Introducing the New AAFP President
PG 4

National Conference for Residents and Students
PG 8
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Introducing the New Alabama AFP President ........................................ 4
Alabama Department of Public Health .................................................. 6
National Conference for Residents and Students .............................. 8
Have You Properly Obtained Informed Consent? .............................. 10
Southeastern Collaboration to Improve Blood Pressure Control .......... 11
Zika Virus Update ............................................................................. 12
The Hope of HPV Vaccine ................................................................. 13
Bipartisan Teaching Health Center Bill Is Vital to Workforce ............... 14
Why did you select family medicine?
I chose family medicine for the relationships that we develop with our patients. I did a brief stint in emergency medicine and was always curious about patient outcomes after leaving the ED. As family medicine physicians, the long-term partnerships we develop with patients and their families provide an extra level of trust and insight to diagnosing and treating problems, as well as being essential to health maintenance and screening. I enjoy the relationships I have established with my patients, celebrating their success or providing an empathetic and supportive role when the prognosis is grave. We all struggle with the frustrations from insurance companies and mounds of ridiculous paperwork, but there is nothing more rewarding than walking into a patient’s room, shutting the door and spending quality time helping them protect their health.

Why is the AAFP important to family physicians?
The AAFP is critical to family physicians in Alabama because we are the fundamental advocates for the specific needs for primary care. There are more family physicians than any other specialty in our state. The AAFP allows us to fight for family medicine and for the individual concerns of our patients. Last year, we were able to reinstitute Medicaid enhanced payment with help from our colleagues around the state. Physician involvement is essential to our success. I challenge every physician to be active in the organization, support the FAMMED PAC, or even recruit other members to keep the academy viable and able to battle for access, reimbursement and political presence. Family physicians are extremely busy and typically perceived as the “nice guys,” so it’s crucial having an organization to be our voice in Montgomery and Washington.

Where is family medicine going to be in five to 10 years?
Considering all of the recent changes in health care and the uncertainties coming from the current administration, family medicine will certainly be affected in the next five to 10 years. The health care system in America is unquestionably broken and in need of a bipartisan correction. There is no doubt that pay for performance will be a large factor in reimbursement, and there may even be a one-payer system. As family medicine physicians, we have an advantage with these impending changes as we routinely focus on prevention and disease outcomes and are accustomed to reporting quality measures. Our daily responsibilities mirror the MACRA/MIPS objective of achieving higher-quality health care and improving the health of populations while reducing cost. We know that quality primary care reduces total cost on the health care system, so as family medicine physicians, I believe we are far ahead of the curve and ready for the changing health care environment.

Please join us in welcoming your 2017-2018 president, Tracy Jacobs, MD, FAAFP.
What is the Vaccines for Children Program?

The Alabama Vaccines for Children (VFC) is a federal entitlement program designed to save parents and providers out-of-pocket vaccine expenses for eligible children. The routine childhood vaccines available in the program are recommended by the National Advisory Committee on Immunization Practices (ACIP) with the goal of protecting eligible children age 0-18 years from a number of preventable diseases and cancers.

What are the benefits of the VFC program?

As a health care provider, you can provide all recommended vaccines to Medicaid, uninsured, American Indian/Alaskan Native, and underinsured Federally Qualified Health Center (FQHC) children—and you will not incur any vaccine costs.

VFC providers can:

- Ensure patients get vaccinated on time.
- Save money on vaccine purchases.
- Receive in-person technical assistance and quality improvements to help increase vaccination rates, as well as assistance with record-keeping, vaccine handling and missed opportunities.
- Reduce referrals of eligible children, allowing them to stay in their medical homes and ensure continuity of care.
- Charge for the office visit, but not the administration fees.

How can I enroll as a provider in the VFC program?

Enrolling in the VFC program is easy! Go online to www.adph.org/immunization, Vaccines for Children, New Provider Enrollment Packet to complete the enrollment process.

Your strength is the ability to provide.
The Scope of Family Medicine

Alabama Department of Public Health (ADPH)
Public Health Physician Vacancies

Description
The Alabama Department of Public Health is seeking physicians with a desire to serve the public through a career in public health. Candidates must possess the knowledge and expertise to act as a public health officer. ADPH is currently in need of physicians in multiple areas, including local Public Health Areas, and state public health, including Family Health Services, and Regulatory Affairs. These positions include responsibilities in administering multiple county health departments or large bureau(s) with responsibilities of statewide public health programs or coordinating the medical and related activities of district or local county health departments throughout an area or areas in the state.

Physician employees in this class are responsible for the development of overall plans and policies, implementation of decisions that apply to ADPH programs and services, and for oversight of personnel in these programs.

The mission of the Alabama Department of Public Health is to promote, protect, and improve the health of individuals and communities in Alabama.

Responsibilities include (Any one position may not include all of the duties listed and may include additional duties.):

• Supervise all programs/functions under the specific program(s) indicated in the description above
• Direct and supervise Bureau directors and/or other staff in the program(s) listed above
• Serve as expert knowledge base for program(s) within responsibility
• Consult and supervise policy development, program planning and implementation, evaluation and review of all programs/functions within area(s) of responsibility
• Consult and communicate with federal, state and local governmental agencies on policies, programs, guidelines, protocols, etc. related to the public health areas of responsibility
• Direct the allocation and oversee budgetary management of programs within areas of responsibility
• Represent the state health officer or chief medical officer at national, state and local meetings, boards and commissions; provides input on behalf of the ADPH on medical issues concerning public health programs.
• Consult with the state health officer or chief medical officer concerning policies of federal agencies affecting the ADPH and confer with representatives of these agencies as necessary; interprets state and federal laws, rules, regulations, policies in coordination with the ADPH general counsel’s office
• Answer and respond to media queries regarding matters of public health importance in coordination with appropriate ADPH program(s) and the public health information officer
• Review and prepare responses to proposed legislation pertaining to areas of expertise and responsibility
• Assume designated role in Incident Management System in response to activation by the ADPH Center for Emergency Preparedness

Requirements
• Must have a medical degree from an accredited medical school followed by at least one year of Accreditation Council for Graduate Medical Education-approved postgraduate training in a hospital
• Must have board certification in family medicine, internal medicine, pediatrics, obstetrics/gynecology, emergency medicine or preventive medicine
• Must have a current, unrestricted license to practice medicine issued by the Alabama State Board of Medical Examiners or have an unrestricted medical license in another state AND qualify for Alabama medical licensure by endorsement/reciprocity
• Must have six years of administrative experience in public health or board certified in the specialty area

Preferred Skills/Knowledge/Abilities
• Excellent oral, written, communication and quantitative skills, with the ability and expe-
Experience to develop, interpret and apply information from scientific materials, including but not limited to laboratory tests, clinical literature, clinical guidelines and protocols

- Experience in supervising employees/staff
- Ability and experience in doing presentations and interviews to audiences of different disciplines, including other physicians, health care providers, consumers and media
- Willingness and ability to learn and apply federal and state rules and regulations governing public health program(s) within responsibility
- Must be able to consult and communicate with other physicians, health care providers, other agencies/organizations in and outside of Alabama, at the state and federal level on concerns and issues related to public health

To Apply
Please follow online instructions at the state of Alabama personnel website. Apply online at www.personnel.alabama.gov for the following classifications:

PUBLIC HEALTH PHYSICIAN DIRECTOR – 40434
Salary: $134,968.80-$205,792.80
http://personnel.alabama.gov/Documents/Announcements/100144_A.pdf

PUBLIC HEALTH PHYSICIAN, SENIOR – 40435
PUBLIC HEALTH SERVICES OPTION – 321
Salary: $116,277.60-$177,266.40
http://personnel.alabama.gov/Documents/Announcements/100145_A.pdf

We appreciate the interest and thank those of you who apply. You will be able to access your application status via the website link provided above.

Only candidates under consideration will be contacted for interviews.

The Alabama Department of Public Health is an Equal Opportunity Employer.
This past July was the AAFP National Conference for Residents and Students. Alabama was well-represented with students from almost all medical schools in the state. Students were able to attend lectures and workshops while also getting to interact with other students and residency programs from across the country. Residency programs from across the state were also showcased in the expo hall.

Alabama received multiple honors throughout the conference. Stacy Arrington, James Burke, Annie Herren and Allison Sullivan all received Family Medicine Leads Scholarships to attend national conference. The following students received scholarships from the Alabama AFP with the help of a grant sponsored by the Alabama Family Practice Rural Health Board: Phillip Ingram, Alan Howard, Luke Bailey, Jacob Guin, Alex Van Hanezhan, Michael Tran, Madison Duckworth, Joni Kay, Whitney Lee, Jazmin Scott, Liz Potts, Paul Strickland, Crystal Skinner, Luke Lannuzzi, Randy Nelson, Ashley Ford, Darcey Perkins, Nic Cobb and Dallas Moran.

The Family Medicine Interest Group (FMIG) at University of South Alabama College of Medicine (USACOM) was one of 17 medical schools across the country to receive a Program of Excellence award from the AAFP. USACOM received the award for Excellence in Collaboration and was recognized during a FMIG breakfast on the second day of conference. All of the award-winning applications are available to read online on the AAFP website.

Multiple Alabama medical students participated in the Emerging Leader Institute. University of Alabama at Birmingham (UAB) medical students Amanda Stisher and Chandler Stisher were recognized as part of the 2016 class while Charles Minor, a second-year UAB medical student, was selected as part of the 2017 class. Amanda was chosen as the best project award winner in policy and public health leadership. Her project focused on using patient navigators to increase breast and cervical cancer screening and focused on the “Alabama black belt.” As one of the 2016 overall award winners, Amanda received recognition, scholarship money and was asked to present her project during this year’s national conference.

Alabama also had multiple students involved in student congress activities. Kitty Cox, a fourth-year UAB student, served as the delegate for Alabama while Charlotte “C.C.” Linder, a third-year USACOM student, served as student chapter president and alternate delegate. Alabama had two students, Chandler Stisher and Linder, sit on reference committees. There were also multiple students who engaged in resolution activities whether through co-authoring resolutions or by participating in discussions on resolutions.

Overall, the 2017 national conference was extremely successful. The number of attendees exceeded the previous record from 2016 with over 5,100 attendees. Alabama was well-represented with our current group of students, and it seems as if interest increases every year. Students received recognition for multiple achievements, which helped to further showcase the support and encouragement students receive from the Alabama AFP, Alabama medical schools and family physicians throughout the state.

Congratulations to Charlotte “C.C.” Linder on being elected 2017-2018 AAFP Student Chapter president! Linder is a third-year medical student at the University of South Alabama College of Medicine. She was elected by her peers at the recently concluded 2017 Annual Student Meeting at the Sandestin Golf and Beach Resort. She is the daughter of Michael Linder, MD, and Carol Motley, MD. Her duties will include being the voice of our student chapter to the AAFP’s Board of Directors as well as representing our student members at the national level. When asked what this title means to her, Linder replied, “Family medicine is more than just a specialty option to me. It is a way to serve my community and give back while also developing rewarding relationships with our patients.” We look forward to working with Linder as she brings her passion for family medicine and commitment to energizing our student chapter across our great state!
Have You Properly Obtained Informed Consent?

by Angie Cameron Smith

In June, the Pennsylvania Supreme Court issued a controversial opinion holding that a physician had to have face-to-face interaction with the patient to effectively obtain informed consent. This has raised heightened awareness of a physician’s obligations to obtain informed consent from his or her patients and caused many to evaluate their own practice of obtaining informed consent.

In *Shinol v. Toms*, a patient brought a medical malpractice case against a neurosurgeon alleging he failed to obtain informed consent. (2017 WL 2655387). The record and testimony at trial established that the physician met with the patient on two occasions prior to surgery to discuss potential complications. The physician testified that he explained the different approaches and options for surgery. The patient also had a telephone conversation with a certified physician assistant (PA), who worked for the physician, and just before surgery, the patient met with the PA, who obtained her medical history, conducted a physical examination and obtained an executed informed consent form. The form gave the physician permission to perform “a resection of recurrent craniopharyngioma.” The patient’s signature acknowledged she had discussed the advantages and disadvantages of alternative treatments, the form had been fully explained to her, she had an opportunity to ask questions, and she had sufficient information to give her informed consent.

Despite her signature on the consent form, the patient alleged in the lawsuit that she was not fully informed of her options (total versus subtotal resection of a nonmalignant brain tumor). According to the patient, if she had been given the option of a subtotal resection, she would have chosen the less aggressive form of surgery.

After the physician received a jury verdict in his favor, the state Supreme Court declared a mistrial based on an improper jury instruction related to informed consent. The jury had been instructed that it could consider any relevant information it found was communicated to the patient by “any qualified person acting as an assistant to the physician.” In granting a new trial, the Pennsylvania Supreme Court held that the surgeon himself had to have face-to-face conversations with the patient about the risks of surgery in order for him to have properly obtained informed consent from his patient. In other words, evidence of the discussions with the PA could not be considered by members of the jury in their deliberations of whether informed consent was properly obtained. The court’s opinion was an extension of a previous opinion that held informed consent could not be delegated to a hospital; the physician was responsible for obtaining it.

Similar to Pennsylvania, Alabama courts have found that a hospital and its staff do not have an independent obligation to obtain informed consent from a patient. *Wells v. Storer*, 792 So. 2d 1034 (Ala. 1999). However, this does not necessarily equate to the ruling in *Shinol*. Based on *Shinol*’s strict interpretation and possible increased scrutiny as a result of the holding, a review of Alabama law on informed consent is warranted.

It is the duty of the physician to inform the patient of the risks and obtain his or her consent, and if the physician fails to get informed consent, a patient has a cause of action under the Alabama Medical Liability Act (AMLA). Historically, the cause of action for a failure to obtain informed consent evolved through the legal theory of battery. The reason being that a person has the “‘right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages.’” See *Fain v. Smith*, 479 So. 2d 1150 (Ala. 1985) (quoting *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (1914)).

The elements of the claim are (1) the physician’s failure to inform the patient of all material risks associated with the procedure, and (2) a showing that a reasonably prudent patient, with all the characteristics of the plaintiff and in the position of the plaintiff, would have declined the procedure had the patient been properly informed by the physician. The test for determining whether the physician has disclosed all material risks to the patient is “a professional one, i.e. whether the physician had disclosed all the risks which a medical doctor practicing in the same field and in the same community would have disclosed. Expert testimony is required to establish what the practice is in the general community.” *Giles v. Brookwood Health Services*, 5 So. 3d 533 (Ala. 2008).

In one Alabama case, the physician entered into evidence an informed consent form signed by the patient. Although the patient stated she did not give consent, the court found the forms alone sufficient to dismiss the patient’s claims for assault and battery. There was no discussion in the court’s opinion as to how the form was presented to the patient or whether there was detailed discussion between the patient and the physician.

In another Alabama case involving the scope of consent, the physician obtained an executed form from the patient consenting to a specific procedure but also stating that the physician was authorized to perform “such additional operations/procedures during the course of the above as are considered therapeutically necessary.” *Shinol v. Toms*, 2017 WL 2655387. The court held that the surgeon himself had to have face-to-face conversations with the patient about the risks of surgery in order for him to have properly obtained informed consent from his patient.

Continued on page 15
Southeastern Collaboration to Improve Blood Pressure Control

We are asking for family physicians in the following counties to participate in an important initiative to improve blood pressure control: Barbour, Bullock, Butler, Choctaw, Crenshaw, Dallas, Greene, Hale, Lowndes, Macon, Marengo, Montgomery, Perry, Pickens, Pike, Russell, Sumter and Wilcox.

Led by investigators from the University of Alabama at Birmingham (UAB), the University of North Carolina (UNC) and East Carolina University (ECU), this study aims to help practices and patients improve care and self-management for hypertension.

Over the next two years, a total of 80 practices (50 in Alabama, 30 in North Carolina) will be enrolled and randomized to receive one of four interventions as an adjunct to usual care:
- A free online patient education program, accessible to all patients
- Education plus peer coach (PC) services
- Education plus practice facilitator (PF) services
- Education plus both PC and PF services

Each practice will refer 25 adult African-American patients with uncontrolled hypertension to participate in their assigned intervention for one year. Blood pressure measurements will be collected at baseline, six months and 12 months. Practices must also be willing to work with study staff and perform medical record abstractions. In addition to the intervention(s), each practice will receive a total of $4,000 and a computer workstation, and 25 enrolled patients will receive home blood pressure monitors.

The only requirement is that your practice has internet access and enough adult African-American patients with uncontrolled hypertension to refer 25 within a two- to three-month period. Your participation, and that of your patients, is completely voluntary.

If you would like to participate or need more information, please contact us (Tameka Turner, PhD, or Jean Marie White) at 205-934-9376 or abprn@uab.edu. Thank you for your consideration.

Pankaj Dangle, MD, Mch, has joined the Pediatric Urology team at Children’s of Alabama as director of the recently established robotic surgery program. Robotic surgery allows for tiny incisions and minimal effect on surrounding healthy tissue. Benefits include:
- Faster recovery time
- Less pain
- Minimal scarring
- Minimal blood loss
- Shorter hospital stay

Dr. Dangle, an assistant professor at the University of Alabama at Birmingham (UAB), joins David Joseph, MD, FAAFP, FACS, and David Kitchens, MD, FAAP, to offer comprehensive diagnostic and therapeutic services for diseases of the urinary and genital tract. In addition to robotic surgery, his practice focuses on:
- Complex hypospadias
- Vesicoureteral reflux
- Renal stone disease
- Ureteropelvic junction obstruction

Choose Children’s. To make an appointment, call 205.638.9840 or fax 205.975.6024.
The most common route of infection remains the bite of an infected mosquito. ADPH has so far identified 44 cases of confirmed or probable Zika virus infection among Alabama residents, all of which were acquired by travel overseas to countries where mosquito transmission is occurring. Most of these infections were acquired in South or Central America or the Caribbean. Local transmission was identified in areas around Miami, Florida, and near Brownsville, Texas, in 2016, leading the Centers for Disease Control and Prevention (CDC) to caution pregnant women to avoid nonessential travel to these areas. No additional local cases have been found in south Florida over the past several months, and there are currently no travel advisories for this region. However, cases of Zika virus infection have been seen more recently in parts of southeastern Texas, and the CDC continues to suggest pregnant women avoid travel to the affected areas. Updated information on areas with ongoing Zika transmission can be found here: www.cdc.gov/zika/geo/index.html.

No mosquito transmission of Zika has yet been identified in Alabama. When travel-associated cases are identified in our state, ADPH implements a response plan to reduce the risk of local transmission. Infected patients are educated on how to avoid mosquito exposure, particularly during the first three weeks of illness when they are more likely to have circulating active virus. Also, environmentalists from the health department perform property inspections around the dwelling place of all infected persons, to identify potential mosquito breeding locations and to reduce mosquito activity.

Sexual transmission remains a concern, and current evidence supports the recommendation that men who have been infected with Zika or who have traveled to an area with local transmission of Zika should take steps to prevent passing Zika through sex and to avoid or delay pregnancy by using condoms with any nonpregnant partners for six months after the last potential exposure. If their partner is pregnant, they should use condoms consistently and correctly for the duration of her pregnancy. Women who have potential exposure to Zika through travel or through sexual contact are advised to wait at least eight weeks after the last potential exposure before attempting to become pregnant.

Numbers of new infections have been declining this year, in part because so many people in endemic areas have already been infected that the remaining pool of those who could potentially be infected is shrinking. In February 2016, with the outbreak just beginning, the CDC initiated a Level 1 Emergency Operations Center (EOC) activation, the agency’s highest level for coordinating public health response, and maintained this level of activation for over 18 months. Recently, on August 4, 2017, the CDC decreased this to a Level 2 activation in response to declining numbers of new Zika cases. Because the overall risk has reduced somewhat, new testing guidelines have emerged. We at ADPH, along with other expert bodies, are looking into these new guidelines. At this time, we have chosen not to make any changes to our testing criteria or the guidance that we provide our state’s health care providers until the additional anticipated guidance is issued.

While ADPH has not yet altered its testing recommendations, the key takeaways from the CDC’s newly issued interim guidance are:

- All symptomatic patients, including pregnant women, with potential exposure to Zika through travel or sexual contact, should receive testing for the virus.
- Pregnant women who reside in or frequently travel to areas with Zika transmission should be offered Zika testing at the first prenatal visit, followed by two additional rounds of testing at subsequent prenatal visits during the pregnancy.
- For pregnant women without symptoms who had recent exposure to Zika but do not have ongoing exposure, testing is no longer routinely recommended. However, testing should be considered as a shared decision between patients and providers, based on a balanced assessment of risks and expected outcomes, clinical judgment, patient preferences and values, and the jurisdiction’s recommendations.

ADPH continues to provide updated information on its website to the public and to providers: www.alabamapublichealth.gov/mosquito/zika.html. Alabama physicians are encouraged to contact the department’s Infectious Disease and Outbreaks Division at 800-338-8374 for any questions regarding testing or evaluation for Zika.
Many have heard about human papillomavirus (HPV), but there are few who understand the virus, how it is transmitted or how to prevent it. HPV is such a common virus, and nearly all men and women contract it at some point in their lives. The danger of HPV is the nine different types of strains, seven of which are cancer-causing.

But there is hope when it comes to HPV, and the hope lies in the HPV vaccine. The vaccine is approved by the U.S. Food and Drug Administration (FDA) and recommended by the Centers for Disease Control and Prevention (CDC) for both males and females. Vaccine is the most important method to prevent becoming infected with the virus.

HPV is transmitted through intimate skin-to-skin contact and can be passed to a partner even when the infected person has no signs or symptoms. The virus causes cancer of the cervix, vulva, vagina, penis or anus. HPV infection can also cause cancer in the back of the throat, including the base of the tongue and tonsils. People can develop symptoms years after being infected, making it difficult for a person to determine when they first became infected and supporting the recommendation to vaccinate before exposure is critical.

Since its introduction in 2006, the HPV vaccine, Gardasil® 9, has consistently demonstrated effectiveness by decreasing the number of infections and HPV precancers in young people. The vaccine underwent years of extensive safety testing before being licensed by the FDA. According to the National Cancer Institute, the HPV vaccine is highly effective in preventing infection with the types of HPV it targets, when given before initial exposure to the virus.

In the trials that led up to the approval of Gardasil, the vaccine was found to provide nearly 100 percent protection against persistent cervical infections with HPV types 16 and 18 and the cervical cell changes these persistent infections can cause. Because of the vaccine’s efficacy rate, physicians, associations and parents are encouraged to take an active role in preventing at least one type of cancer, giving children and teens a chance at a hopeful and healthy future.

Vaccination for HPV is routinely given at 11 or 12 years of age, but may be given beginning as early as age 9 and continuing to age 26. The number of doses of the vaccine varies according to the age of the patient when the vaccine is initially given. Adolescents age 9 through 14 years of age should receive HPV vaccine as a two-dose series with doses being separated by six to 12 months. Those who start HPV vaccination at 15 years of age and older should get the vaccine as a three-dose series with the second dose given one to two months after the first dose, and the third dose given six months after the first dose.

As with any vaccine, there is a chance of side effects to the HPV vaccine, but they are mild in nature. The possible side effects include the following:

- Reactions in the arm where the shot was given – soreness and redness
- Fever – mild (100 degrees Fahrenheit) or moderate (102 degrees Fahrenheit)
- Headache
- Fainting or dizziness

For more information about the side effects of the HPV vaccine, visit www.cdc.gov/vaccinesafety/.

The Alabama Department of Public Health’s Immunization Division also has various types of information on both the virus and the HPV vaccine, including broadcasts, reports, fliers and research materials located on its website at www.alabamapublichealth.gov/immunization and its Facebook page: Alabama Immunization Info at www.facebook.com/AlabamaImmunizationInfo.
At a time when members of Congress can’t seem to agree on much related to health care, a bill introduced this week in the House has — and deserves — strong bipartisan support.

Rep. Cathy McMorris Rodgers, R-Wash., and 49 co-sponsors have introduced the Training the Next Generation of Primary Care Doctors Act of 2017. If enacted, the bill would reauthorize the teaching health center graduate medical extension (THCGME) program through 2020 and provide funding for its continuation. Without congressional action, this vital program will expire Sept. 30.

The program, which was created by the Patient Protection and Affordable Care Act in 2010, addresses three key workforce issues: the severe shortage of primary care physicians, their geographic maldistribution and the need for physicians willing to serve in medically underserved areas.

The program provides GME funding directly to community-based health centers that expand or establish new primary care residency programs, and the incentive has worked. There were 295 family medicine residency slots at THCs in the 2016-17 academic year, up from 49 in 2011-12. In all, there were 740 primary care residents trained in 59 THC residencies in 27 states and Washington, D.C., in the recently completed academic year. THC residents and faculty are expected to provide more than 1 million patient visits this year in underserved communities.

Access to care is critical. A CDC report released earlier this year (www.cdc.gov) found that rural patients are more likely than their urban counterparts to die from the five leading causes of death: heart disease, cancer, unintentional injuries, chronic lower respiratory disease and stroke. The same report said the percentage of deaths that were potentially preventable were higher in rural areas than in urban areas.

HHS’ National Center for Health Workforce Analysis estimates the shortage of primary care physicians will top 23,000 by 2025 (bhw.hrsa.gov), and the THCGME program invests in care where it’s needed most. During the 2014-15 academic year, 84 percent of THC residents trained in medically underserved communities (bhw.hrsa.gov), and 22 percent trained in rural areas.

That’s important because a national survey of third-year family medicine residents (www.graham-center.org) by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care found that those who trained in THCs were nearly twice as likely to practice in safety-net clinics than residents who trained in traditional family medicine programs.

In general, we know that more than half of family medicine residents will practice within 100 miles of their training sites (www.stfm.org), so locating programs in communities where they are needed addresses the maldistribution of physicians and increases access to care for the underserved.

THCs accounted for 33 percent of the increase in family medicine residency slots between 2011 and 2015, but no new slots have been created since initial funding for the program ended two years ago. The Medicare Access and CHIP Reauthorization Act of 2015 extended the program, but Congress opted to provide funding for just two more years (notably, one year short of the length of a family medicine residency). The same legislation cut funding per resident 40 percent, from $150,000 to $90,000.

The newly introduced THCGME bill would extend the program for three years with $116.5 million in annual funding. This additional money could support the current residency slots at the recommended amount of $157,000 per resident and provide an additional $20 million for new programs in rural and underserved communities.

The bill also would maintain mandated reporting requirements to ensure the program is working. Accountability standards require reporting on the number of patients treated, the number and percentage of residents that stay in primary care, and the number and percentage of residents who continue serving in rural and medically underserved areas. The bill will also require cost reports by the end of 2020.

The AAFP has released a statement to tell the public why this bill is important. Now you can add your voice to help preserve access to care for the underserved and maintain needed family medicine residency slots. The AAFP’s Speak Out tool makes it easy to tell your legislators to reauthorize the program.

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peutically necessary or advisable in the exercise of professional judgment.” The patient alleged that the consent form did not give the physician “carte blanche” to perform any procedure. In this case, the physician had mistakenly removed an ectopic kidney the physician thought was a tumor. The Alabama Supreme Court overturned the lower court’s ruling in favor of the patient on the issue of informed consent and stated that there must be expert testimony as to whether the procedure performed by the physician was reasonable in light of the findings during the surgery.

Although the cases and elements mentioned above require the physician to inform the patient, there are no cases in Alabama that specifically require a face-to-face meeting/encounter with the patient to give informed consent (although this is definitely best practice) and certainly nothing in our case law that says a PA or other qualified health care professional may not explain the risks associated with a procedure. The law requires a physician to exercise that level of reasonable care, skill and diligence as a similarly situated physician, and this rule should be followed when it comes to informed consent. It would also be wise to review consent forms to ensure they are not too limited in the grant of consent and ensure you are documenting all discussions with patients about the risks of procedures.

Angie Cameron Smith is a partner at Burr & Forman LLP, practicing in the firm’s Health Care Industry Group.
improving health in your community

The University of Alabama College of Community Health Sciences operates one of the largest and oldest family medicine residencies in the nation. Our renowned program offers seven fellowships for family medicine physicians, including behavioral health, emergency medicine, geriatric medicine, rural public psychiatry, obstetrics, hospital medicine and sports medicine.

Each fellowship is concentrated in addressing health care needs of West Alabama communities, as well as further preparing family medicine doctors to provide comprehensive, competent and compassionate care for all patients.

For more information about the fellowships and the residency program, visit fmr.ua.edu.