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

Table 1. Executive Summary of AAFP Clinical Practice Guideline on Trial of Labor After Cesarean

The American Academy of Family Physicians Commission on Clinical Policies and Research convened a panel to systematically review the available evidence on trial of labor after cesarean (TOLAC) using the Agency for Healthcare Research and Quality "Evidence Report on Vaginal Birth After Cesarean (VBAC)." The panel's objective was to provide an evidence-based clinical practice guideline for pregnant women and their families, maternity care professionals, facilities, and policy makers who care about trial of labor and maternity care for a woman with one previous cesarean. The recommendations are as follows:

Recommendation 1: Women with 1 previous cesarean delivery with a low transverse incision are candidates for and should be offered a trial of labor (TOL). (Level A)

Recommendation 2: Patients desiring TOLAC should be counseled that their chance for a successful vaginal birth after cesarean (VBAC) is influenced by the following: (Level B)

Positive factors (increased likelihood of successful VBAC)	Negative factors (decreased likelihood of successful VBAC)
Maternal age < 40 years	Increased number of previous CDs
Previous vaginal delivery (particularly previous successful VBAC)	Gestational age > 40 weeks
Favorable cervical factors	Birthweight > 4,000 g
Presence of spontaneous labor	Induction or augmentation of labor
Nonrecurrent indication that was present for previous cesarean delivery (CD)	

Recommendation 3: Prostaglandins should not be used for cervical ripening or induction, as their use is associated with higher rates of uterine rupture and decreased rates of successful vaginal delivery. (Level B)

Recommendation 4: TOLAC should not be restricted only to facilities with available surgical teams present throughout labor, because there is no evidence that these additional resources result in improved outcomes. (Level C) At the same time, it is clinically appropriate that a management plan for uterine rupture and other potential emergencies requiring rapid cesarean section should be documented for each woman undergoing TOLAC. (Level C)

Recommendation 5: Maternity care professionals need to explore all the issues that may affect a woman's decision, including issues such as recovery time and safety. (Level C) No evidence-based recommendation can be made regarding the best way to present the risks and benefits of TOLAC to patients.

same time, it embodies the AAFP's dedication to promoting evidence-based medical practice—a hallmark of all clinical practice guidelines the Academy produces.

The TOLAC guideline and its recommendations offer guidance for pregnant women and their families, health professionals and facilities that provide maternity care, and health policy makers with an interest in this area of maternity care. An executive summary of the guideline, including the practice recommendations, appears in Table 1.

The rigorous process the Academy uses to develop its clinical practice guidelines begins with the identification of clinically relevant topics. The AAFP Commission on Clinical Policies and Research (CCPR) has established criteria it uses to select topics important to family physicians and their patients.

The next step is to perform or obtain a systematic review of all the available evidence on a given topic. To this end, the Academy usually avails itself of the services of the Agency for Healthcare Research and Quality (AHRQ) and its Evidence-based Practice Centers (EPCs).

AHRQ partners with private and public organizations to support their efforts to improve the quality, effectiveness, and appropriateness of health care delivery in the United States. Professional societies, health systems, employers, insurers, consumer groups, and others may nominate topics for scientific analysis and evidence synthesis. AHRQ supports about 9 evidence reports each year.

These organizational partners are, in turn, expected to serve as resources to the EPCs as they develop the evidence reports related to the nominated topics, including serving as external peer reviewers of draft evidence reports. The organizations also commit to timely translation of the evidence reports into clinical practice guidelines, performance measures, educational programs, and/or reimbursement policies. Finally, the partners agree to disseminate these derivative products to their memberships.

In the case of the TOLAC guideline, the topic was nominated to AHRQ independently by both the Academy and American College of Obstetricians and Gynecologists. The evidence synthesis, performed by AHRQ's Oregon EPC (Oregon Health & Science University in Portland), was released in March 2003. The executive summary of that evidence report, titled "Vaginal Birth After Cesarean (VBAC)," is available at http://www.ahrq.gov/clinic/epcsums/vbacsum.htm.

Specific questions examined during the VBAC evidence synthesis addressed such issues as the frequency of successful vaginal delivery in women who undergo a trial of labor (TOL) after a previous low transverse cesarean; accuracy of risk-assessment tools in identifying patients likely to have a successful vaginal delivery after a TOL; and relative harms associated with a TOL versus repeat cesarean, including the incidence of uterine rupture.

AAFP guideline panels are composed of members of the CCPR and additional experts in content and methodology. The goal is to convene a panel of family physicians representing both community and academic practice settings to ensure the clinical relevance of the resulting practice guideline for all family physicians. In the case of the TOLAC guideline, a panel of family physicians with particular expertise in this

Table 2. Clinical Practice Guidelines Developed by the AAFP Either Alone or in Conjunction With Other Groups

Guideline	Collaborating Group(s)	AAFP Web Address
The Benefits and Risks of Controlling Blood Glucose Levels in Patients With Type 2 Diabetes Mellitus	None	http://www.aafp.org/PreBuilt/diabpol2.pdf
Management of Newly Detected Atrial Fibrillation	College of Physicians	http://www.aafp.org/x25474.xml
Migraine Headache Treatment Guidelines	American U.S. Headache Consortium*	http://www.aafp.org/x21710.xml
The Management of Minor Closed Head Injury in Children	American Academy of Pediatrics (AAP)	http://www.aafp.org/x1595.xml
Diagnosis and Management of Acute Otitis Media	AAP	http://www.aafp.org/x26481.xml
Otitis Media With Effusion	AAP, American Academy of Otolaryngology-Head and Neck Surgery	http://www.aafp.org/x1596.xml

* In addition to the AAFP, members of the consortium are the American Academy of Neurology, American College of Emergency Physicians, (then) ACP-American Society of Internal Medicine, American Osteopathic Association, American Headache Society, and National Headache Foundation.

area of maternity care reviewed the VBAC report findings, conducted a systematic update of the evidence by reviewing studies published since the report was released and created the guideline.

Components of the TOLAC guideline include background information: the rationale for developing the guideline; a review of the methodology used to create the guideline; results of the evidence review; a set of practice recommendations, including summaries of the quality of evidence for each recommendation; and suggestions for future research in this area.

Once an AAFP clinical practice guideline panel has completed its work, the guideline is peer-reviewed by members of the CCPR and other content experts as appropriate. The full CCPR and the AAFP Board of Directors must approve the guideline before it becomes official Academy policy. AAFP clinical policies are reviewed every 5 years and are at that time reaffirmed, revised, or removed.

Whenever practicable, the AAFP collaborates with other specialty medical organizations—primarily those whose members deliver primary health care services—and occasionally with subspecialty medical and even patient advocacy groups to permit development of a single clinical practice guideline that can be applied in various primary care settings. The rationale for this process: Creating a single set of comprehensive, evidence-based practice guidelines reduces the burden on busy practicing physicians and avoids the potential for patient confusion posed by differing guidelines.

Generally, the Academy collaborates with the American College of Physicians (ACP) on guidelines relating to adults. Most recently, AAFP and ACP published jointly developed guidelines for atrial fibrillation and migraine headache. The 2 organizations are currently developing joint guidelines on 3 different topics: diagnosis and management of venous thromboembolism, pharmacologic management of dementia, and management of impaired glucose tolerance.

For guidelines relating to children, the Academy collaborates with the American Academy of Pediatrics. The 2 groups most recently published jointly developed guidelines on managing acute otitis media and on treatment for otitis media with effusion.

See Table 2 for additional information on evidence-based clinical practice guidelines developed by the AAFP either alone or in conjunction with other groups. All of the Academy's clinical policy statements and recommendations may be accessed at http://www.aafp.org/x132.xml.

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