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“There’s more than one way to skin a cat.” I know many of us were raised around at least one family member who used this phrase to get across various points of wisdom. Although crude in nature, the point is fairly easy to learn — there are multiple ways to reach an end result. Clinical medical education has proven itself to follow this same train of thought. During my years with the academic programs at the University of Alabama School of Medicine – Tuscaloosa Campus, I have seen many ways to approach medical education. I have had the opportunity to attend many Society of Teachers of Family Medicine (STFM) conferences and truly know there are as many ways to teach medical students as there are medical schools.

Traditionally during the clinical years, students spend a block of time doing one focused clerkship and, at the end, are tested by various formats to determine mastery of that subject. Longitudinal integrated curriculum (LIC) experiences are a way to increase depth as well as breadth of experiences. I have had the opportunity to precept students in short traditional block experiences and longitudinal experiences varying from 17 to 36 weeks. As a preceptor of a private practice, I prefer the longitudinal students. No offense to those traditional students, but the ability for camaraderie is far exceeded with the LIC students, and the gratification in seeing the LIC students master a technique or move forward in their diagnostic acumen is like none other.

My LIC students have had experiences with my patients that even I am jealous of because of their ability to follow the patient. They are able to attend specialty appointments and serve as a conduit of information that may not always appear in the printed pages of the electronic medical record of patient encounters. They have been praised by many specialists because of their depth of understanding of that individual patient. Generally, they get additional social and past history that hasn’t yet been harvested in quick primary care visits. My care of my patients has improved because of the additional time the students spend with them.

As we go forward in our state with additional medical schools establishing further mid-level training opportunities and branching out of current medical schools, I hope we as family physicians will continue to be on the leading edge of improving our outcomes in training these students. I know my practice has improved by opening the doors to various students during the past 10 years, and I look forward to contributing to the education of many more in the years to come.

FROM THE PRESIDENT

Why Pick an LIC?

by Julia Boothe, MD

2014 Family Physician of the Year: Dr. Steven Donald

Dr. Steven Donald graduated from the University of South Alabama School of Medicine in 1994. He completed his family medicine residency at the University of South Alabama Family Medicine Residency Program in 1996. Dr. Donald is board-certified in family medicine, as well as hospice and palliative medicine. His practice, Chatom Primary Care, P.C., is located in Chatom, Alabama. He serves as Jackson Medical Center courtesy staff physician, preceptor for the University of South Alabama Medical Program and medical director of ASERACARE Hospice. He was presented the award at the AAFP Fall Forum, December 13-14, 2014, in Hoover, Alabama. Please join us in congratulating Dr. Donald for being selected as the Alabama Academy of Family Physicians 2014 Family Physician of the Year.

Dr. Steven Donald (right), pictured with his wife, Karen (left), and daughter, McKenzie (center).
Health Home Expansion to Benefit Patients with Chronic Health Conditions

More than 250,000 Medicaid recipients with chronic health conditions can now access enhanced care coordination and other services to improve their overall health as a result of the expansion of the Alabama Medicaid Agency’s Health Home program on April 1, 2015.

Six probationary Regional Care Organizations (RCOs) have qualified to operate Health Home programs in Alabama. The groups include: Region A: Alabama Community Care – Region A and My Care Alabama; Region B: Alabama Care Plan; Region C: Alabama Community Care – Region C; Region D: Care Network of Alabama; and Region E: Gulf Coast Regional Care Organization.

The program, which has operated since 2012 as Patient Care Networks in 21 counties of the state, is expanding statewide as an interim step toward implementation of full-risk Regional Care Organizations. RCOs are locally led managed-care systems that will ultimately provide health care services to Medicaid enrollees at an established cost under the supervision and approval of the Alabama Medicaid Agency.

In contrast, the Health Home program is defined by the federal government as an optional Medicaid program that integrates and coordinates care for patients with certain chronic conditions to achieve improved health outcomes. In Alabama, the Health Home program is set up to add an additional level of support to Patient 1st Primary Medical Providers (PMPs) by intensively coordinating the care of patients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease and hepatitis C.

Care management, or coordinated care, in the Health Home program is done by connecting patients with needed resources, teaching self-management skills, providing transitional care, and bridging medical and behavioral services, among other efforts.

“This interim step is designed as a building block for probationary RCOs that are working toward full certification by facilitating network development and providing resources while offering the probationary RCOs an opportunity to demonstrate that they have resources to manage patients in their region,” said Dr. Robert Moon, chief medical officer and deputy commissioner for health systems.

The Health Home program will operate alongside the Patient 1st program until October 1, 2016, when the Health Home program will be incorporated into the full-risk RCOs’ operations. The Agency will continue to operate its current fee-for-service program until full-risk RCOs are implemented in October of 2016.

For more information on the Health Home Program, go to the Alabama Medicaid Agency website at www.medicaid.alabama.gov and click on “Regional Care Organizations.”

Workgroup to Evaluate, Report on Medicaid Long-Term Care Services

Members of a workgroup tasked with evaluating the state’s long-term care services began work in January to study potential ways to improve quality and outcomes for Medicaid recipients. The workgroup, comprised of 17 members, includes long-term care and home care providers as well as state agency officials and consumer advocates.

The group was commissioned in 2013 state legislation creating Medicaid Regional Care Organizations (RCOs). Once complete, the workgroup’s findings are to be reported to the state Legislature and to Gov. Robert Bentley on October 1, 2015. Long-term care services are currently exempted under the RCO law.

The group is looking at a wide range of services including both institutional and community-based long-term care, according to Kathy Hall, deputy commissioner for program administration. During February, the group heard presentations from Medicaid, the Alabama Nursing Home Association, the AARP and the Alabama Department of Mental Health and Mental Retardation. The presentations are available on the Agency’s website at: www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.2.3_LTC_Workgroup.aspx.
Probationary Medicaid RCOs
How Do Physicians Respond Without Subjecting Themselves to Potential Criminal and Civil Liability?

by John T. Mooresmith, Esq., Burr Forman LLP

There are now eleven organizations across the State of Alabama that have been granted probationary certification as Medicaid Regional Care Organizations or “RCO”s. Physicians have begun receiving notices from some of these RCOs asking them to return a letter of intent to participate in the RCO network of providers. RCOs must be able to demonstrate to the Medicaid Agency that they have an adequate provider network in place by April 1, 2015. The RCOs are now on a fast track to put together the Primary Care Networks, and will be sending provider contracts out next. This will be the time that physicians and other providers will be negotiating with the RCOs for the best agreement they can get.

The letters of intent that are being sent out are non-binding on physicians, and merely acknowledge that the physician is willing to negotiate with the RCO. However, the issuance of the letters of intent by the RCOs will trigger discussions among physicians that may have antitrust implications. While a physician who simply sends in a letter of intent is acting individually, if that physician begins discussing with other physicians whether or not the physicians should send letters of intent, the physicians involved in the discussions may be deemed to be acting collectively.

Under antitrust laws, physicians are considered horizontal competitors who compete with each other for patients just as car dealers are horizontal competitors who compete for customers. Any distinction in the law for professions has long been abandoned. Violations of the antitrust laws carry very severe penalties including potential criminal prosecution, trebled damages and an award of the plaintiff’s attorney fees. The enormous legal fees involved in defending an antitrust investigation by the Department of Justice or the Federal Trade Commission alone can be devastating to a physician practice.

In order to protect physicians who negotiate with RCOs, the Alabama Legislature sought to provide immunity from liability under the antitrust laws by putting these negotiations under an exemption to antitrust known as the “State Action Doctrine.” This is a doctrine set forth by the U.S. Supreme Court that exempts actions of a state from application of the antitrust laws. To qualify for the exemption, the state must clearly articulate and express a state policy to exempt the anticompetitive conduct and then actively supervise the anticompetitive conduct.

The Legislation in which MASA actively participated provides the necessary elements to exempt physician negotiations from antitrust liability if the physicians carefully follow the Medicaid Regulations that implement the exemption. Before talking with other physicians about the pros and cons of contracting with a Medicaid RCO, physicians should apply through an online process to the Medicaid Agency for a Certificate to Collaborate. The electronic application is available at https://rcoportal.medicaid.alabama.gov. Once the application is approved, a Certificate to Collaborate will be issued which will allow for collective negotiation, bargaining, and cooperation regarding payment and health care delivery. Careful attention must be paid to the Medicaid Regulations to assure that the Certificate to Collaborate continues in force.

In order to protect physicians who negotiate with RCOs, the Alabama Legislature sought to provide immunity from liability under the antitrust laws by putting these negotiations under an exemption to antitrust known as the “State Action Doctrine.”

Now is the time for physicians to get their Certificates to Collaborate, as the provider contracts will be next on the agenda for the RCOs. In all likelihood, physicians in the different regions who jointly negotiate with the RCOs either solely as physicians or in collaboration with one or more hospitals will be in position to get better contracts than those who individually negotiate.

MASA will be publishing another article on what to look for in the provider contracts themselves.
Operating on the principle that more can be accomplished by working together with a common vision to improve health, the Alabama Department of Public Health began a process to seek input in identifying leading health care concerns in the state.

In early 2014, the Alabama Department of Public Health conducted a comprehensive community health assessment survey (CHA) of individuals, organizations and selected interest groups. Local community interest group meetings were held to identify leading health care concerns to use in developing a Community Health Improvement Plan (CHIP) for Alabama.

Leaders organized a CHIP Stakeholder Group, which first met in August 2014. Its purpose was to review the Alabama CHA; set priorities; and develop goals, objectives and action plans for the development of a statewide CHIP. The diverse stakeholder group, including Executive Vice President Jeffrey Arrington of AAFP, represented 60 different organizations from across the state.

“The issues are driven by these stakeholders and partners,” said Carolyn Bern, Alabama Primary Care office manager. “The process had an amazing, collaborative way of bringing in stakeholders. Improving health is a shared responsibility of health care providers, public health practitioners, and a wide variety of organizations and individuals that contribute to the well-being of our state.”

The partners and stakeholders agreed that not all of the health issues presented could be effectively addressed in a plan. The partners and stakeholders also concurred that the CHIP should focus on a consensus of the top three health care concerns based on the extent of need for improvement within the state, the chance of making a significant difference in the health of the state by implementing the plan, and the available resources and assets of stakeholders and partners to address the health care issue.

The stakeholders and partners participated in a Q-sort exercise led by UAB. Each stakeholder and partner took the 13 top health care concerns identified in the CHA and sorted the 13 issues into five categories. Fifty-one of the 60 participants submitted their Q-sort ranking. The results prioritized the following top three issues as focus areas for the CHIP:

- Access to care
- Physical activity and nutrition
- Mental health and substance abuse

Participants self-selected a workgroup from one of the three areas to begin developing goals, objectives and action plans to address these critical health issues in Alabama. Additional information on assets and resources were gathered during the workgroup discussions. The ADPH took the workgroup recommendations and crafted draft CHIP plans for each of the three issues. The draft plans were sent to workgroup members with a follow-up conference call scheduled for further input and changes to draft objectives, goals, performance measures, partners, and stakeholders; assets and resources; and alignment with national, state, and local goals, objectives, and measures.

In addition to other benefits, the CHIP will position the department to apply for national accreditation through the Public Health Accreditation Board (PHAB). PHAB is the nonprofit entity that oversees national public health department accreditation, a process that was launched on September 14, 2011. The CHIP is an accreditation prerequisite.

The CHIP is still a work in progress. However, the workgroups are focused on the following broad goals/issues:

**Priority Issue 1: Access to Care**

**Goal 1:** Reduce Transportation Barriers to Healthcare — identify transportation options by county, identify promising practices to support transportation to medical appointments, and close transportation service gaps.

**Goal 2:** Increase Access to Ambulatory Primary Care — increase the number of
adults who think of one person as a personal physician, decrease the number of adults with no health insurance, increase the number of primary care clinicians in Alabama, and increase the utilization of telemedicine in rural and underserved areas.

Priority Issue 2: Nutrition and Physical Activity

Goal 1: Increase Physical Activity — expand and build on existing resources for community implementation.


Priority Issue 3: Mental Health and Substance Abuse

Goal 1: Strengthen infrastructure for mental health promotion and substance-abuse prevention.

Goal 2: Integrate mental health and primary care through cross-systems training and technical assistance, addressing behavioral health promotion, quality improvement and behavioral health disorder prevention.

The stakeholder workgroups are refining specific objectives and performance measures related to the CHIP. National, state and local resources are also being identified for each objective. The final CHIP plan will be published April 30.

Anyone interested in participating in one of the CHIP workgroups is encouraged to contact Carolyn Bern at Carolyn.bern@adph.state.al.us, 334-206-5226.

Acknowledgement of Funding Source

This project was supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local, and Territorial Support, under grant number 5U58CD001273-03-Revised and 5U58CD001273-04.

Disclaimer

The contents of this article are those of the authors and do not necessarily represent the official position or endorsement by the Centers for Disease Control and Prevention.
The only doctor who ever treated me while I was growing up was the local general practitioner, so my concept of a physician was someone who took care of everyone — from birth to end of life — and was involved in the community. Being exposed to subspecialty care during medical school and residency didn’t change my perception of what I was meant to do. I knew I wanted to be a “real doctor.”

Not to gainsay Thomas Wolfe’s compelling novel *You Can’t Go Home Again*, but when I left Bibb County, Alabama, to attend medical school in Mobile in 1975, that was exactly what I planned to do. I wanted to practice family medicine in my community.

I live in Brent, Alabama, and work in Centreville. These neighboring small towns run together and are home to roughly 6,000 people combined. When I look at my patient list in the morning, I often know patients’ complaints before I see them because I’ve already heard about their illnesses, conditions or concerns at church, in the stores or from my nurse.

At the heart of primary care is the idea that patients should have an ongoing relationship with a family physician they know and trust. I have that kind of relationship with my patients because I’ve lived here most of my life, and I’ve practiced medicine here for more than 30 years.

There were only two other physicians in the county — both family physicians — when I started my practice in 1982. One was another local who had come home to practice. One thing we learned about starting new practices in our hometown is that folks typically fall into one of three groups:

• People who didn’t know you before you became a physician or moved to town while you were away at medical school or residency
• People who knew you before you were a physician and will never come to you for care because they still think of you as a kid
• People who knew you before you were a physician and won’t see any other doctor because they know and trust you

Patients should have the right to choose their physician, and I understand that some of my old high-school classmates might be uncomfortable being patients of mine — particularly women. On the other hand, I’ve delivered the babies of some of my former classmates, so it works both ways. My patient panel also includes former teachers, coaches and my high-school principal.

My wife grew up in a small town, too, and when I finished residency, we visited a few other communities before we decided where to start my practice. In fact, I had an offer to join a friend’s practice in another location. But in the end, we couldn’t find anything we liked better than my hometown.

I’ve built strong relationships in this community. To me, that’s part of being a family physician. And I love what I do.

John Meigs, MD, is speaker of the Congress of Delegates, the governing body of the AAFP.


Good Luck to Dr. John Meigs

The Alabama Chapter of the American Academy of Family Physicians proudly announced the candidacy of John Meigs Jr., MD, of Brent, Alabama, for president-elect of the American Academy of Family Physicians (AAFP) last October in Washington at the annual Congress of Delegates. Dr. Meigs is a past president and chairman of the Board of the Alabama Chapter of the American Academy of Family Physicians. Dr. Meigs is a fellow in the American Academy of Family Physicians and serves on the American Academy of Family Physicians Board of Directors and currently serves as speaker of the Congress of Delegates. His campaign will be decided this September 28-30, 2015, at the annual Congress of Delegates in Denver, Colorado. Please join your Board of Directors in the support of Dr. Meigs for president-elect of the American Academy of Family Physicians!
My name is Miguel Diaz, and I am a third-year resident at the St. Vincent’s East Family Medicine program. My wife and four children currently live in Trussville, Alabama, but we’re originally from Miami, Florida. As you can imagine, the residency had us packing and not looking back as we really enjoy living in BAMA (Roll Tide).

The journey to family medicine was not a traditional route. Out of high school, I joined the Navy and was deployed a “few” times, and truthfully, at times I wondered if I ever would make my dreams a reality. Once honorably discharged from active duty, I completed my Bachelor of Science degree in nursing. As a nurse, I worked in the emergency department and the intensive care unit before deciding to return to school for a degree in medicine. It was in medical school where I met my wife, who is also a physician but has chosen the homemaker specialty, which we both agree is best for the children. Our oldest is 11 years old, and then we have a 4-year-old and a 2-year-old, and the most recent addition is just 8 months old — and, of course, born at St. Vincent’s East. Despite residency and the hefty work hours, the children have come to realize medicine is a demanding field and part of our lives.

Training in Alabama, especially at an unopposed program, has been a blessing. The unique patients, size of the hospital and setting allow for a great learning environment and ensures countless work hours. That being said, it is never a dull moment. Because of my experience, family medicine was an easy fit. I appreciate the diversity of care one can provide and realize the need. I’m a bit of a traditionalist and believe medicine was better in the old days. At any given time, you can be admitting a patient in the ER, delivering a baby on the fourth floor and then running up to the ICU for ventilator management. I am one who likes the diverseness of the field and praise God I never specialized into one subspecialty. Along those lines, being a family doctor also allows me to go abroad and participate in mission trips. Both my wife and I have done mission work in the past and find it very gratifying. My most recent mission trip was last year in the Dominican Republic, where I was able to treat adults, children and even complete OB/GYN exams. I am fluent in Spanish, which helped in caring for patients spiritually and medically, as this was a Christian mission.

Our family’s long-term goals are to open up a clinic; hang our own shingle, as they say; and enjoy this endeavor as a family. Mission trips, providing good care to our community and teaching the children about giving back is of the utmost importance to my wife and me. If awarded the scholarship, I would use it for my family medicine board exams. This would be the last step in my training before I will be allowed to practice medicine as an attending. Thank you for the consideration, and we would also like to thank the family of Dr. Brasfield.

Sincerely,
Miguel A, Diaz, MD
Family Medicine, PGY-3

Hello to all family physicians of Alabama from ALL Kids! We enjoyed visiting with you during your Fall Forum in December. We wanted to provide you a brief update on the ALL Kids program.

The Affordable Care Act (ACA) brought several changes in 2014 for the ALL Kids Program. Some of those changes included:
• New income ranges, which resulted in a group of ALL Kids enrollees being transitioned to the Alabama Medicaid Agency for coverage
• New methods for determining income
• A new paper application that we continue to share with the Alabama Medicaid Agency and now the federal marketplace
• A new online application providing real-time determination that can also be used for renewing a child’s coverage
• A new eligibility and enrollment system that is shared with the Alabama Medicaid Agency

The program has worked through many challenges this past year to implement requirements of the ACA. Despite those challenges, we think ALL Kids continues to provide a positive impact on the families and children we serve across the state.
Medical Students Follow Patients Throughout Care in New Program

by Kim Eaton

Third-year medical students at the College of Community Health Sciences have an opportunity to follow a patient over time through the health care system as part of an innovative new program.

The Tuscaloosa Longitudinal Community Curriculum, or TLC², is a program that covers medical students’ third-year curriculum.

Third-year medical students learn about pediatrics, internal medicine, surgery, family medicine, psychiatry, neurology and obstetrics/gynecology by working with physicians in clinic settings. The traditional rotation schedule consists of seven eight-week rotations through the various specialties, but through TLC², students spend most of their third-year working with a community physician and following patients throughout the diagnosis or disease.

For example, a student may gain competency in obstetrics during a patient’s visit to her OB/GYN, help deliver the baby, then follow the newborn through well-baby checks. Or, a student might see an adult patient at an initial visit, accompany him or her to specialty consults, assist in surgery on the patient then see the patient back in the primary care doctor’s office for follow-up visits, said Brook Hubner, CCHS program director of medical education.

“Many of the patients we treat, especially in Alabama, have multiple chronic diseases for which they need treatment,” says Kay Rainey, a third-year medical student at the College who is participating in the pilot program and currently working in Dr. Vernon Scott’s practice in Tuscaloosa.

“With that comes the need to see multiple specialists, and patients are required to navigate between all of the specialists, receiving different medications and instructions from each one,” Rainey says. “I think that this new integrated curriculum will make a lasting impression on me about how patients and our health care system interact, as a whole. I see it as an opportunity to see more of ‘the big picture’ of health care.”

While longitudinally integrated clerkships have been part of medical education for some time, medical schools are beginning to create these programs as evidence of their effectiveness and ben-
benefits accumulate. Medical students who have participated in these clerkships say they feel better prepared to care for patients, and studies show that the students perceive better clinical education and access to patients.

The length of the experience also allows time for students to become involved in the community, complete a community scholarly project, develop trusting and respectful relationships as a team member with physicians, clinic and hospital staff and patients, learn about the business of providing health-care services and appreciate the rewards and challenges of primary care.

“We encourage students to become involved in the community by attending ball games, religious services and otherwise becoming part of the town in which they are living,” Hubner says. “In other areas of the country where similar programs have been in place for years, communities view the student experience as a recruiting opportunity to attract physicians to the area.”

Third-year medical student Elizabeth Junkin is working closely with Dr. Julia Booth in Reform through the TLC² program. Junkin says the biggest thing she has learned from her experience with the program is the “art of communicating with the patients.”

“From convincing a patient to stop smoking to telling a family that their daughter is not going to wake up, there is an art to how to get your point across to a patient while providing the support they need to accept the news or make a change,” she says. “A lot of this art comes with experience, but it also comes with truly knowing your patients. My hope is that I will be able to develop my own art of communication through the long-term personal relationships that I will develop with my patients in the TLC² program.”

The College’s TLC² program will have other special curriculum components in primary care leadership, community engagement and population health that will be delivered through onsite and teleconferenced seminars throughout the nine-month experience. Admission to TLC² is through a competitive selection process.

“We know that this type of program will prepare future physicians with vigorous general professional clinical training,” says Dr. Richard Streiffer, dean of the College.

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Physician’s name (as you prefer it on your name badge): _____________________________________________  
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**Full Four-Day Conference Registration Fees**

<table>
<thead>
<tr>
<th>Registration Type</th>
<th>Pre-Registration</th>
<th>At-Meeting Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four-Day Conference Alabama AFP Member</td>
<td>$400</td>
<td>$500</td>
</tr>
<tr>
<td>Four-Day Conference Alabama AFP Life Member</td>
<td>$195</td>
<td>$295</td>
</tr>
<tr>
<td>Four-Day Conference Non-Member/Allied Health Professional</td>
<td>$455</td>
<td>$555</td>
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**Two-Day Conference Registration Fees**

<table>
<thead>
<tr>
<th>Registration Type</th>
<th>Pre-Registration</th>
<th>At-Meeting Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-Day Conference Alabama AFP Member</td>
<td>$215</td>
<td>$315</td>
</tr>
<tr>
<td>Two-Day Alabama AFP Life Member</td>
<td>$105</td>
<td>$205</td>
</tr>
<tr>
<td>Two-Day Non-Member/Allied Health Professional</td>
<td>$245</td>
<td>$350</td>
</tr>
</tbody>
</table>

**Activities Registrations and Fees**

Conference Registration (see prices above) $ _______

**Thursday**

Business Breakfast for Members only: I will attend _______ I will not be able to attend _______ $ FREE
Get Acquainted Party: Number of people in family attending _______ $ FREE

You may pay by check or credit card. Please select your payment method.

MasterCard____   Visa____   Discover____   American Express____

Check (make check payable to: Alabama Academy of Family Physicians)____

Please Print Clearly

Card Holder Name: _____________________________________________  
Email: _____________________________________________

Credit Card #: _____________________________________________  
Expiration Date: ____________ Verification Code #: _________

In order to process credit cards, all information must be completed, including email address.

Address (NOTE: If paying by credit card, please give us the address where you receive your credit card bills)

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City/State/Zip: ______________________________________________________________________

Signature: _____________________________ Phone: (_____) _____________________________

(Your signature constitutes an agreement to pay the amount indicated.)

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Daily Aspirin May Reduce Mortality From Prostate Cancer With Risk of High Recurrence
Daily postdiagnosis aspirin use has been linked with lower mortality from prostate cancer in patients diagnosed with high-risk, nonmetastatic prostate cancer, according to a recent study. Although previous studies have reported mixed results regarding the postdiagnosis use of aspirin and prostate cancer-specific mortality (PCSM), the current study includes a larger cohort than previous articles as well as data regarding aspirin dose, which, according to the authors, is lacking in other studies.

Published online: 01/30/15

Electronic Cigarettes Did Not Help Patients With Cancer Stop Smoking
A recent article reports that electronic cigarette (E-cigarette) use among patients diagnosed with cancer who are enrolled in a tobacco treatment program is not associated with subsequent tobacco abstinence. It has previously been shown that the continuation of smoking after a diagnosis of cancer adversely affects several outcomes, including treatment complications, disease recurrence, quality of life, and mortality.

Published online: 01/30/15

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