It's Our Bag

The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings.

Julius Caesar, Act I, Scene 2

In years past, the physician was invested by the patient with a magical aura based in part on his knowledge of the arcane arts of healing, the "laying on of hands," and reinforced by the physician's own attitudes. In more recent time, however, the veil of mystery has been ripped away by patient education and disillusionment. We have become the distributors in the marketplace and the patients the consumers of a commodity called health care. In reaction, we have displaced this mystery on to more and more sophisticated and complex medical equipment, and to the unseen oracle of the clinical laboratory. Intended to be merely extensions of our own hands, eyes, and ears, such tools as the CAT scanner, radionuclide scan, chemical profiles of six, 12, 18 or more tests, all orchestrated by the all-knowing computer, are held in such awe and lack of understanding that they can become the doctors, and we the mechanical devices, for they diagnose, prescribe for, and treat the patients' ills, while we may merely follow blindly.

This blind reliance on mechanical devices and the laboratory leads to ignorance about how they work. Such lack of knowledge is necessary to maintain the magic by which they appear to do what we mere physicians cannot. Devices such as we describe have been designed with this ignorance in mind. Safety modifications are added to make sure the operator who is unfamiliar with the mechanism of operation will not cause the patient harm through his inexperience. Partly because of this, experience itself does not become a learning process, and when a so-called safety device itself produces a hazard to the patient, it can go unnoticed even by those operators who should know better.

A recent editorial published in this journal asked whose fault it is when physicians are apparently ignorant of the mechanical foibles of medical equipment. Finding the party on whom to lay the blame is dangerous, lest we forget that the responsibility to rectify a dangerous situation is everyone's, regardless of initial fault. Physicians must take the lead in educating ourselves and our peers, demanding equipment that performs according to our requirements, and seeing this equipment as logical extensions of our own abilities. Manufacturers must respond to these needs, continuing to update and modify equipment as new data about use and hazards become known. They must also participate in the educational process by assuring that operation of these devices does not become overly complex. Safety devices should not substitute one danger for another. We must all take control of the various aids to diagnosis and treatment, making them serve us, not vice versa.

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REFERENCES


Legionella micdadei Pneumonia

Historical Perspective of a New Pneumonia

The recognition of Legionella micdadei (Pittsburgh pneumonia agent) as an etiologic agent of pneumonia in the immune-suppressed host represents the intriguing interaction of basic microbiologic research, clinical medicine, and medical detective work covering a span of approximately 40 years.

The organism was first encountered in 1943. At the time, attempts were being made to determine the cause of "Fort Bragg Fever." Dr. Hugh Tatlock, then a lieutenant in the United States Army, isolated an organism from the blood of a soldier stricken with the disease. The organism was a poorly-staining Gram-negative rod, could not be grown in artificial media but could be maintained via animal passage, and therefore was considered a rickettsial-like organism. Since tests at the time failed to establish any connection between the organism and human disease, and since subsequent serologic tests showed that Leptospira autumnalis was the etiologic agent in Fort Bragg fever, Dr. Tatlock's organism remained a microbiologic curiosity of little clinical importance.

It remained this way until 1979, when two "new agents" causing pneumonia in immune-suppressed patients were described. A new Gram-negative, weakly acid-fast bacterium was isolated by Pascuelle et al from two patients undergoing renal transplantation who developed acute purulent pneumonia. Several months later, the same group expanded their observations to include a total of eight similarly affected patients. At approximately the same time, a group of us at the University of Virginia reported a similar series of immune-suppressed patients with pneumonia in whom an unidentified and presumably new acid-fast bacterium or Myco-