consent, the routine practice in his department is to list on the consent form every possible complication. Even for the most minor procedures, such phrases as 'rarely, perforation of the uterus, colon or bladder' and 'very rarely, death' are used. The onus of imparting this information usually falls on the hapless SHO, who is often very