It Takes a Team

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The *WMJ* continues to bring a wide array of interesting articles to readers, and this issue is no exception. A comprehensive review article by Almasi and Wilson[1] on diagnosing and managing concussions is not only authoritative (the senior author is one of the UW sports medicine physicians responsible for Badger football) but practical and timely. One does not have to see the finest professional hockey player of his era have a career-threatening concussion to understand that concussions have consequences, both acute and long-term, and that "shaking off" injuries, which was the method of handling sports injuries a few decades ago, is no longer appropriate. Many community physicians are involved with sports at the high school level, and this manuscript should be in their first aid kits. As the authors point out, all states need legislation to assure that young people are properly evaluated and treated prior to returning to sports. It is the least we can do for our children.

Villareal and colleagues[2] capitalize on the electronic data warehouse in their large health system to identify patients who have received broad spectrum antibiotics and who subsequently developed Irritable Bowel Syndrome (IBS) compared to patients who did not develop IBS. One of the more interesting possibilities with integrated electronic health records is to find linkages between diagnoses and clinical management that are expected, such as in diabetes, and at times unexpected, such as the possible causal linkage between tetracycline and macrolides and the development of IBS.

Tischendorf and Temte's[3] study in a single community practice demonstrates that giving receptionists at a busy urban practice the authority to ask patients to use masks if the patient's chief complaint suggests a respiratory or influenza-like illness is an effective way of decreasing the likelihood of transmission. Bringing staff into the decision-making process in the clinical environment is a wise choice. The authors' ability to link the use of face masks to diagnoses depended on billing and coding of information that would help them extrapolate rates of illness across 27 separate clinics from their findings in a single clinic. This study, just as the study on IBS, would have been virtually impossible to carry out without a well-functioning clinical data warehouse. Every community practice with a diagnostic data base should use the same approach to predicting the demand for facemasks in each flu season and, in the process, decrease viral illness in their community.

Tumerman and Carlson's article on team cohesion and leadership[4] tries to adapt a widely used process in the world of business and hospitals to a community clinic environment and finds the process challenging. The redesign of clinical practices, whether in primary care medical homes or specialty clinics, demands transparency, communication, and a culture of safety. Doing so requires the input of all members of teams—a fact well-known in industry but one not widely used in clinical practice in communities. The 2-year experience with the 360-degree process outlined by Tumerman and Carlson resulted in improvement in morale, collegiality, and team function. The process required commitment of time and resources and a willingness to stay with it. High levels of satisfaction for patients, doctors, and staff call for processes to improve and sustain teams that trust and depend on each other. Too many examples of a lack of professionalism and less-than-optimal clinical functioning arise in risk-averse systems that embrace hierarchy and passivity. The least successful component of the national demonstration project on transforming primary medical care was the establishment of well-functioning clinical teams, despite time and effort.[5] Talking constructively with colleagues shouldn't seem hard. It is, though.

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The case report by Fawole and colleagues[6] demonstrates that a continuing search beyond the usual suspects for rapidly progressing renal failure can find a heretofore undescribed source from which others with a similar primary disease might benefit.

Finally, a word from 100 years ago on

medical education in the post-Flexner report era describing the need for quality in terms still translates to today's world.[7] The last part of this "Looking Back" piece refers to the University of Wisconsin, which had not developed a clinical service at that point and had little likelihood of doing so in the short term, something that might come as a surprise to many in Madison today. But other sections of the 1911 *WMJ* editorial mention that Milwaukee was not doing all that much better. The change from trade schools to a profession was expensive and still is.

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