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Correspondence

Letters to the Editor should not exceed 500 words.

Salmonella in Imported Meat

SIR,—Your leading article (2 March, p. 532) states that in most outbreaks of salmonellosis few are traced to the original food source. It then goes on to state that infected food-handlers are blamed for starting the infection but that these food-handlers are the victims through handling or tasting contaminated raw food.

That food-handlers excreting salmonellae can cause food-poisoning no one would deny, but far the most important cause of human salmonellosis in Great Britain is home-produced meat and poultry. The regular monitoring of abattoirs with sewer swabs will show that the appearance of a salmonella serotype in an abattoir is usually followed by human cases due to the same serotype occurring in the area supplied by that abattoir.

This was shown very clearly in a report of the P.H.L.S. on home-produced meat entitled "*Salmonellae* in abattoirs, butchers' shops and home-produced meat, and their relation to human infections."[1] In this report eight outbreaks involving 281 persons were considered to be directly due to home-produced meat. Continuation of this work since the publication of this report by various workers in this field has confirmed these findings. In Portsmouth during the last three years 331 isolations of salmonellae have been made from cases or symptomless excreters, and it has been shown that in 271 cases a similar serotype was isolated from the local abattoir or poultry-processing plant; in some cases infection was traced from the patient via the butcher's shop and slaughterhouse to the farm itself. Anderson[2] has clearly shown the very close correlation between the great increase in *Salm. typhimurium* type 29 infections in calves and the corresponding rise of cases in the human population.

The remarks about cross-contamination from raw meat to other foods by hands or kitchen equipment are only too true, and this has been stressed for some time, but the raw meat is generally home-produced. South American frozen meat has taken a hard knock from foot-and-mouth disease, but it need not be incriminated as the principal source of human salmonellosis in Britain. One need go no further than the local slaughterhouse.—I am, etc.,

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REFERENCES

1 Working Party of the P.H.L.S., *J. Hyg. (Lond.)*, 1964, 62, 283.
2 Anderson, E. S., *Brit. med. J.*, 1965, 2, 1289.

Bedside Teaching

SIR,—Your leading article entitled "Bedside Teaching" (9 March, p. 591) should be read by every doctor who teaches medical students or junior staff. You rightly point out that failure of communication is often the cause of the grievances of patients. This can be a serious hazard during the grand round that is a tradition in teaching hospitals, but which I believe should now be obsolete. The complexity of modern medicine has made it impossible to achieve all that is needed at such a round: critical analysis of symptoms, physical examination, discussion of results of numerous and complex investigations, interpretation of radiographs (often without a viewing box), teaching students, and (most important) speaking to the patient. It is too easy to become absorbed by the intellectual and technical problems of diagnosis and treatment. The patient waits expectantly and anxiously for information and advice, but, according to my ward sister, may receive only a nod or word of exhortation and the round passes on—an anticlimax indeed! He is left with anxieties from observing uncertainties about the diagnosis or with fears induced by him seeing through synonyms like neoplasm or necropsy. It is hardly surprising that patients may prefer the more intimate atmosphere of a small non-teaching hospital.

The grand round should be subdivided, as I am sure is already the custom with many consultants. Firstly, there is the *academic round*. This takes place in a side-room without patients but with the comfort that is more conducive to clear thinking than is prolonged standing: a chair, a clip-board for taking notes, and coffee. The house-officer, sitting at a table with an *x*-ray viewing box beside him, gives a brief synopsis of each patient. Senior students sit in and take part in the discussion. The sister or staff nurse is present whenever possible, someone such as the ward-clerk dealing with the telephone. A secretary or tape-recorder is available for writing immediate letters to general practitioners concerning unexpected developments in their patients. The consultant, acting as chairman, keeps the discussion moving at a suitable pace. Secondly, the *personal round*. The object is to examine the patient and to discuss his problems and worries. He is told about any decisions concerning diagnosis and treatment, and uncertainty from arguments taking place around him is largely avoided. Patients can be invited to write questions down, for they often forget what they wish to ask even during a small personal round. Some may, as your leading article suggests, have to be answered privately, though generally they are discussed with students for the purpose of teaching and illustrating problems with which patients are concerned. For example, "Can I eat normal food?" "Will angina prevent me playing golf or sleeping with my wife?" and so on. Students observe and learn about speaking to patients (bedside manner) on this round.

This arrangement is preferable for both patients and staff. Special teaching rounds can take place at other times, either by the