ideas for new areas of curriculum. This information is to be used as part of the program's determination of the degree to which the program's goals are being met. The program requirements recommend that a written survey after 1 year and every 5 years thereafter be conducted to collect the above data.

To fulfill this requirement and to further develop research activities into their programs, the family medicine residency programs affiliated with the SC AHEC have developed a flexible, graduate survey tool. Starting with 1999, this instrument is mailed from a central office every 5 years to the more than 1,400 graduates of the 8 programs in South Carolina. The survey has been constructed to include questions regarding graduates' demographic and practice profiles, along with the other information recommended by the RRC. In addition, the survey includes a section that is devoted to questions developed by faculty or current residents regarding research topics of current interest.

To date, the surveys have produced the desired results of providing feedback to the programs regarding their graduates as well as promoting research. From the initial survey, the program directors were able to examine the following issues: practice profiles and patterns, career satisfaction, the graduates' perceptions of the relevancy of training to practice, and activity in medical student and resident education of the graduates of the SC AHEC's affiliated family medicine residency programs.[1] Further research from this has determined whether there were important differences in practice patterns of physicians based on the academic affiliation of the residency in which they trained. Finally, several faculty members were able to evaluate the practice profiles of all female compared with male family physician graduates of SC training programs.

From the most recent survey, the program directors were again able to examine the education and practice location of and the services provided by their graduates so they could give the SC AHEC and these programs specific, up-to-date information regarding these physicians.[2] For this specific survey, questions regarding practice management curriculum; lifestyle activities, such as physical activity, tobacco use, obesity, influenza vaccination, and tetanus immunization; and interaction with pharmaceutical representatives were included as a part of additional research projects.

Not only are faculty using the graduate survey for research purposes; residents have also developed research projects using this information. During the recent SC AHEC Hickory Knob Research Symposium, William M. Tucker, III, MD (a second-year resident at the Trident/MUSC Family Medicine Residency Program in Charleston, SC), presented his project, "An Analysis of Procedure Training and Practice Trends: Which Procedures Should be Taught in a Family Medicine Residency?"

The graduate survey is one opportunity for a residency program to incorporate research and other scholarly activity. Consistent with the ACGME core competencies, critically evaluation of the manner in which program requirements are being met through research and quality improvement initiatives parallels the practice-based learning, improvement, and professionalism expected from residents. Furthermore, the presentation and publication of these projects contributes to the professional and public awareness of the discipline of family medicine.

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From the North American Primary Care Research Group

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THE ANNUAL MEETING: 2005 IN QUEBEC CITY, 2004 PLENARY ON SOCIAL EPIDEMIOLOGY

NAPCRG Prepares for 2005 Annual Meeting in Quebec

The NAPCRG Annual Meeting has historically provided the opportunity to share ideas and knowledge with individuals from around the world, and this year should be no different. The 2005 Annual Meeting will be held October 15 to 18 in Quebec City, and we have 3 outstanding plenary speakers who will provide us with a variety of insights and perspectives:

• Martin Roland, MD, a general practitioner who heads the National Primary Care Research and Development Centre at the University of Manchester in the United Kingdom. Dr Roland wrote in the September 2004 *New England Journal of Medicine* on the unprecedented move by the National Health Service to link physicians' pay to the quality of care provided.

• Michaele Christian, MD, associate director, Division of Cancer Treatment and Diagnosis, Cancer Therapy Evaluation Program at the National Cancer Institute. Dr Christian works with the Office of the

Director of NIH on dissemination of the NIH Roadmap.

• Antonia Maioni, PhD, director of the McGill Institute for the Study of Canada, will discuss international comparisons in health care policy.

For more information on the 2005 Annual Meeting, go to http://www.napcrg.org.

As NAPCRG prepares for its upcoming Annual Meeting, one member reflects on a plenary presentation from last year's meeting that he found inspiring.

Looking Upstream: A Social Epidemiologist's View

At the 2004 NAPCRG annual meeting in Orlando, Ichiro Kawachi, MD, PhD, professor of Social Epidemiology at the Harvard School of Public Health, presented a plenary address on health disparities. Dr Kawachi is among the most prominent US social epidemiologists and coeditor of one of the major texts in the field, as well as author of many other key publications. Attendees were treated to a skillful overview of the concepts and potential impact of social epidemiology.

As a scientific endeavor and point of view, social epidemiology is a powerful antidote to narrow conceptions of illness causation and treatment. Important thinkers in the field have sought to trace the roots of illness back to fundamental causes, digging down to the political and social structures that perpetuate the stratification of illness by sex, class, and race/ethnicity. Dr Kawachi provided a series of examples in this tradition, beginning with the "missing women" phenomenon, particularly evident in China and India, where the female populations are tens of millions below expected numbers as a result of selective abortion, infanticide, and neglect. He then moved on the more locally familiar problems of disparities in life expectancy by race and class in the United States.

Examining proposed explanations for the observed disparities, Dr Kawachi contrasted 2 different perspectives: (1) disparities derive mostly from failures of personal responsibility for following a healthy lifestyle, and (2) disparities reflect environmental constraints that limit the range of available or realistic behavioral options. The social epidemiology thesis interventions that focus on personal responsibility (for example, increasing motivation and self-efficacy) are likely to be ineffective when the underlying social context of normative behavior, economic disincentives, and competing stresses is not addressed. For example, the near-term trade-offs necessary for taking a long-term preventive orientation may not seem worth the trouble when the social environment is viewed as incompatible with long life. Kawachi illustrated this idea with the story of a worksite smoking intervention in which blue-collar workers' quit rates doubled in the intervention arm that addressed the workplace's serious respiratory hazards as well as smoking.

Dr Kawachi brought the message home through parody of the usual "tips for better health" aimed at personal behavior. For example "Don't smoke. If you smoke, stop." is replaced by his social epidemiology version: "Don't be poor. If you are poor, stop. If you can't, try not to be poor for too long."

He ended by considering the contributions, both positive and negative, of medical care to population health. He presented the well-known Institute of Medicine statistics on medical errors but also pointed out how modern trauma care is mitigating what would otherwise be an even worse epidemic of deaths due to intentional injury. Fittingly for NAPCRG, his last example was the contribution of primary care to improved health outcomes.

The summary lessons of the talk were that equal access to medical care—especially primary care—is an important means to reduce health disparities, but focusing on medical care is not enough. Without improvements in the unhealthy social environments to which minorities and economically disadvantaged people are commonly exposed, we will continue the dispiriting exercise of rescuing people from the river rather than preventing them from falling in.

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GUIDELINE SHOWCASES AAFP'S COMMITMENT TO EVIDENCE-BASED, PATIENT-CENTERED CARE

The clinical practice guideline published as a supplement to the online version of this issue of the *Annals of Family Medicine* (http://www.annfammed.org/cgi/content/full/3/4/378/DC1) combines elements both unique and ubiquitous. The guideline, "Trial of Labor After Cesarean (TOLAC), Formerly Trial of Labor Versus Elective Repeat Cesarean Section for the Woman With a Previous Cesarean Section," is unique in that it reflects family medicine's patient-centered approach to care. At the