Prevention of Miscommunication and Injury

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Intraprofessional communication—how doctors talk with each other about mutual patients—is perhaps the most poorly taught component of current medical practice. When I was starting practice, doctors gathered in the hospital for meals and conversations and "cafeteria consults," which were important to the culture of developing mutual respect in a given medical community. As a new doctor in town in 1973, I learned the culture and values of that community from senior doctors over pancakes and coffee, not through online courses. In the present disconnected world of medical practice, electronic messaging is substituted for face-to-face communication over breakfast. We are too busy having "meetings" to actually talk with each other. Today most hospitalists and primary care doctors wouldn't even recognize one another, even though they share patients and are in the same "group." Neighborliness is as important in medicine as it is in the community but is not taught or structured in the efficient world of modern medicine. Lack of good communication between primary care doctors and consultants also has the greatest potential for tragedy and poor outcomes. Substituting an electronic bulletin board or e-mail does not replace personal, contextual, unhurried collaboration about patients. The article by Farrell and colleagues[1] might help to change that dynamic in one important area. They discuss a newborn screening team that acts on positive results by engaging the primary care provider to counsel that provider on how to convey positive screening information to parents. The best people to convey worrisome information in a clear and understanding way to parents should be the doctors they know best and trust. But primary care doctors often can benefit from education, not only to the facts but to the language that would best convey those facts to parents. Having a coach and collaborator as part of a team overseeing the statewide newborn screening process, which—with new genetic markers—will only get more complicated, should make all primary care providers for children feel better. The solution to some of the concerns raised in this article may come with the next generations of doctors who learn, early in their careers, to work together.

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When my male patients ask me what they should do different as they get older, I have always advised them to stay off ladders and roofs unless doing so is part of their job. In that regard, the very complete course in injury prevention outlined by Webb and colleagues[2] offers an experiential and evidence-based approach to educating medical students about what can be done to both decrease injury and to manage it once it happens. The course nicely demonstrates that advice and counsel for patients is important, but that advocacy for policies that would avoid injury is also the responsibility of physicians. There are many examples of such work in this state ranging from decreased temperatures in hot water heaters to avoid burns in children to seat belt and safe food laws. While the course may be logistically challenging, an abbreviated version might be an appropriate continuing education module for each of the health systems in the state. The problem is that in our offices we only see examples of accidents and injuries after they happen rather than those we prevented by counseling and policy.

The Health Innovation article by Khan and Simon[3] on a vision-friendly hospital follows the same principle – education of health care staff about the needs of low vision patients will not only create a more satisfying experience for patients and the staff but may decrease adverse outcomes, like falls. Our aging population will include

more patients with low vision so hospitals had best prepare in the most proactive way possible.

In their review of clinician adherence to appropriate Lyme disease screening guidelines for children, Al-Sharif and Hall[4] demonstrate the value of mining data in electronic health records (EHR). Since the disease is so prevalent in rural Wisconsin and the national guidelines are part of the Marshfield Clinic's EHR, one would expect closer adherence; but the study results continue to point out the difficulties inherent in moving agreed-upon guidelines into practice, even with the new tools available to us.

Aryal and Pathak[5] describe a case report where the unexpected, once again, is found to complicate the ordinary. We continue to advocate for looking for horses when hoof beats are heard, but occasionally zebras do appear.

Finally, we look back at the *WMJ* from 100 years ago to see how "advertising" oneself was discouraged and deemed unethical by organized medicine. Times have changed – doctors advertise on TV, billboards, buses and YouTube. It leads one to wonder if patients are asking each other "what brand is your doctor?"

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