EDITORIAL

In This Issue: Developing and Amplifying the Effectiveness of the Primary Care Workforce

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In addition to a number of interesting clinical research studies and reflections, articles in this issue illuminate how the primary care workforce can be expanded and made more effective.

A shortage of primary care physicians and a shortfall in production rates is projected in analyses by Liaw and colleagues.[1] Changing care delivery models toward small panel sizes substantially increases the shortage.

Willard-Grace et al show how the effectiveness of the primary care workforce can be enhanced by involving medical assistants as in-office health coaches.[2] Medical assistant health coaches are effective in helping patients to meet goals for diabetes control and cholesterol reduction, but not blood pressure treatment. This article is this issue's *Annals* Journal Club.[3]

Social networks within primary care practices, in terms of the density of interactions among team members, are associated with fewer hospital days and lower medical care costs for patients with cardiovascular disease, according to a study by Mundt and colleagues.[4] This important relationship is mediated by the team's degree of shared vision about goals and expectations.

For those evaluating change toward the patient-centered medical home, Goldman and colleagues provide a mixed methods roadmap that examines both patient and practice processes and outcomes.[5]

Jackson and colleagues provide information to guide how we arrange follow-up of patients to reduce hospital readmissions.[6] They find that most patients do not benefit from early outpatient follow-up, and they identify a subgroup based on multimorbidity and risk that may benefit from early hospital follow-up.

A study of a large sample of older people with multiple medical conditions finds that continuity of care is associated with lower rates of hospital use, even in an integrated delivery system with shared electronic medical records that provide continuity of information to different health care providers.[7]

Another study of patients with multiple chronic medical conditions, by Mercer and colleagues, finds that multimorbidity is strongly associated with hospitalization across 3 widely different health care systems, but the relationship between socioeconomic deprivation, multimorbidity, and hospital admission varies across different systems in ways that give insights into how systems might be made equitable and effective.[8]

Inviting people to be screened for type 2 diabetes turns out to have a limited effect on cardiovascular morbidity, self-rated health, or health behavior after 7 years of follow-up, in a study by Griffin and colleagues.[9]

A longitudinal study of chronic abdominal pain in children finds that pain persists for at least 1 year in one-third of children. The study identifies some modestly useful but practical predictors of persistent pain.[10]

Two essays hit hard with personal reflections on challenging interpersonal relationships. Vidal asks why medical schools tolerate unethical behavior by their faculty[11] and Hughes shares her personal struggle after witnessing a man commit suicide.[12]

Finally, a pair of Point-Counterpoint articles argue the question: is secondhand smoke exposure a form of child abuse?[13,14]

We welcome your reflections at http://www.AnnFamMed.org.

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POINT / COUNTERPOINT

Is Exposure to Secondhand Smoke Child Abuse? Yes.

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Scientific research over the last decade has increasingly demonstrated that exposure to secondhand smoke is not simply a nuisance; it is deadly.[1] Secondhand smoke exposure causes multiple diseases in children, including asthma and pneumonia, and results in thousands of avoidable hospitalizations.[2] Secondhand smoke exposure is a major cause of sudden infant death syndrome and may cause lung cancer and heart attacks with repeated exposure.[2] No safe level of exposure exists.[1,2]

Purposefully and recurrently exposing children to secondhand smoke—a known human carcinogen—despite repeated warnings, is child abuse. Federal law defines child abuse as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or *an act or failure to act which presents an imminent risk of serious harm*."[3] In the case presented below, our patient's parents failed to act in a way to remove their child from recurring, life-threatening harm by secondhand smoke, thereby constituting child abuse.

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Case

At least 10 times over 3 years, we counseled the family to quit smoking around the 5-year-old patient and her 7-year-old sister, as the kids repeatedly came to the clinic for ear infections, coughing, bronchitis, and asthma. Two months after a recent visit, the younger child developed pneumonia. We successfully treated her with antibiotics and inhalers, and gave strong admonitions to the parents to avoid smoking anywhere near the children, offering the parents detailed counseling support. The parents, however, refused to engage with us about quitting smoking, pharmacotherapy for cessation, or about not letting their children be exposed to cigarette smoke.

In the clinic, the residents and I discussed the case in detail, asking ourselves what more we could do. We reviewed the Public Health Service guidelines on tobacco use treatment that document optimal ways to help people quit smoking, then reviewed our attempts at counseling and referral and the quality improvement efforts in our office systems to support improved outcomes.[4] In short, we did everything that evidence-based guidelines tell us to do.

We still did not do enough. Not long after, the younger child showed up in the emergency room with a recurrence of pneumonia and severe asthma. By the