ination of pet food, a detection method involving liquid chromatography–mass spectrometry became widely available and reliably identifies both cyanuric acid and melamine. A number of suspect foods from China tested by the FDA were found to contain melamine (see table), and more are being reported around the world each week. Furthermore, the FDA has found trace levels of melamine in several U.S. infant formulas and, as of the end of November, states that 1 part per million is permitted. Yet it is not certain what should be done going forward. In the United States, common-sense suggestions have been posted on the Web sites of both the FDA (www.fda.gov/oc/opacom/hottopics/melamine.html) and the Centers for Disease Control and Prevention (http://emergency.cdc.gov/agent/melamine/chinafood.asp), and similar content is available on the WHO Web site (www.who.int/foodsafety/fs_management/infosan_events/en/index.html). The pediatric nephrology community, the American Society of Pediatric Nephrology, and the International Pediatric Nephrology Association recommend vigilance without panic (www.aspneph.com/ASPNStatement%20Melamine%20Oct22_cbl%20(3).pdf). All these organizations suggest examining at-risk children exposed to the brands of infant formula, such as Sanlu, that are known to have been heavily contaminated by melamine.

The bottom line, however, is that nobody knows the true extent of the present epidemic or the risks to come. No more deaths have been reported since the Chinese government and the international public health community became aware of the problem. Yet the long-term health effects remain unknown.

In today’s world, it is crucial to understand and deal with the global implications of foodborne diseases if problems like the melamine epidemic are to be prevented. In 2006, the WHO launched an ambitious project to estimate and understand the global burden of foodborne disease, and the Foodborne Disease Burden Epidemiology Reference Group appears to be well on its way to achievement of its initial goals. In addition, the group will be developing much-needed user-friendly tools so that outbreaks, be they due to organisms or chemical substances, can be studied more rapidly and the causes identified, reported, and eliminated.


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Culture Shock — Patient as Icon, Icon as Patient

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On my first day as an attending physician in a new hospital, I found my house staff and students in the team room, a snug bunker filled with glowing monitors. Instead of sitting down to hear about the patients, I suggested we head out to see them. My team came willingly, though they probably felt that everything I would need to get up to speed on our patients — the necessary images, the laboratory results — was right there in the team room. From my perspective, the most crucial element wasn’t.

For the next few weeks, I ensured that we spent as little time as possible in the bunker. These were excellent residents who cared enormously about patients’ welfare. They enjoyed being shown common findings — white nails of liver disease, an accessory nipple, Dupuytren’s contracture, parotid enlargement, spider angiomas, café au lait spots, the paradoxical splitting of the second heart sound in left bundle-branch block, signs of pseudo-
PERSPECTIVE

bulbar palsy — which today are uncommonly recognized. When I stroked a patient’s palm and caused a twitch of the mentalis muscle under the chin — the palmamental reflex — it was as if I were performing magic. Still, the demands of charting in the electronic medical record (EMR), moving patients through the system, and respecting work-hour limits led residents to spend an astonishing amount of time in front of the monitor; the EMR was their portal to consultative teams, the pharmacy, the laboratory, and radiology. It was meant to serve them, but at times the opposite seemed true.

This ward experience highlighted for me an evolving tension between two approaches to patients. In the first way — call it the traditional way — the body is the text, a text that is changing and must be frequently inspected, palpated, percussed, and auscultated. The scent in the room, a family member’s statement contradicting what the patient says, the knobby liver, clonus, the absent nasolabial fold, the hoarse voice — a multitude of such soundings help us understand the patient, and on this foundation, data from the chart can be selectively applied. This approach helps slay “chartomas” — disease labels immortalized by being cut by sheer repetition, a whiff of tri-cuspid insufficiency turns into a raging torrent.

The other way — call it the expedient way — is not formally taught, and yet residents seem to have learned it no matter where in the United States they trained. The patient is still at the center, but more as an icon for another entity clothed in binary garments: the “iPatient.” Often, emergency room personnel have already scanned, tested, and diagnosed, so that interns meet a fully formed iPatient long before seeing the real patient. The iPatient’s blood counts and emanations are tracked and trended like a Dow Jones Index, and pop-up flags remind caregivers to feed or bleed. iPatients are handily discussed (or “card-flipped”) in the bunker, while the real patients keep the beds warm and ensure that the folders bearing their names stay alive on the computer.

The problem with this chart-as-surrogate-for-the-patient approach is — to quote Alfred Korzybski, the father of general semantics — that the map is not the territory. If one eschews the skilled and repeated examination of the real patient, then simple diagnoses and new developments are overlooked, while tests, consultations, and procedures that might not be needed are ordered. Every seasoned attending physician has seen examples of this error mode: distended neck veins, pedal edema, weight gain, and cardiomegaly labeled as pneumonia instead of congestive heart failure because the infiltrates on a chest x-ray were given too much weight; missed embolic lesions of endocarditis in a febrile patient; a report by the intern of “small intra-abdominal masses” that were in fact subcutaneous neurofibromas also abundant on chest, forearms, thighs — anywhere an examiner might lay a hand. The financial costs of imprecise observations that lead to unnecessary or risky investigations are not known; in a health care system in which our menu has no prices, we can order filet mignon at every meal.

Pedagogically, what is tragic about tending to the iPatient is that it can’t begin to compare with the joy, excitement, intellectual pleasure, pride, disappointment, and lessons in humility that trainees might experience by learning from the real patient’s body examined at the bedside. When residents don’t witness the bedside sleuth aspect of our discipline — its underlying romance and passion — they may come to view internal medicine as a trade practiced before a computer screen.

If we in academia have managed to ignore the loss of bedside skills, our patients see the deficiency easily. Patients recognize how the perfunctory bedside visit, the stethoscope placement, through clothing, on the sternum like the blessing of a potentate’s scepter, differs from a skilled, hands-on exam. Rituals are about transformation, and when performed well, this ritual, at a minimum, suggests attentiveness and inspires confidence in the physician. It strengthens the patient–physician relationship and enhances the Samaritan role of doctors — all rarely discussed reasons why we should maintain our physical-diagnosis skills.

In my years of teaching, I’ve found that residents increasingly approach the patient with little expectation of discovering tangible findings. When such a finding presents itself, it is the exceptional resident who pursues and refines the observation, most being content to murmur vaguely about a murmur without describing its qualities, the effect of the Valsalva maneuver, the location of the apical impulse, the presence
iPatients are handily discussed in the bunker, while the real patients keep the beds warm and ensure that the folders bearing their names stay alive on the computer.
ter clinicians. This step was easy — professionals at every institution seem to know who these physicians are. We have invited master clinicians from other institutions to round with our residents, to challenge them and demonstrate techniques. Regular bedside rounds and faculty-development sessions showcasing good bedside technique demonstrate the excitement of this approach and, we believe, will bring about cultural change.

I feel fortunate to live in this age of incredible technology, with its remarkable new ways of seeing the body. I am excited about portable ultrasonography, for example, which allows us to instantly confirm findings at the bedside and discover the limits of our own skills. We need more of that kind of translational work — to develop the next generation of stethoscopes, ophthalmoscopes, and tendon hammers. Surely having physicians become more discerning, more comfortable, and eager to spend more time at the bedside is a good thing for patients. For the clinician, the bedside is hallowed ground, the place where fellow human beings allow us the privilege of looking at, touching, and listening to their bodies. Our skills and discernment must be worthy of such trust.

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