From the Association of Family Medicine Residency Directors

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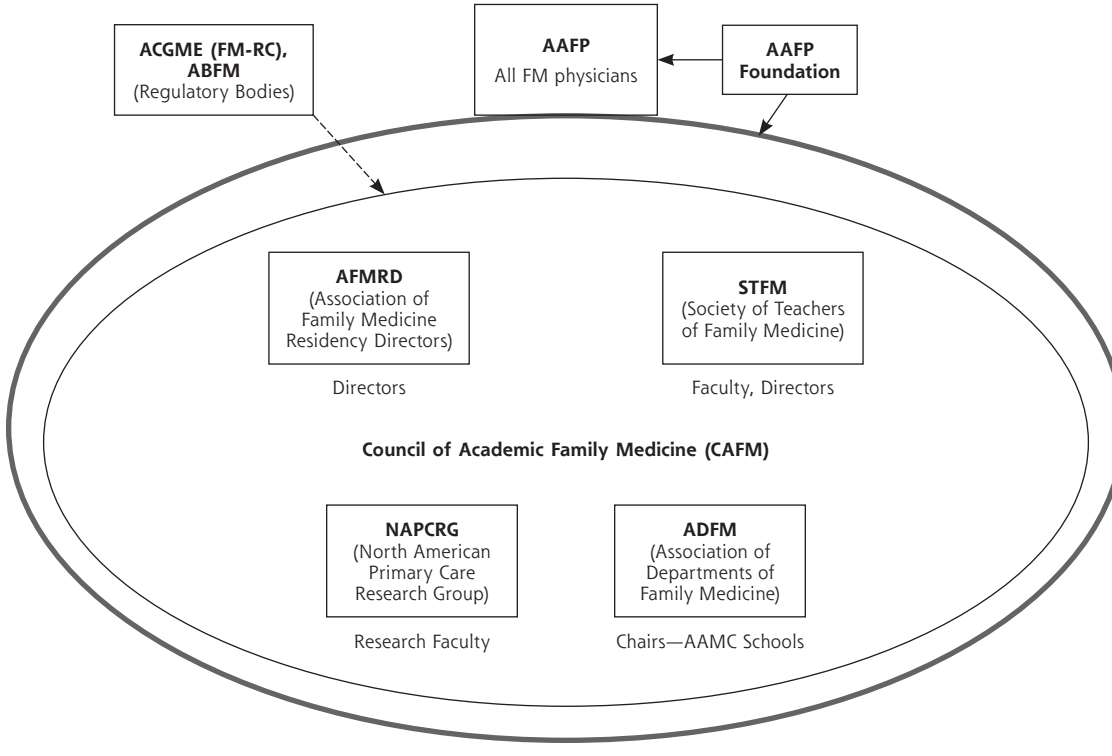
THE "FAMILY" OF FAMILY MEDICINE

Most of us joined the American Academy of Family Physicians (AAFP) as active members upon graduation from our residency training programs. During our careers, our memberships in other family medicine organization have likely evolved. However, the alphabet soup of abbreviations of our varied family medicine organizations can be a bit confusing and the relationships among them are often equally unclear. We are entering a time where collaboration among family physicians of all backgrounds will be increasingly important. With over 400 family medicine training sites, 65,000 family physicians, and 338 million patient touches by family physicians annually, the family of family medicine has an enormous impact on this nation's health. Family physicians are being thrust into leadership positions in many health systems as they seek to save costs and improve quality. In this environment, knowing your "family" is critical to success since each organization brings special skills, relationships, and resources to the table.

The diagram below shows our key relationships and will hopefully clarify the various roles and constituencies that make up these organizations.

Our regulatory bodies, the American Board of Family Medicine and the Family Medicine Review Committee of the ACGME, are entrusted with overseeing the training and certification of our current and future physicians. Due to their regulatory roles, they must be distinct from the rest of the family but as our specialty evolves, they remain heavily engaged with all of our leaders to keep the training and certification rules relevant. The academic core of the family is made up of 4 organizations: The Association of Family Medicine Residency Directors (AFMRD), the Society for Teachers of Family Medicine (STFM), The North American Primary Care Research Group (NAPCRG), and the Association of Departments of Family Medicine (ADFM). Together the leadership of these 4 groups makes up CAFM, the Council of Academic Family Medicine. In a time where our government's budget battles are drawing attention to graduate medical education reform, this relatively new subgroup allows for greater collaboration and advocacy for family medicine education. Finally, there is our Academy and Founda-

Figure. The 'family' of family medicine.



tion which nurture and support the practicing physician. The AAFP is the center of the family and leads in advocacy that affects us all.

So what does this mean for you? It boils down to participation and engagement. Many family physicians are members of 2 or 3 of these organizations. Are you looking for ways to be part of this important work? More than ever each organization needs your support, participation in advocacy, and your ideas for solutions. Find your niche, join a task force or committee, step into a leadership role, and find a seat at the table. Your family needs you—now.

Michael Tuggy, MD; Michael Mazzone, MD
Stoney Abercrombie, MD; Brian Crownover, MD;
Grant Hoekzema, MD; Nathan Krug, MD;
Lisa Maxwell, MD; Karen Mitchell, MD;
Stephen Schultz, MD; Todd Shaffer, MD, MBA

From the North American Primary Care Research Group

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PRIMARY CARE RESEARCH FROM THE WOMEN'S HEALTH INITIATIVE

Primary care research can encompass not only a broad range of topics, but also a variety of methodologies, one being secondary data analysis. Secondary data analysis involves the analysis of existing data to evaluate questions not addressed by the original study, and can be used by primary care researchers to conduct clinical, epidemiological, and health services research. The use of secondary data analysis can have several advantages, as it can provide access to large sample sizes in a quick and inexpensive manner. However, the data available is often limited by the measures included in the original study. A variety of sources for secondary data are available, such as the Women's Health Initiative. The Women's Health Initiative is an ongoing study of a multiethnic cohort of postmenopausal women from 40 centers in the United States. This study is in its second extension and has over 15 years of cumulative data. Its present focus is on healthy aging, natural history of multiple chronic diseases, symptoms, and functional status. It is thus an ideal cohort for primary care researchers interested in these outcomes. One of the distinguished papers presented at the 40th NAPCRG Annual Meeting in the fall of 2012, reported successfully performed secondary data analysis of the Women's Health Initiative. The distinguished paper, entitled *Social Support and Physical Activity as Moderators of Life Stress in Predicting Baseline Depression and Change in Depression Over Time in the Women's Health Initiative*, was presented by primary care researcher Lisa Uebelacker, PhD, from Brown University.

Uebelacker's research expands on previous research that has shown negative life events, acute stressors and chronic stressors increase risk for onset, persistence, or worsening of depression. Different types of stressors may increase risk for depression. These include interpersonal stressors, such as verbal abuse, physical abuse, social strain, care giving, or negative interpersonal life events; financial stressors such as low income or self-report of financial stress; and medical stressors such as chronic medical conditions or pain. In contrast, social support and physical activity may decrease the risk of depression. The purpose of this analysis was to determine whether social support and/or physical activity actually buffer the association between stressors and increased risk of depression symptoms at a single time point and after a 3-year follow-up period.

Uebelacker and colleagues conducted a secondary analysis of data from the Women's Health Initiative Observational Study. This prospective cohort includes 92,063 community-dwelling post-menopausal women who participated in the study. Depression symptoms were measured at baseline and 3 years later; social support, physical activity, and stressors were measured at baseline. For baseline analyses, the investigators used the entire sample; in order to look at new-onset depression at 3-year follow-up, they used data only from the 68,368 women who were not depressed at baseline and provided follow-up data. They conducted adjusted logistic regressions, with depression status as the dependent variable.

Stressors at baseline, including verbal abuse, physical abuse, care giving, social strain, negative life events, financial stress, low income, acute pain, and a greater number of chronic conditions, were all associated with higher levels of depression symptoms at baseline and new onset elevated symptoms at 3-year follow-up. Social support and physical activity were associated with lower levels of depressive symptoms at baseline and at 3-year follow-up. Social support at baseline attenuated the association between concurrent depression and physical abuse, number of medical conditions, financial stress, social strain, and low income. Social support also attenuated the association between financial stress and low income on new-onset depression 3 years later. Physical activity was not a significant effect moderator.

These results highlight the important role that social support can play in reducing risk of depression in older women, particularly in times of stress. Although physical activity did not buffer the effects