

In This Issue: Social Context; Disease Causes

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This issue of *Annals* provides new insights into the social and systems context of practice, and the etiology of disease.

In this issue we also call for diverse readers to help foment a revolution by sharing on-the-ground innovations in primary health care.¹

The degree to which mobile technology use by young children affects families is evaluated in an in-depth qualitative study by Radesky et al.²

In a complement to a recent *Annals* supplement on peer support for diabetes self-management,³ a meta-analysis of peer support intervention trials among adults with diabetes discovers a small but significant effect on glycosylated hemoglobin, and larger effects among studies with predominantly Hispanic participants and among predominantly minority participants.⁴ If this personal intervention has an effect on this impersonal outcome, it would be interesting to know the effect of peer support on more overtly patient- and community-centered outcomes. This article is the basis for this issue's *Annals* Journal Club.⁵

Another study uses qualitative methods to discover a conceptual model of the development of strong relationships as a foundation for effective health coaching to support health decision making and behavioral change.⁶

Kiran et al examine the reach of voluntary medical home reforms in Ontario, Canada, and find that patients enrolled in fee-for-service practices are more likely than patients in medical homes to be poor, urban, and new immigrants, and less likely to receive recommended screening services.⁷

Several studies in this issue have particularly direct relevance to primary care practice, and to understanding the causes of disease.

A study discovers an unrecognized and potentially modifiable risk factor for falling. This study of hospital inpatients finds that nearly one-third of patients at risk for falling have subclinical peroneal neuropathy. Even after controlling for potentially confounding factors, patients with subclinical peroneal neuropathy are nearly 5 times as likely to have fallen in the past year.⁸

Three studies provide new insights into the pathophysiology of respiratory infections.

Teepe et al observe the natural history of lower respiratory infection by following more than 1,000 people in the control arm of a clinical trial of people with acute cough. They find that a bacterial etiology, as determined by microbiological and serological analysis, is associated with more follow-up consultations and worse symptoms on days 2 to 4 after presentation, but no difference in resolution of symptoms rated moderately bad or worse.⁹

Two meta-analyses by Ebell and colleagues synthesize the literature to provide new insights into potential pathogens that are not typically subjected to diagnosis and treatment. The authors find high rates of atypical bacterial pathogens in patients with acute lower respiratory tract diseases.¹⁰ In patients with sore throat, the researchers find rates of Group C beta-hemolytic *streptococcus* of about 6% and of about 19% for *Fusobacterium necrophorum*.¹¹ These findings raise the possibility of undiagnosed and untreated causes of common respiratory tract infections. However, the clinical implications are uncertain since we do not know whether treatment of these pathogens improves outcomes.

A research brief by Hero et al finds that in a nationally-representative sample, the high-risk behavior of saving opioid pills for later use is substantially less likely among patients who report having been counseled by their physicians about the risks of prescription painkiller addiction.¹²

Finally, in an era of rising clinician burnout, an essay by Doolittle asks, "Are we the walking dead?"¹³

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

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