Does it matter who serves as the scribe?

As a scribe and accepted future medical student, I was quite interested in the article, "Medical scribes: How do their notes stack up?" by Misra-Hebert, et al (*J Fam Pract.* 2016;65:155-159) and the editorial, "Working with scribes—the good, the surprising" (*J Fam Pract.* 2016;65:154,176) in the March issue. I was struck, however, that both pieces implied that only medical assistants (MAs) are scribes.

I am familiar with practices where MAs assume a "documentation support" function in addition to their traditional role, and I currently work in a practice with professional scribes. Professional scribes are often recent college graduates who are working before beginning their studies to become a physician or physician assistant.

In my experience, MAs want to do the work they were hired and trained to do and are not enthusiastic about extensive charting. However, professional scribes apply to the position expecting to do this very task, with the goals of learning from the doctor-patient interaction, deepening their medical knowledge, and becoming comfortable in a clinical setting.

Although I am glad to see that MAs improve documentation quality per the original research mentioned above, it would be beneficial to compare the outcomes of professional scribes to those of cross-trained MAs or to traditional providers who do their own note-writing.

D. Brendan Johnson, BA
Minneapolis, Minn

Account for all medications, even if they're banned

I recently saw a 73-year-old Hispanic woman in the emergency department who said (through her daughter, who was translating) that she was experiencing mild headache, shortness of breath, and throat swelling. She had previously sought care for these complaints, but her condition had not improved. Her past medical and surgical history was otherwise unremarkable.

On examination, her voice was hoarse and she had bilateral 1+ pitting edema of her lower extremities. Her vital signs were stable, her lungs were clear, her throat appeared normal, and she didn't have any skin rashes. However, her lab results included a white blood cell count of 2100/mcL, platelet count of 73,000/mcL, and an absolute neutrophil count of 1000/mm^3. Her b-type natriuretic peptide, cardiac marker, and thyroid-stimulating hormone levels were normal.

The diagnosis was clear—neutropenia and agranulocytosis—although the cause was not.

I gathered a more detailed history and learned that the patient had been living in the United States for years, but she occasionally returned to Mexico for visits and routine medical care. During one of these trips, she'd obtained metamizole—a drug banned in the United States—and was taking it for her headaches.

A Web search revealed rare adverse effects of agranulocytosis, neutropenia, and anaphylaxis from metamizole. It is highly probable that the metamizole caused my patient's symptoms and abnormal labs findings. I advised her of my suspicions and recommended that she stop taking the medication. A hospitalist then took over her care.

The key takeaway from this case is to account for all medications when gathering a patient's history, including those that may be obtained outside of the United States.

Nick Ly, DO
Lillington, NC

The diagnosis was clear—neutropenia and agranulocytosis—although the cause was not. That is, until we learned about a drug the patient had obtained in Mexico.

Children's environmental health: An updated resource

In 1996, 2 exposure incidents sparked a movement to better understand children's environmental health. In both incidents, children were exposed to significant toxicants in unexpected ways. In one, the or-

CONTINUED ON PAGE 501

CONTINUED FROM PAGE 437

ganophosphate insecticide methyl parathion was applied illegally in indoor settings.[1] In another, elemental mercury residue was detected in apartments converted from a fluorescent bulb facility.[2] These incidents, and others like them, alerted physicians and government agencies to the collective lack of training and experience in the field of pediatric environmental health.

To address the situation, the Agency for Toxic Substances and Disease Registry and the Environmental Protection Agency created the Pediatric Environmental Health Specialty Unit (PEHSU) program. The program, which is now jointly operated by the American College of Medical Toxicology and the American Academy of Pediatrics, maintains sites in 10 regions[3] and seeks to enhance education and promote consultation and referral related to reproductive and children's environmental health.

This past fall, PEHSU updated its Web site at www.pehsu.net, which provides information, training, and resources for health professionals and the general public. The Web site provides news, fact sheets, and online education regarding environment-related pediatric and reproductive health issues. It also provides a tool for finding a local expert in the PEHSU national network, should a family physician need to refer a patient for more extensive assistance.

We believe that family physicians will find the PEHSU program resources informative, educational, and relevant to their practice. JFP

Carl R. Baum, MD, FAAP, FACMT,
Medical Director
Dana Turner, MPH, CHES
Amanda Allen, MS
PEHSU Program
National Office—West
Phoenix, Ariz

References

1. Esteban E, Rubin C, Hill R, et al. Association between indoor residential contamination with methyl parathion and urinary para-nitrophenol. *J Expo Anal Environ Epidemiol.* 1996;6:375-387.
2. Centers for Disease Control and Prevention (CDC). Mercury exposure among residents of a building formerly used for industrial purposes—New Jersey, 1995. *MMWR Morb Mortal Wkly Rep.* 1996;45:422-424.
3. Wilborne-Davis P, Kirkland KH, Mulloy KB. A model for physician education and consultation in pediatric environmental health—the Pediatric Environmental Health Specialty Units (PEHSU) program. *Pediatr Clin North Am.* 2007;54:1-13.

PRACTICE OPPORTUNITIES