Those of us of a certain age can remember being taught to drive by a frustrated—and often terrified—parent in some parking lot after hours. Most of us wanted a car with an automatic shift to avoid the embarrassment of lurching forward after a stop and killing the engine altogether. We would pray for the easiest Department of Transportation (DOT) examiner when our time came to drive solo. Fortunately, things have changed.

Corden and colleagues (Graduated Driver Licensing Policy in the Great Lakes States: Current Benefits and Future Potential. *WMJ*. 2009;108(8):393-397) review national guidelines for driver education and show the terrible toll that anything short of a full implementation will bring to states, in terms of teen mortality and morbidity. Using a calculation that takes the number of recommended steps for graduated driver license guidelines into consideration, they show that if all Great Lakes states don’t show these data to parents, teens, and legislators and ask what possible reasons might exist to delay full implementation of national guidelines.

Dorothy, the Tin Woodman and the Scarecrow reflect the fears of many urban dwellers who venture into the scary woods as they chant “Lions! And tigers! And bears! Oh My!” on the road to Oz. But Lemke and her colleagues (Blastomycosis in Urban Southeastern Wisconsin. *WMJ*. 2009;108(8):407-410) show that urban dwellers can, in fact, become infected with blastomycosis, a disease more associated with beavers “up north” than the streets of Milwaukee, without venturing into the scary woods at all. More than half of the reported cases in Milwaukee had no exposure to the woods but shared a risk factor with northerners by living close to waterways (excluding Lake Michigan). Rivers contain more than fish, it seems. This study should alert us that infectious disease knows no boundaries and that clinicians should keep our decision-making assessments open to the atypical as well as the expected in communities of all types.

We are threatened by too much rather than too little information. Organizing and using health information of all types will be the challenge going forward. Rooney and Thompson (The Value of a Web-Based Interactive Regional Health Scorecard in Setting Public Health Priorities. *WMJ*. 2009;108(8):403-406) report on a web-based compilation of public health data in 20 counties in western Wisconsin that has been used by communities, health systems, and health departments to set priorities. The data were organized collaboratively through a regional consortium of universities and health systems that, in other situations, might be competitors but, fortunately for western Wisconsin citizens, have found that working together helps the whole region. It is a model that the rest of the state might learn from.

Finally, medical education is
always in need of review. Practice changes more rapidly than education, so a periodic assessment of relevance is in order. Lewis reports on a survey of practicing generalists about their surgical and subspecialty surgical practice needs (Does the Surgical Clerkship Meet the Needs of Practicing Primary Care Physicians? WMJ. 2009;108(8):398-402). His findings support the value of surgical training in generalist residency education and suggest that current primary care practice be adopted by increasing musculoskeletal and ear, nose, and throat education. In an era when we are trying to do more at the primary care level, both for cost and patient convenience, Lewis’s findings support the need for such care. He found that suturing and wound care are important skills in primary care practice and that the approach to undifferentiated (potentially surgical) problems such as abdominal pain and the evaluation of “lumps and bumps” also continue to be an important part of primary care practice. Teaching these skills should be a part of residency curriculum going forward.