agency's imprimatur to dietary supplements, even though the agency would have no new powers to ensure their quality, efficacy, or safety.

Public health could be better served by the creation of a high-quality registry of all lawfully marketed dietary supplements. We believe the new bill should be extensively revised to introduce basic safeguards. Congress could give the FDA the authority to read a supplement's label before registering the product and not register the product if the label lists unlawful ingredients or claims. The bill could also be revised to permit the FDA to swiftly remove products from the registry if the agency determines that they are hazardous — for example, if a supplement contains toxic levels of selenium or has been adulterated with a new designer drug. The legislation could require manufacturers to submit a certificate of analysis to ensure that labels are accurate representations of products' ingredients. In addition, to avoid misleading consumers, health claims submitted to the FDA shouldn't be posted publicly on its website unless the agency confirms that they are supported by high-quality clinical trials.

These revisions would benefit consumers only if members of the public could easily confirm that a product was properly registered with the FDA. The proposed bill requires that each registered product be assigned a unique identifier. If this identifier were incorporated into a quick response (QR) code that could be scanned before purchase, whether in stores or on the Internet, consumers could confirm that no prohibited ingredients or disease claims appeared on the label — although such registration still wouldn't provide information about the product's efficacy or safety.[5]

If advocates of the new legislation, including the leading supplement trade association, succeed in maneuvering the bill through Congress and into law, it will give supplement manufacturers a new channel for broadcasting misinformation: the FDA's own website. By contrast, a thoughtful revision of the bill could create a useful resource for regulators, clinicians, and consumers to confirm that — at a minimum — the ingredients listed on a supplement's label are compliant with current law. Ensuring that all dietary supplements are safe and accurately promoted, however, will require much bolder legislation that comprehensively reforms DSHEA.

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The Portal

Suzanne Koven, M.D.

I am a primary care physician who, for many years, did not have a primary care physician. Instead, I presented myself annually and grudgingly to the Ob/Gyn who had delivered my babies, even long after those babies were in high school. He checked my blood pressure and cholesterol, ordered mammograms, and placed a stethoscope over my heart and lungs, about which I teased him — though no doubt his skills in auscultation were at least as advanced as mine in performing pelvic exams.

Then, when I hit 50, I decided it was time to get serious about my own medical care. This is how I got serious about my own medical care: I enlisted a colleague in my internal medicine group to serve as my doctor and then ignored most of what she advised

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me to do. It's not that I'm obstinate or self-destructive; it's just that I couldn't quite submit myself to the role of patient. I'd been lucky to have enjoyed mostly excellent health, with the exceptions of an appendectomy in childhood, a complicated pregnancy culminating in a cesarean section, and a shoulder fracture requiring surgery. During these episodes, I'd considered myself a temporary visitor in what Susan Sontag called "the kingdom of the sick," my scars mere souvenirs of a place I'd visited but where I'd had neither the need nor the desire to linger. So, predictably, I balked when my PCP recommended that I take vitamin D and calcium, or schedule a bone-density test, or accept treatment for the osteoporosis that this test revealed.

Furthermore, I back-channeled nearly every aspect of my medical care. I waited in my office rather than the patient waiting room for my appointments, which I scheduled at the last minute, by email. I looked up my own lab results. When, rarely, I had a question about my health, I texted my physician as you'd text a friend, complete with emojis. *Do I really, really need to take vitamin D? Smiley face!*

Not long ago, my (infinitely patient) physician retired, and I needed to find a new one. I chose another doctor in my practice, a woman two decades my junior. That I selected someone so much younger didn't surprise me. I'm at that stage in life where I note with relief that my trusted hair stylist, car mechanic, and accountant will all outlast me. (My beloved dentist is a few years my senior, but he assures me he'll be managing the consequences of my indifferent flossing for years to come.) What did surprise me was how I chose to communicate with my new doctor: not by text or email or intercom, but through the electronic medical record, like any other patient.

Patient access to the electronic medical record at my hospital is called "Patient Gateway." At other facilities it's called the "patient portal." Gateways and portals are frequent and potent images in religion, mythology, and literature. They separate, but allow passage between, heaven and hell, earthly and divine, real and imagined. Other conduits are more figurative gateways and portals: the looking glass that transports Alice to Wonderland, the twister that hurtles Dorothy to Oz. In all cases, moving from one realm to the next leaves the traveler indelibly changed.

It may seem melodramatic to imply that the minor administrative gesture of signing up for patient access to my electronic medical record constituted a personal transformation. And yet, as I clicked through the screens and set my password, I felt that I *had* changed in some way. I'd always resisted enrolling, preferring the physicians' interface, which contains more complete and timely data than those visible to patients. I think many of my patients are aware of the inequality of information available to them through the patient portal and resent being consigned to that limited domain. They tell me that they don't use the portal because it "never works," though, in truth, it works quite well. Many clinicians, too, have been wary of the portal, fearful that we'll be inundated by queries from patients about inconsequential but flagged abnormalities in chloride levels and mean corpuscular hemoglobin concentration. Given my own negative feelings about the portal as a patient (not enough patient access) and as a physician (too much patient ac-

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cess), I wondered at my sudden acceptance of it.

The boundary between patients and clinicians has always fascinated me, and my relationship to it has evolved. Early in my career, I struck a formal pose, wearing a white coat and revealing little about myself to patients. As the years passed and my clinical confidence grew, I became more relaxed, ditching the white coat and being more open about myself with my patients, bridging the gap between us as appropriate. But part of me continued to enjoy the perks of my special and separate status: the ID badge that gained me entry to locked hospital wards, my ability to stride through doors marked "Staff Only," not to mention the fact that prescriptions and consultations for me or my family were rarely more than a phone call or email away. I'd acquired very early in my medical training the illusory notion that what distinguished me from patients could somehow protect me from ever becoming one.

As a medical student and trainee, I found being assigned to care for ill, older physicians particularly upsetting. At first I thought that as a novice I was intimidated by the prospect of providing care for doctors who were so much more experienced than I was. Treating an infection acquired by an infectious diseases specialist and listening to a cardiologist's heart murmur were, indeed, daunting. But I now think that what bothered me more was the idea that my elder colleagues were patients at all.

One scene, which occurred when I was a third-year medical student, haunts me still. A retired psychiatrist who'd been known for his expertise in psychotherapy was admitted after a stroke that impaired his speech. One morning on rounds, the neurology team with which I was rotating startled him awake, shone bright lights in his eyes, threw off his blankets to see if he could move his limbs, and then hurried out the room. The psychiatrist, red-faced, strained toward the door, sputtering "Wait! . . . Wait! . . . We . . . have more . . . talking . . . to do here!" The psychiatrist's helplessness moved and frightened me as few other patients' had — or have since.

I'm just a few years younger than that psychiatrist was then, and I now think that his age upset me as much as his illness. His disabling stroke seemed to me a dreadful fate, but what I now realize I feared more were the losses associated with his retirement: of professional authority, of agency, of relevance.

When I was young, I thought old age happened all at once. In my first years in practice, I had a patient named Mary, an elderly widow. No matter the season, she came to my office wearing a beige wool coat, a shapeless brown hat, and heavy, crepe-soled shoes. Each time I saw her I wondered when, exactly, Mary had decided to dress like an old lady. At what age did she look in the mirror and say "Mary, today's the day!" Of course, I now know that one doesn't decide to become old one day. One doesn't decide at all. Aging, as I would learn, is a process you're only aware of retrospectively. You're a resident powering through rounds, your patients' cancers and atherosclerosis abstractions to which you feel invulnerable, unless you have experienced illness as a young person (as many, but not most, have). Then suddenly, it's time for your first screening colonoscopy and maybe, a few years later, your first MI. Soon enough, you find yourself a whole corridor away, peering back through the doorways at your inconceivably young self and noticing how much less you have in common with her than with your older patients. Aging is a portal we traverse unawares. As novelist Mohsin Hamid puts it, whether or not we journey from place to place, "We are all migrants through time."

Maybe my readiness to pass through the patient portal is simply an acknowledgment of this fact. Maybe I'm ready to enter the patient portal because I'm old enough to understand that I already have.

Identifying details have been changed to protect the patients' privacy.

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