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Happy New Year!

Those of us in academic medicine run on a somewhat different calendar than does the rest of the world. We fondly say our goodbyes to our graduating residents and by July 1, welcome our new recruits. They seem to be getting younger every year, but I remain in total awe of their enthusiasm, their dedication to their chosen professions, and their extraordinary competence. Residents today seem to know more than just medicine. Many of them arrive at our door already well equipped with research skills; some have expertise in public or global health, and they plan to use these skills to advance our field and better the world. I have every confidence that they will succeed, and I know our specialty is being set up for future success.

In the spirit of endings and new beginnings, we took the opportunity this month to reminisce a bit about the “good old days.” My residents show infinite patience when I inflict upon them stories of how we did things “back then.” Yes, we really did do Tzanck prep on blisters and gram stains on pustules and we came in on weekends to give phototherapy to our inpatients receiving Goeckerman treatment for psoriasis, never dreaming that someday a simple (albeit rather pricey) injection would replace our beloved tar. I hope you will enjoy hearing from some of our esteemed colleagues as they reflect on how the practice of dermatology has changed over the past few decades. Some changes are good, others maybe not so good, but all definitely worthy of reflection.

As we hopefully embrace change and benefit from the many opportunities that it affords, it is important that we be mindful of potential harm and unintended consequences that may result. Electronic health records, for example, when used well, offer the promise of improved health communication, but at what cost? Read contributing writer Ruth Carol’s thought-provoking article on distracted doctoring to learn more about the darker side of electronic devices in medicine. I was also very inspired to read this month about the laudable efforts put forth by Drs. Brad and Sandra Marchese Johnson, who have taken the task of “going green” to a new level in designing the first LEED-certified medical clinic in Arkansas. The unpredictable and volatile weather alone should convince even the most cynical among us that climate change is a real and imminent threat. Many of our colleagues have been impacted by natural disasters, ranging from wildfires to hurricanes and catastrophic flooding. I’m proud to see some of our own doing their best to make a difference and hope that more of us will be similarly inspired.

And happy birthday, JAAD! We appreciate the innumerable hours of largely uncompensated effort our colleagues put into producing this and other stellar medical journals. I cannot imagine how we would all stay current on our medical knowledge without JAAD, and I appreciate the efforts Drs. Dirk Elston, Bruce Thiers, and the entire staff have put in over the years making this information as timely and readily accessible as possible. Thank you for all your hard work!

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR
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Skin care products can help you attract and keep patients.

Financing can help them pay for your full recommendation.

Healthy skin looks good on everyone, so it’s no surprise skin care is a growing trend. In 2018, skin care category sales were $5.6 billion.¹ And, 1.35 million Americans spent $500 or more on skin care products over a three-month period in 2017.² Patients are shopping for products such as cleansers, moisturizers, sunscreen, serums, creams, oils, chemical peels and face masks, and want to know what’s best for their skin.

Retail products account for 18% of medical spa revenue.³ As a dermatologist, offering skin care products in addition to procedures can help you attract more patients and keep them coming back. When you accept the CareCredit health, wellness and beauty credit card, patients can pay for your full recommendation for healthy skin.

Leverage their trust in your expert recommendation.

With an ever-growing list of products available, patients turn to their dermatologist to make recommendations. 50% of consumers said their dermatologist is their top influencer for skin care purchases.⁴ From acne treatments to daily skin care to anti-aging, patients trust you to suggest products that fit their skin type, lifestyle and desired outcome.

For patients who want skin care procedures, let them know you have products that can help them maintain their results at home. When compared to standard over-the-counter options, consumers reportedly show preference for medically recommended skin care.⁴ With CareCredit, they can pay over time for their procedure and products in one monthly payment.*

Help them overcome cost concerns with financing.

The cost of a complete plan of premium products that includes cleansers, moisturizers, serums and creams can add up. Patients may have reserved their credit cards for other expenses, and often consider whether they need to withdraw from savings or save up to pay for care.

More than half of skin care patients pay with credit.⁵ CareCredit can help give patients the flexibility they need to fit skin care into their monthly budget.⁶ They can choose a special financing option* to pay over time, and worry less about balancing their other expenses with the products and procedures they want.

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⁴ 2018 ASDS Consumer Survey on Cosmetic Dermatologic Procedures.
⁵ CareCredit Path to Purchase – Cosmetic, 2018.
* Subject to credit approval. Minimum monthly payments required. See carecredit.com for details.

CareCredit cardholders on average have an 8X higher spend than on a general purpose credit card.⁶

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What’s hot?

In this monthly column, members of the Dermatology World Editorial Advisory Workgroup identify exciting news from across the specialty.

Rosalie Elenitsas, MD

Approximately 25 to 50% of patients with chronic lymphocytic leukemia (CLL) develop non-specific or paraneoplastic dermatoses. Eosinophilic dermatosis of hematologic malignancy is one of these types of reactions. It is also termed insect bite-like reaction. While initially thought to be an exuberant reaction to insect bites, it is now accepted that insect bites are not the etiology. It was assumed that these patients had an altered immune response resulting in skin lesions containing many eosinophils. In a recent paper by Meiss et al (Journal of Cutaneous Pathology. 2019; 46(3): 175-181), the authors examined eight biopsies from five patients with eosinophilic dermatosis in patients with CLL. By immunohistochemistry, they noted up to 20% of the lymphocytes in the infiltrate were B cells. Additionally, IgH clonal rearrangements were noted in four of the five patients and three of them had identical clones to the patients’ known CLL clones. This suggests that the leukemic B cells may play a role in the pathogenesis of these skin lesions, and are not just simply “along for the ride.” In either case, dermatologists should be familiar with this entity, as patients may seek care for these persistent and refractory lesions.

Mallory Abate, MD

Many dermatologists initiate a test dose of methotrexate, followed by laboratory evaluation prior to prescribing the second dose. However, **is a test dose of methotrexate really necessary?** A recent retrospective study — Initiation of methotrexate with or without a test dose: A retrospective toxicity study — demonstrates that laboratory evaluation after the test dose rarely leads to management changes and results in significantly more lab draws (J Am Acad Dermatol. 2019; 80(4): 1160-2). No difference in the incidence of methotrexate toxicity was found in patients initiated with and without a test dose. Thus, the authors conclude that **this practice can be safely omitted in patients with normal renal function.** The authors further note that data from clinical trials even suggest that starting doses of 15 to 17.5mg/week are associated with a low risk of serious adverse events.

Methotrexate toxicity: What’s in a name?

The commercially available bullous pemphigoid 180 (BP180) NC16A enzyme-linked immunosorbent assay (ELISA) is a test that can be used to aid in the diagnosis of bullous pemphigoid (BP). A result of > 9 U/mL is defined as a positive test. However, does a positive test necessarily mean the patient has BP? The answer is no. Circulating BP180 autoantibody can be detected in patients who do not have BP. In this study, the authors sought to determine an optimum cutoff value of BP180 ELISA to detect true BP. A total of 173 inpatients were included: 26 patients with BP and 147 patients in which BP was initially suspected, but later excluded (J Am Acad Dermatol. 2019; 80(3): 774-5). The titers of BP180 autoantibodies in non-BP patients were significantly lower than those of BP patients (median titer 17.1 U/mL versus 67.1 U/mL). Receiver operating characteristic curve [plot of sensitivity vs. [1 − specificity]] analysis was used to generate paired sensitivity and specificity values based on BP180 autoantibody titers. The optimum cutoff value to determine true BP patients from non-BP patients was calculated on the basis of maximizing the Youden index (J = sensitivity + specificity − 1). This optimum cutoff was found to be 27.2 U/mL, which has a sensitivity of 65.4% and a specificity of 98.0%, in contrast to the standard cutoff of 9 U/mL, which has a sensitivity of 73.1% and much lower specificity of 85.7%. These results show that low-level BP180 autoantibodies can be found in patients who do not have BP and the results of BP180 ELISA should be interpreted in conjunction with clinical findings and immunopathologic test results.

I wish medical journals more often read like Consumer Reports. That’s not because I’m obsessed with consumer goods. I’m not.) Rather, it’s because their approach — comparing goods or services within a category — is incredibly valuable to me as a consumer. I want to know how one vacuum cleaner stacks up against another, after all, not whether it beats a placebo.

By contrast, too often in medicine we get placebo-controlled trials, often done to obtain FDA approval for a new treatment. For conditions for which a treatment is available, trials like those arguably have little value for clinicians and patients seeking to choose between treatments.

Research that studies the comparative effectiveness of treatments is called, not surprisingly, comparative effectiveness research. A good example relevant to dermatology is a randomized trial of four treatments for actinic keratosis (N Engl J Med. 2019; 380:935-46).

Enrolling 624 participants who each had at least five clinically diagnosed AKs on the head, the trial investigated effectiveness of fluorouracil 5% cream, imiquimod 5% cream, methyl aminolevulinate photodynamic therapy (MAL-PDT), and ingenol mebutate 0.015% gel. The primary outcome — a ≤ 75% decrease in the number of AK lesions 12 months after treatment ended — was reached by significantly more participants who received fluorouracil (75%; 95% confidence interval [CI], 67% to 81%) compared with imiquimod (54%; 95% CI, 45% to 62%), MAL-PDT (38%; 95% CI, 30% to 45%), or ingenol mebutate (29%; 95% CI, 22% to 36%).

Bottom line: For AKs, fluorouracil appears to be the best vacuum. dw
Don’t miss this month’s Insights!

In the latest commentaries, Dr. Heymann and the Dermatology World Insights & Inquiries editorial board address topics including:

• Order from chaos: Conceptualizing atypical fibroxanthomas, pleomorphic dermal sarcomas, and undifferentiated pleomorphic dermal sarcomas

• Oy, another “Oid” to worry about: Cryptococcoid lesions

• The pachydermoperiostosis prostaglandin paradigm

• Should dermatologists be anti-antihistamine for atopic dermatitis?

Look for DW Insights & Inquiries every Wednesday in DW Weekly, or go online to www.aad.org/dw/dw-insights-and-inquiries to read the latest and search the archives.
Is there a genetic basis of CCCA and, if so, what is it?

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Clinical Applications column, Physician Editor Kathryn Schwarzenberger, MD, talks with Amy McMichael, MD, about her recent NEJM article, “Variant PADI3 in Central Centrifugal Cicatricial Alopecia.”

Dr. Schwarzenberger: In your recent study published in the New England Journal of Medicine, you and your colleagues identified a genetic mutation associated with central centrifugal cicatricial alopecia (CCCA). What inspired you to look for a genetic basis for this challenging condition?

Dr. McMichael: What inspired us to look for genetics was an interesting tale of two cities. Ncoza Dlova, MD, associate professor, chief specialist, and head of the dermatology department at the Nelson R. Mandela School of Medicine in Durban, South Africa, and I had observed that many of our patients with CCCA reported a strong family history of this form of hair loss. It seemed to be too many in one family to be related only to hair care practices. There were some patients who actually brought their family members to appointments, so we could see the hair loss for ourselves. Dr. Dlova was the first to report an autosomal dominant pattern of inheritance in CCCA, working with Drs. Ofer Sarig and Eli Sprecher in Israel.

Meanwhile, I had approached Dr. Sprecher about a more in-depth genetics study of CCCA when he visited my department. He was the one who suggested that Dr. Dlova and I work together to study the genetics in the families of affected patients as well as in unrelated patients. We had the patients and he had all the genetics expertise.

Dr. Schwarzenberger: What were your findings?

Dr. McMichael: We collected both RNA and DNA from women of African ancestry with CCCA as well as from controls of at least age 50 who did not have CCCA. Our findings identified one splice site and three heterozygous missense mutations in PADI3 in five patients (31%) in a discovery set of 16 patients. PADI3 encodes peptidyl arginine deiminase, type III (PADI3), an enzyme that post-translationally modifies other proteins that are essential to hair-shaft formation. These mutations were found to result in reduced PADI3 expression, abnormal intracellular localization of the protein, and decreased enzymatic activity — findings that support their pathogenicity. We then directly sequenced PADI3 in an additional 42 patients and observed genetic variants in nine of them. A post hoc analysis of the combined data sets showed that the prevalence of PADI3 mutation was higher among patients with CCCA than in our control cohort.

Dr. Schwarzenberger: Do you and your colleagues feel this genetic mutation is the answer to this condition? Does it adequately explain the pathogenesis of the condition, or is it possible that other factors contribute to the hair loss and scarring?

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**Dr. McMichael:** It would appear that the PADI3 mutation is one factor in the development of CCCA, but there is likely an environmental factor as well. It is likely that the environmental factor or factors are able to start the process of loss in those who have the underlying mutation. Since we do not have a way to test for the mutation yet, we have to be diligent about prevention of the condition by counseling all our patients of African ancestry to use gentle hair care practices starting at a young age.

**Dr. Schwarzenberger:** How will this new knowledge impact the care dermatologists provide to patients with this condition? Should we start doing genetic testing on our patients with hair loss?

**Dr. McMichael:** It would be my dream to have genetic tests for all forms of hair loss. Even when that day comes, the answer to treating these diseases in those already affected will still be complicated. Knowing the underlying genetics of diseases will help us explain to patients that they are not to blame for their hair loss, which many of my patients report. These findings allow dermatologists to let their patients know about the underlying risk to using hair care practices that put tension on the hair or extreme heat on the scalp. The findings also allow us to educate the younger generations before there is damage to the scalp. Our patients want to know why they have CCCA, and this gives them the start to the answer. *dw*
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Distracted Doctoring

Experts discuss a growing health care concern
There is a growing patient safety concern that is unrelated to a specific diagnosis, medication, procedure, or treatment, but it can impact all patients. If you have a personal electronic device or use an electronic health record (EHR) system, you are at risk. It’s called distracted doctoring.

The explosion of personal electronic devices coupled with the use of work-related technology, such as EHRs, computer tablets, and smartphones, not to mention beepers and pagers, have created the perfect storm for distraction. Spoiler alert: Multitasking only makes it worse. >>
Distraction is on the rise

Physicians are under greater pressure to do more with less time and fewer resources, said Steven Chinn, DPM, MS, MBA, administrative director, accreditation, regulations and quality management at Stanford Health Care, and clinical associate professor at Stanford School of Medicine. During shorter appointment times, they are required to diagnose and treat the patient while documenting everything they’ve done on the EHR. Studies suggest that distraction might be attributed to the volume of work that physicians must accomplish on a daily basis, he added. And it’s not just physicians; residents, nurses, pharmacists, and therapists are also impacted.

Distraction is a growing societal problem and health care is not immune to it, stated Jennifer Gardner, MD, assistant professor of medicine and dermatology at the University of Washington School of Medicine. “The only difference is that the stakes are higher in health care than in a lot of other realms of life, which is why it’s that much more important to address.”

Peter J. Papadakos, MD, author of Distracted Doctoring: Returning to Patient-Centered Care in the Digital Age, believes the pivotal event that brought this issue to the forefront in health care was the 2014 case of the Dallas anesthesiologist who was using his iPad during a procedure and failed to notice that his patient’s blood oxygen levels had dropped substantially until it was too late. The patient subsequently died. Organizations started questioning if their physicians were engaging in that type of behavior too, said the anesthesiologist who lectures around the country and internationally about distracted doctoring and how to interact with devices in the patient care setting. “I hear that errors are on the rise due to distraction at hospitals around the world,” he added.

Different than previous technologic advances, the recent onslaught of personal electronic devices has blurred the lines of work and home life, Dr. Gardner explained. “The perception is that we should be available 24/7 because we have the ability to respond to any issue any time of day via email and text — a perception promoted by employers. That ‘always on’ mentality is underappreciated and draining our ability to focus.”

While some believe that younger physicians are more susceptible to distraction because they have grown up being constantly connected with social media, others maintain that physicians of all ages are vulnerable. As proof of the former, Dr. Papadakos cited a 2012 study published in the Journal of Hospital Medicine in which smartphones were used during patient rounds by 85% of residents compared with only 48% of faculty. About 37% of residents compared with only 12% of faculty read and/or responded to personal texts/emails.

Moreover, 19% of residents and 12% of attendings believed that they had missed important information due to distraction from smartphones. Residents are more adept at using this technology because it is part of their processes, Dr. Chinn said, but that doesn’t necessarily mean they are more vulnerable to distraction caused by it. Younger generations are not always aware of how connected they are, said Sarah Kasprzowicz, MD, from Medical Dermatology Associates of Chicago, who relayed the story of a resident who took out her cell phone to respond to a personal text while in the room with a patient. When Dr. Kasprzowicz later asked the resident if everything was okay and if she needed to leave to address a personal emergency, the resident wasn’t sure why the doctor was asking. “What the resident did is unacceptable on a number of levels,” Dr. Kasprzowicz said. “But I don’t think she was even aware of her actions.”

Electronic devices are addictive

Chances are she probably wasn’t. “The tech world has hijacked our dopamine systems,” Dr. Gardner said. “That’s why we feel vulnerable when we don’t answer the cell phone or a text; the technology is working on a subconscious level.”

Dopamine causes people to engage in “seeking” and “wanting” behaviors, such as checking emails or social media. “We’re never quite sure when we’re going to receive a text message and from whom, so we keep checking,” said Shelley Rizzo, MSN, CPHRM, patient safety risk manager who presents across the nation about distracted doctoring for The Doctors Company, the nation’s largest physician-owned medical malpractice insurer. “When the device rings or vibrates, we know there’s a reward coming. Anticipation of the reward is sometimes better than the reward itself.” The instant gratification that one gets from receiving an email, text, or tweet encourages more seeking behavior. This is referred to as dopamine looping. Constant stimulation of the dopamine system, however, can be exhausting and cause lack of focus.

People typically use their devices right out of the box without adjusting their settings, Dr. Gardner said. “The devices are loaded with shiny, colorful flashing banners
and notifications designed by tech developers to grab our attention, and it takes a lot more than will power to beat out this psychology,” she stated. To make matters worse, studies have shown that these devices can interfere with sleep. The blue light from cell phones and internet devices disrupts melatonin production, which can lead to insomnia and/or sleep deprivation.

Dr. Papadakos, director of critical care at the University of Rochester Medical Center, and his colleagues modified the CAGE substance abuse screening tool to help identify very high users of electronic devices who may benefit from getting additional help with preventing distraction from electronic devices in the operating room. During his lectures, he typically polls his audiences to determine whether they are addicted to electronic devices. “We have found that 50-75% of respondents, all of whom are health care professionals, are addicted,” Dr. Papadakos said.

Sources of distraction
“The smartphone is the most common distraction because it’s always with us whether it is used at work or not,” Dr. Gardner said. Just having it around is a distraction. “It’s playing on your mind because it makes you wonder, ‘What am I missing?’” she added.

The institutional reliance on email forces physicians to routinely check their smartphones, Dr. Papadakos noted. As a university-based physician, he receives more than 100 emails a day from the medical center, many of which he must respond to, despite their lack of urgency.

Next on the list is the EHR. Having all the patient’s health information in one place can be very helpful, Dr. Chinn said, but it also means that physicians have to filter through potentially thousands of entries to find information relevant to the patient’s current health issue. That can be very distracting and frustrating, he said. There is so much pressure to chart everything in the EHR that it inevitably feels like a distraction to the clinician and patient, Dr. Kasprowicz added.

None of the information in the EHR is prioritized; it just shows up, Dr. Gardner said. “You can’t look at all of the folders at once, so you have to scroll through them all.” Sometimes it takes scrolling through 30 charts to find the patient who should be seen right away. It’s assumed that if a patient calls that it’s a more urgent matter, but that’s not fool proof because younger patients tend to send email messages and they expect a quick response. This lack of prioritization creates an artificial sense of urgency and opportunities to miss truly emergent situations, she said.

Another significant source of distraction is not electronic. It’s the insurance hurdles that physicians and/or their staff must wade through. “What used to take a five-minute phone call now requires 80 emails to three different people,” Dr. Papadakos quipped. Nothing is more frustrating than to take the time to explain a treatment to a patient who can’t follow through because it’s not covered, the recommended referral doctor is out of network, or the medication is unaffordable, Dr. Chinn said. Ironically, this is one area where technology could pull its weight, Dr. Gardner said. If the EHR interfaced with insurance requirements, for example, the physician would know that the insurer prefers that an equivalent medication be prescribed or that the prescription must be sent to a specific pharmacy. “Then patients could get the medication they need when they need it and not to have to navigate the system themselves,” she said. “And it would eliminate a lot of back and forth between the insurance companies and physicians.”

Kaiser Permanente’s LEVEL guidelines

Kaiser Permanente developed the LEVEL guidelines for clinician-patient communication. They are:

☑ Let the patient look on. Move the computer screen so the patient can see it, invite the patient to view information, ask the patient to verify information as it is entered.

☑ Eye contact. Greet the patient, maintain eye contact.

☑ Value the computer as a tool. Acknowledge the computer, let the patient know how it improves care.

☑ Explain what you are doing. Inform the patient about actions and decisions, tell the patient what you are doing, such as ordering lab tests.

☑ Log off and say you are doing so. Tell the patient you are logging off to safeguard their information.
Impact and consequences of distraction

“Distraction is a big patient safety issue,” Dr. Gardner said. “Any time you are distracted, errors can occur. They could be detrimental to your patient’s health as well as to your career because it puts you at risk for liability.” Both complex and routine tasks can be affected.

“It doesn’t take much if you’re interrupted by a ding from your cell phone to lose your situational awareness, and then you might not notice that something is out of place,” Rizzo said. Studies have shown there is a 60% increase in errors when a nurse is interrupted during medication administration preparation. Furthermore, interruptions lasting just 2.8 seconds double the likelihood of errors. “Among my colleagues, we often talk about medication errors that do occur and how many times this issue of distraction and multitasking is a factor,” Dr. Chinn noted.

“It’s not uncommon for physicians to have multiple screens on their computer open at one time. “They can inadvertently put a prescription or test order into the wrong patient’s file,” he said. This very simple mistake could lead to adverse outcomes either by the correct patient not getting their medications or being referred for an unnecessary test. Other errors due to distraction could include delaying or missing a diagnosis, mislabeling a specimen, obtaining consent for a different procedure, not correctly identifying the patient prior to a procedure, and performing a biopsy or surgery on the wrong site, or worse.

Even if an error doesn’t occur, productivity may be affected. Staff at her office were checking their social media on their smartphones so often that this past February Dr. Kasprowicz’s office implemented an unpopular policy requiring employees to keep their cell phones in their personal lockers. In the case of an emergency, they could be reached via the main office number. “People were so connected that they were not hearing their name being called,” she said. They were making administrative errors and generally not following up on tasks or giving tasks the level of attention they needed. “Since implementing the policy, our productivity has improved and people appear to be more connected to their job,” Dr. Kasprowicz added.

Cyberloafing, which is using internet access at work for personal reasons while pretending to be doing work, is a big problem in all workplaces, Rizzo said. It causes people to be pre-occupied, which in a physician’s practice could lead to delays in room turnover, incomplete or inaccurate recordkeeping, documentation errors, and delays in obtaining test results.

Patient satisfaction scores are highly dependent on the quality of the interaction between the physician and patient. Dr. Chinn said. Patients are very cognizant when the doctor isn’t paying attention to them, especially when the physician is looking at the EHR screen. A physician who is staring at their smartphone similarly gives the impression that they are not engaged. Many patients feel that they’re not being listened to when there is so much technology in the room, which Dr. Kasprowicz believes is a valid concern. The EHR takes the focus away from patients by creating the e-patient, the patient in the EHR, not the one in front of the physician, Dr. Papadakos said. “Instead of making eye contact and having basic human interaction with the sick person, the physician is checking automated boxes on the e-chart, checking lab results in the EHR, and typing notes. That’s a big breakdown in the physician/patient relationship.” It can lead to complaints, or in the case of an adverse event, a lawsuit. “We know there is a link between decreased patient satisfaction and increased medical malpractice claims,” Rizzo said.

Interacting with electronic devices increases a physician’s risk of medical malpractice. Whenever there’s a medical malpractice claim and an allegation that the adverse event was caused by distracted practice, the physician’s cell phone records can be subpoenaed, Rizzo explained. All of the quality care that was provided by the physician can be overshadowed if there is hard evidence that they, for example, were surfing the Internet during a procedure. The mere suggestion that a physician was distracted can make it more difficult to defend a defensible case.

Multitasking is a myth

People often brag about how they can multitask, but studies have shown that it’s not such a good thing after all. Multitasking causes people to make more mistakes and retain less information, the latter of which can hinder one’s ability to problem solve and be creative.

“Approximately 2% of us are super taskers who can truly multitask and the rest of us are just in denial,” Dr. Gardner said. “We’re really doing serial mono-tasking, not multitasking.” The problem is that every time people shift their focus to do a different task, they get as much as 40% less efficient and more tired. For complex tasks, the percentage is even higher. “Studies have shown that it can take upwards of 30 to 40 minutes to get back to where you left off when you are distracted,” she said. “The more you’re distracted, the harder it is to return to the task at hand.”

While humans can focus on more than one auditory cue at a time, they can’t focus on more than one visual cue at a time, Dr. Papadakos added. “We can’t change our evolution. So instead of doing one task well, we do 10 tasks poorly.”

“Take the time to look up from the computer screen and make eye contact. I often pause when I need to document a physical finding and I will tell the patient what I’m doing so the patient knows that the moment is about him or her.”
Avoid or manage distractions

More and more, hospitals are educating their physicians about the dangers of distracted doctoring and how to interact with the patient and technology simultaneously. For the past several years, Dr. Gardner has presented two annual workshops on the topic, one for residents and one for faculty.

Some institutions are developing e-etiquette programs and protocols. For example, Kaiser Permanente developed guidelines for clinician-patient communication (see sidebar), and UCLA Health System developed an educational video to demonstrate how to use computers while maintaining patient-centered care. Along those lines, when Dr. Kasprowicz is in the exam room, she positions herself so that she is focused in front of the patient. “Take the time to look up from the computer screen and make eye contact,” she said. “I often pause when I need to document a physical finding and I will tell the patient what I’m doing so the patient knows that the moment is about him or her.” To engage patients, best practices suggest that physicians should explain step-by-step what they are doing, Rizzo noted.

Dr. Gardner advocates for physicians to put boundaries between them and their technology to minimize distractions. For example, turn off notifications and social media apps. Allow only certain individuals’ texts or calls to get through. “Do not bring your cell phone into the exam room with the patient,” she said. “Keep it in a work bag, not on the desk.” Dr. Papadakos recommends using separate devices for personal and professional use, making it easier to maintain focus on patient care uses while at work. Dr. Kasprowicz recently purchased a smartwatch that she uses only at work. Dr. Kasprowicz programmed the settings to allow a handful of information to come through and the rest gets categorized as noise that she scrolls through at the end of the day. It has helped her disconnect from things that are not the primary focus at work.

To avoid multitasking, Dr. Gardner schedules her day by deciding how much time to devote to the various tasks she needs to accomplish. Designate a certain time to check emails, and don’t try cramming that in on the elevator or between patients because the latter is not good use of your time or attention, she said. “Humans tend to underestimate how much time it’s going to take to do a given task,” Dr. Gardner added. “Give yourself the time and space you really need to focus. If you’re really present and mindful and do the task at hand, you will do it better.” Dr. Chinn recommends a “team huddle” or “reset,” that is taking a momentary pause before starting a new procedure or task.

Feeling stressed or burned out? Get relief at www.aad.org/burnout.
Electronic consultations

BY ALEXANDER MILLER, MD

Alexander Miller, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Miller, who is in private practice in Yorba Linda, California, represents the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

Physician-to-physician and patient-to-physician electronic communications have increased recently, and in some cases, have become the norm. Unlike years ago — when remote communications were principally facilitated through telephone discussions — today, physicians and patients may communicate through telephone conversations, email, text messaging, and patient portals. Such communications require responses from physicians. Realizing that responses require physician time and work, the Centers for Medicare and Medicaid Services (CMS) has allowed for reimbursement of electronically delivered services, with some qualifiers.

The 2019 Current Procedural Terminology (CPT®) offers codes 99446-99449 and 99451 for reporting interprofessional telephone/internet/electronic health record consultations. These codes may be used for reporting services conducted by a consultant at the request of a treating physician or qualified health care professional. The consultant provides services using technology, without direct physician-to-patient or physician-to-physician contact. The consulting physician may offer an opinion about a new or established patient with the consultant. If the consultation is requested for an established patient, the patient should present with a new or worsening problem. The written or verbal request and the reason for the advice from the requesting provider must be documented in the patient’s medical record.

There are restrictions to reporting CPT 99446-99449 and 99451. The patient must not have been seen by the consultant in the preceding 14 days and the consultant must not care for the patient in person within 14 days of the consultation, or when there is a “next available appointment.” Additionally, more than 50% of the electronic communication time must involve verbal or internet discussion rather than records/data review for codes 99446-99449. If the consultation requires more than one telephone/internet/electronic health record contact(s) (e.g., discussion of test results), the entire service and the cumulative discussion and information review time is reported with a single code. The consultation codes are limited to reporting once during a seven-day period.

Code 99451 does not have a greater than 50% discussion time requirement and may be used when the predominant time spent was for records review. Lastly, CPT 99446-99449 require a verbal and written report from the consultant to the consultation requestor. Code 99451 only requires a written report, and no verbal report.

These are the interprofessional consultation codes, revised for 2019:

- **99446** Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- **99447** 11-20 minutes of medical consultative discussion and review
- **99448** 21-30 minutes of medical consultative discussion and review
- **99449** 31 minutes or more of medical consultative discussion and review
Coding quizzes

Test your knowledge with more coding quizzes at www.aad.org/coding-resource-center.

Example 1

You provide 15 minutes of an interactive telephone consultation with a referring physician. You generate a written report to the physician, send it electronically, and then schedule the patient, who is new to you, for your first available appointment, which is in one month. You report your consultation with CPT 99447, “11-20 minutes of medical consultative discussion and review.”

Answer: Incorrect. You did the work, and you didn’t see the patient in the subsequent 14 days, as stipulated in the code definition. However, you did make an appointment for the patient in a month, and since that was your “next available appointment date of the consultant,” billing for the electronically generated consultation service, which included a written report, is not allowed. If you schedule the patient for your next available appointment, regardless of when it is in the future, the electronic consultation codes may not be reported. What is not clear is whether the service is reportable if the patient declines a next available time and chooses a later appointment date.
Example 2
You spend nine minutes on an electronic health record consultative interchange with a referring physician. The patient was last seen by you for bullous pemphigoid therapy three weeks prior, but as the pemphigoid was flaring and required an adjustment in therapy. You report CPT 99446 for your service after discussing the patient verbally and generating a written consultative report within the electronic health record.

Answer: Correct. Although the consultation involves an established patient with an established diagnosis, the patient’s condition had worsened, thereby justifying both the consultation and the reporting of CPT 99446.

Example 3
You perform an internet physician-to-physician consultation, generate a report, and bill for the service. You recommend that the patient see you for management of the patient’s problem and take over the care of the patient. You bill for the electronic consultation.

Answer: Incorrect. The guidelines stipulate that if a ‘transfer of care’ to the consultant occurs, the consultation codes may not be reported/billed. CMS Medicare Claims Processing Manual, Pub 100-04, Section 30.6.10 (available at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R788CP.pdf) states that a physician or qualified non-physician provider consultant may initiate diagnostic services and treatment at the initial consultation service or subsequent visit. However, ongoing management, following the initial consultation service by the consultant physician, shall not be reported with consultation service codes. CMS further defines ‘transfer of care’ as when a physician or qualified NPP requests that another physician or qualified NPP take over the responsibility for managing the patient’s complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

Example 4
You do a telephone physician-to-physician consultation and three days later, after reviewing pertinent laboratory results, do a second, internet-based consultation. You spend 12 minutes on the initial verbal consultation and 10 minutes on the second consultation, including the time spent reviewing laboratory results. You submit CPT 99448 for your total of 22 minutes of consultation.

Answer: Correct. The CPT instructs that multiple same-patient consultations done during a seven-day period must have their times summed, and only one consultation code should be reported.

Example 5
At the request of a family practice physician you do a telephone and internet consultation on a patient. You recommend a therapeutic intervention for the patient, who remains under the original physician’s care. You generate a verbal and written report then bill an appropriate consultation code to the patient’s MAC. You receive a request for records review from the MAC, which disallows payment for the consultation and demands a refund.

Answer: Correct. You did not document the verbal or written request for an electronic consultation in the patient record. The CPT coding guidelines stipulates that the consultant should document the request and the reason for the request in the patient’s medical record. dw
15th Annual Dermoscopy Intermediate Course

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For course details and registration: mskcc.org/cme
The American Academy of Dermatology Association (AADA) strives to maintain strong relationships with state medical societies to ensure that the combined advocacy efforts of the AADA, the state dermatology society, and the state medical society are aligned, where appropriate, and strengthened through strategy together.

Many state medical societies convene a House of Delegates at least once per year to allow for a democratic process to shape the policies, priorities, and actions of the state medical society to best advocate for the practice of medicine and quality patient care in their state. With regard to advocacy, members of the state medical societies can write and submit resolutions to bring attention to a particular issue or influence the state medical society to take a specific action. Resolutions can call for the state medical society to prioritize a specific bill or issue for the next legislative session. Resolutions are generally referred to reference committees where they are debated among a smaller group of members first before reaching the full House of Delegates. Every state operates differently, but in many, any member of a state medical society can introduce a resolution, while specified delegates of the state medical society ultimately vote to adopt, reject, or re-refer the resolutions.

Academy members are encouraged to join their state medical society and take part in their House of Delegates forum or other policymaking forum to further dermatology’s own advocacy priorities at the state level. The AADA has helped several dermatologists develop resolutions for their state medical society House of Delegates.

In Maryland, the AADA drafted resolutions encouraging the Maryland State Medical Society (MedChi) to:

- support legislation prohibiting mid-year formulary changes, prohibiting health plans from reclassifying a drug mid-year to a more restrictive tier or a higher cost-sharing tier, and prohibiting health plans from reducing the maximum coverage of prescription drug benefits mid-year.
- support legislation requiring the Maryland Health Care Commission to study the rising cost of generics through a questionnaire to patients, providers, and insurers to determine its effect on health care in Maryland.
- support legislation requiring transparency in the structure in which pharmacy benefit managers (PBMs) operate in order to prevent conflict of interest when developing formularies and/or tiers, support transparency of the negotiation process between PBMs and pharmaceutical manufacturers, and support legislation directing a study to investigate the extent to
which PBM negotiations and arranged rebates affect formularies, tiers, and drug prices.

- advocate for legislation requiring any manufacturer of a generic prescription drug that is 50% or more of the average wholesale price of its associated name brand drug to notify health insurers and state agencies prior to its selling to pharmacies if the drug price increases more than 10%.

In Tennessee, the AADA drafted a resolution encouraging the Tennessee Medical Association to oppose efforts authorizing the independent practice of physician assistants.

How can you get involved?

1. Join your state medical society and encourage your peers to join. There is strength in numbers!

2. Some states have replaced the traditional House of Delegates forum with another method of policymaking. Be sure to review your state medical society’s process, House of Delegates, or otherwise, for deadlines and resolution-drafting guidelines.

3. Get in touch with AADA staff if you need help molding an idea into a resolution. The AADA has several template resolutions you can introduce or customize, including resolutions on truth in advertising, scope of practice for physician assistants, and medical spa standards of practice.

4. Study your state medical society’s parliamentary procedure.

5. Consider becoming a delegate and serve on a reference committee.

State Advocacy Grant Program applications due July 30

The AADA State Advocacy Grant Program is accepting applications for 2020. The application process is on a different timeline this year to allow grantees the opportunity to plan their advocacy activities with earlier knowledge of their award. This year, the grant application process opened April 30 and closes July 30. Notifications of awards will be sent in October (instead of December), and checks will still be cut in January 2020. The State Advocacy Grant Program provides financial assistance to state dermatology societies for the advancement of their health policy initiatives. To learn more about the program and to access the web-based application, visit www.aad.org/StateAdvocacyGrant.

Applications are due July 30.

Take action

Getting involved in advocacy is easier than you think! Check out the AADA’s Advocacy Action Center to learn how you can get involved at https://takeaction.aad.org.
The AADA continuously advocates on several key issues that affect the practice of dermatology and its patients. Recently, the Academy advocated against cuts to reimbursement, offered insight to key policymakers on telemedicine best practices, and shared dermatology’s expertise on sun protection.

**Physician payment**

The AADA advocates with the private payer sector to ensure the definition, development, and implementation of coverage and payment policies that facilitate the delivery of quality dermatologic care. Recently, the AADA:

- Met with Anthem to discuss its new policy that denies reimbursement for follow-up E/M encounters appended with modifier 25 if a recent visit occurred with the same diagnosis. The AADA also sent a letter to Anthem voicing its concerns that it is unclear how the policy will impact dermatologists and the physician community and requested the payer to delay enforcement of this policy.
- Wrote a letter to Anthem advocating against a new dermatopathology contract change that would reduce reimbursement for in-office pathology labs in Ohio to about 50% of 2018 Medicare rates — with the exception of 86 codes that would be reimbursed at 70% of 2018 Medicare rates. It is anticipated that similar contract modifications will be implemented in other Anthem states in the near future.

**Telemedicine**

The AADA supports policies that protect patient safety while enabling dermatologists to appropriately use teledermatology services to meet the needs of communities and populations across the country. The AADA recently responded to a request for information (RFI) from the Congressional Telehealth Caucus co-chairs and Senate telehealth leaders on best practices for teledermatology. These congressional telehealth leaders intend to introduce a telehealth package later this year based on the feedback stakeholders, such as the Academy, send them. In its response, the AADA:

- Reiterated its support for the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act in the 114th and 115th Congresses — specifically the provisions that
would ensure patient choice of provider as well as those providing for appropriate supervision of nonphysician practitioners and respecting state licensure requirements.

✓ Highlighted information regarding the Academy’s telehealth program, AccessDerm, as well as Project ECHO (Extension for Community Healthcare Outcomes) — an online learning collaborative model of medical education and care management that the Academy supports.

Sun protection
The AADA consistently works with policymakers to introduce and support laws, regulations, and resolutions that promote skin cancer prevention awareness.

The AADA sent a letter of support for House Resolution 323, which supports state, local, and community initiatives to encourage parents, teachers, camp counselors, and childcare professionals to take measures to prevent sunburns among minors. Rep. David Joyce (R-Ohio) introduced the resolution, which also supports initiatives that encourage healthcare providers to educate parents and children about sun-safe behaviors. Rep. Joyce was joined by his Congressional Skin Cancer Caucus Co-Chairs, Reps. Jim Cooper (D-Tenn.), John Joyce, MD (R-Pa.), and Carolyn Maloney (D-N.Y.), along with Reps.:

- Julia Brownley (D-Calif.)
- Salud Carbajal (D-Calif.)
- Rosa DeLauro (D-Conn.)
- Ruben Gallego (D-Ariz.)
- Raja Krishnamoorthi (D-Ill.)
- Linda Sanchez (D-Calif.)
- Bradley Schneider (D-Ill.)

Not sure which topics are important to the specialty right now? Review the AADA’s top advocacy priorities at www.aad.org/advocacy/advocacy-priorities.

Take action
Getting involved in advocacy is easier than you think! Check out the AADA’s Advocacy Action Center to learn how you can get involved at https://takeaction.aad.org.
Back in *the* day...

Dermatologists reflect on how the practice of dermatology has changed over the past 40 years.
“Back in my day in order to find your way anywhere, you purchased an atlas and then plotted your journey like a 17th Century explorer.” Who hasn’t been on the receiving end of a story like this? Often these stories are met by those who did not share the experience with a roll of the eyes, a blank stare, or a deferential nod of the head. In reality, however, there is much to be gained from listening to those whose experiences have been different.

What did being a solo practitioner look like 30 to 40 years ago? Are there generational differences in how dermatologists practice? This month, Dermatology World talks to seasoned dermatologists to explore how the practice of dermatology has changed over time. >>
Back in the day…

Regulations and insurance
Illinois dermatologist Michael Greenberg, MD, who has been practicing for 40 years, has seen a dramatic shift in how dermatology practices operate. “We didn’t worry so much about the regulations. It was a much simpler time.”

Back in the day, malpractice insurance was relatively cheap. “When I was a resident, the biggest crisis began with malpractice insurance. Malpractice insurance used to be really inexpensive,” said Dr. Greenberg, who watched as his insurance skyrocketed from $200 per year to nearly $4,000.

Back in the day, physicians practiced medicine without a computer. “When I first started practicing, we had a peg board where patients would walk away with a peg board receipt with their diagnosis on it, pay for their visit in cash, and then they would send the receipt to their insurance company to get reimbursed.”

Back in the day, when you prescribed a medication, a patient would be able to fill it. “Doctors never had to worry about insurance companies turning down claims. Medications were so inexpensive we used to distribute them in the office as a convenience,” Dr. Greenberg said. “Insurance companies were not turning down medications — you could prescribe the medication that you felt was best for the patient.”

Speed up your prior authorization process
Quickly create appeal letters to help overturn denials for prior authorizations using the Academy’s interactive letter generator at www.aad.org/priorauth.

Insurance hurdles have become burdensome and frustrating for physicians. “Physicians have lost control of medicine. Nonphysicians who have no pre-existing relationship with the patient are making decisions on how medicine is practiced and are attempting to tell us what we should do and what we shouldn’t do,” said Bruce Thiers, MD, president-elect of the Academy, and distinguished professor in the department of dermatology and dermatologic surgery at the Medical University of South Carolina.

“Insurance companies want to make a lot of money, pharmacies want to make a lot of money, doctors want to make a lot of money, and patients want their health care for free. Somehow we have to come to the middle and say what’s enough here,” Dr. Greenberg said.

So long, solo
Back in the day, physicians aspired to running their own practice. Owning and operating a private practice has become increasingly difficult over the years. It used to be that a lot of people went into private practice, Dr. Greenberg said. “The economics are different now; we didn’t come out of training with huge loans. It was easy to open a practice by yourself. People weren’t looking for group practices.”

What practice model is right for you?
Take an assessment quiz to learn more about practice models that may be right for you at www.aad.org/epm.

“There was a different mindset of work back then. It was about building a practice. You worked as hard as you had to. You didn’t worry about life — you worried about old-fashioned building a practice,” he said.

Dr. Greenberg, along with his colleagues, formed the Illinois Dermatology Institute because he could see the increasing expenses coming down the road. “Groups are getting bigger and bigger because the cost of running a practice to get a decent income requires that we join together,” he explained.

Technology: Friend and foe
EHRs can be a sticky subject for some physicians, especially those who began practicing before the technology existed. With conflicting studies and opinions about whether EHRs are more efficient or whether they improve patient care, Dr. Greenberg sees both sides of the coin. He doesn’t believe EHRs improve patient care. “We are paying to collect data for insurance companies.” However, “The positive side is that everything is accessible electronically and easily organized. Going back to my paper records to find things can be horribly inefficient.”

It was only a little more than a year ago that Dr. Greenberg agreed to transition to an EHR because the younger physicians in the practice taught him how to use the system in a way that would not detract from time with his patients. “I use macros, which make
Dynamic duo: A mother-daughter dermatologist team

Portland dermatologist Phoebe Rich, MD, was a latecomer to medicine, and so her daughter Anna was born during her second year of medical school. "Sometimes she would go on rounds with me on the weekends — in a little backpack — and the patients all loved it." Anna Hare, MD, is the daughter of Dr. Rich and has been practicing dermatology in her mother’s practice for nearly a year.

Anna grew up watching her mother passionately pursue medicine. While pursuing medicine was not always her dream growing up (she received her undergraduate and graduate degrees in environmental science and policy), it’s hard to argue that her home life did not play a part in her eventual pivot to medicine. "I had always hoped that she would go into medicine. I think I talked it up a bit too much at certain times and that may have pushed her away. Little girls go through a phase in life where they want to do something different — they don’t want to be their mother," Dr. Rich said.

"I grew up not wanting anything to do with medicine or dermatology," Dr. Hare said. "I was born when my mom was in medical school and grew up when she was in residency and starting a practice, so I didn’t see her a lot, but she always made a point of doing a lot of global travel with me, and we would almost always do some sort of volunteer project. From that, I got to see very early the difference that one person can make in an individual’s life. I grew up with the idea of service as part of our role in our communities and in the world and seeing how medicine can fit into that," she said.

"When she was a toddler, I was in medical school studying anatomy and all the basics," Dr. Rich said. "During bath time we’d be talking about anatomic parts — her axilla and her patella. She would never talk about belly buttons — it was always umbilicus. It was something that was really special between us — and really fun."

Dr. Hare grew up in and out of her mother’s clinic. Eight-year-old Anna helped her mom fill syringes and fold gowns. "I remember the first time I sat in on a biopsy with her, and I nearly passed out when I saw fat for the first time. Later on she had me rooming patients and I would take little notes," Dr. Hare said. "I’ve seen more and more the role of creativity in medicine, particularly in dermatology, and that’s part of why within medicine I decided to become a dermatologist," she said.

Now, Dr. Rich and Dr. Hare have become a dermatology force to be reckoned with. They share patients and perform surgery together. "We share patients a lot. Sometimes I’ll take her into the room while I’m seeing a patient just to get her ideas; we learn a lot from each other. It’s not direct teaching, but it happens almost every day with patient interactions," Dr. Rich said.

Dr. Hare believes that her generation may be more adaptable because they were trained with the expectation that the practice of medicine is changing with technology and they would regularly encounter things like EHRs and prior authorizations. "But that doesn’t mean we don’t complain about it," she said. Dr. Hare helped her mother become more efficient with EHRs. "We sat down and talked about how to respond to results on the EMR system, and now she’s doing it all — and sometimes looks at my in-basket," she said.

On the other side of things, Dr. Hare recognizes that her mother has knowledge she doesn’t. "Besides years of clinical experience, she has a lot of knowledge of things we did not experience in residency, like how to do a Tzanck smear. I think I maybe did one in residency. We share a lot and we both learn from each other all the time."

"I’m old enough that I probably should have retired a long time ago," Dr. Rich said. "But having Anna in the clinic, I’m never going to retire. They’re going to have to carry me out of here! It is just so much fun, and I want to do it as long as I can."
certain updates automatically in the few minutes between patients," said Dr. Greenberg.

Initially Dr. Greenberg was hesitant to use an EHR because he prides himself on spending quality time with each patient. "As there are more and more distractions, there is less careful listening to patients," he said. In fact, a few years ago, Dr. Greenberg started doing improv classes as a way to strengthen his listening skills. "We used to spend our time talking with patients because the records could be minimal. And now we’re so worried about getting the record right — putting in the right code so we get paid, and then asking all the right questions so that Medicare will give us a bonus, that we’re not listening to the patient as much.”

Some physicians hire medical scribes to help allay the time and attention burdens, however, Dr. Greenberg believes the exam room is sacred space. "Patients talk to me about a lot of other problems besides their skin. They trust me. I don’t want a scribe there while a patient is talking to me about their feelings about their parents dying or their child’s problem with addiction."

"Our job isn’t just to hand out pills or do procedures. Our job is to hold patients’ hands and give them peace of mind whether the diagnosis is good or bad. A lot of the additional technology and regulations have gotten in the way of that," he said.

Dr. Greenberg also laments the rising importance of internet rating sites. "Any patient with an axe to grind can go online and write terrible things about you. Since we’re bound by HIPAA requirements, we can’t respond." As more patients come into the office with unrealistic expectations about insurance and drug costs, negative reviews continue to grow. (The issue is such a concern for physicians that Dermatology World has run two recent Legally Speaking columns on it; see www.aad.org/dw/monthly/2017/july/avoiding-the-pitfalls-of-social-media and www.aad.org/dw/monthly/2017/october/responding-to-online-defamation.)

While technology has certainly brought with it many challenges, the benefits may outweigh the disadvantages. “Whoever thought that we would be able to sit down at a computer and Google a list of symptoms and come up with a differential diagnosis for a patient sitting right there in our office?” said Phoebe Rich, MD, owner of a dermatology practice in Portland, Oregon. “When I was a resident we had to go to the library and sift through stacks of journals to do that. I would take an entire weekend to get the information that we can get now in three minutes. Technology has been a trade-off,” she said.

Burnout

According to a Medical Economics survey of 300 physicians across varying specialties, physician burnout was identified as the number one challenge. When Dr. Greenberg first started practicing, the concept of burnout didn’t really exist. “Now it’s so easy to burn out these days because of all the frustrations. We send out prescriptions and then get all these calls back from patients saying that they can’t afford their medication, or that it’s not approved by their insurance company, and then we’re the ones in the middle. The patients get angry — and since we’re the face they see, we get the brunt of the anger,” he said.

Ultimately, increased regulation by those outside medicine can impact patient care and create a vicious cycle in which burnout may be a likely endpoint. After an insurance company denies a prescribed medication, a patient may call back and ask for another option, said Dr. Greenberg. “I’m forced to write another prescription that I know won’t work as well, and then the patient has to come back because I didn’t help them.”

Stressed out?
Assess your stress level, find inspiration, and overcome work challenges with the Academy’s burnout resources at www.aad.org/burnout.

“I don’t think anyone is tired of treating and helping patients. Physicians are burned out from 21st Century-style medicine — they’re burned out from all this oversight and nitpicking done by others,” Dr. Thiers said. “If we could practice medicine with the freedom that we once had, we wouldn’t be talking about burnout.”

Game-changing clinical advances

It’s not all bad news for the dermatology newcomers, however. Dr. Thiers, who has been practicing dermatology for more than 40 years, divides his career into two halves. During the first 20 years there was very little in the way of innovation in dermatologic
therapy, he said. Between 1980 and 2000, the only real therapeutic blockbuster was isotretinoin. “It was huge! That drug, of all the drugs that have come out in my career, probably had the most positive impact on the most people. But that was it for the first 20 years,” he said.

Dermatologic therapy took a great leap forward at the turn of the century. Since 2000, there have been advances in biologic therapy to better treat inflammatory diseases, such as atopic dermatitis and psoriasis, and cancer, notably melanoma, Dr. Thiers said. “We’ve also had new oral therapies, like the JAK inhibitors, for which the ultimate therapeutic potential is still being explored. The advances in biologics and small-molecule therapies have been incredible. They have made diseases that we previously couldn’t treat — or treated very poorly — very amenable to treatment.”

“If you had a patient with severe psoriasis or acne — people who were at one point afraid to be seen in public and all of sudden their skin is clear or nearly clear — it totally changes their perspective and outlook on life. It’s part of what makes medicine so satisfying,” Dr. Thiers said. But it’s also a double-edged sword. “It’s frustrating because these drugs are really expensive, and it’s a constant fight with insurance companies to get them covered.”

Work-life balance

Dr. Rich was busily raising a young daughter while finishing up her dermatology training and opening her own practice. “I worked hard — I struggled a lot in terms of trying to balance my life. In many ways I feel like I was an absentee parent during some of the more rigorous parts of my training when I’d have to spend nights in the hospital. But I think she knew that I was trying to make it up in other ways.” (Read the sidebar to learn about what it’s like for Dr. Rich and her daughter to practice dermatology together.)

Back in the day, work took precedence over family. “The younger people think a little bit differently than the older people do,” Dr. Greenberg said. “When we would have practice meetings that were sometimes called on short notice, the older physicians would just show up, and we’d hear the younger physicians say, ‘Well, it’s my day to watch the children.’ Now there are more lifestyle choices.”

Despite past perceptions of dermatology, it’s clear that becoming a dermatologist now is no easy feat. Dr. Rich remembers very little competition when she was applying for dermatology residency. “It’s way more difficult to become a dermatologist now than it was when I was a resident. As I’ve watched her [Dr. Rich’s dermatologist daughter] over the last three years, I’m very impressed with the academic rigor that dermatology residents, in particular, go through,” Dr. Rich said.

“When you watch TV, you’ll see commercials for drugs where the bottom line is ‘ask your dermatologist.’ It puts dermatology out there — and that’s our opportunity to educate the public,” Dr. Thiers said. 

Specialty perception

While specialty perception is an area that dermatologists and the Academy are continually striving to improve, significant gains have been made over time. When Dr. Thiers was first dating his wife, she told a friend that he was a dermatologist, and her friend replied, “Oh, I thought he was a doctor.” This misconception about dermatologists and the seriousness of the diseases and conditions they treat is less pervasive than it once was.

For decades, the American Academy of Dermatology has led in educating the public about dermatology and the value of dermatologists, fielding around 25 media inquiries a week, delivering authoritative information to the public on AAD.org with more than 32 million visits annually, and educating the public on social media and via high profile campaigns like SkinSerious (wwwskinserious.org) and the annual Skin Cancer Awareness Month.

As a result, dermatologists have a higher profile and have more respect now than in the past. “We are overwhelmed with patients. The demand for dermatology services far exceeds the supply of board-certified dermatologists,” Dr. Thiers explained.

“Forty years ago, we were the butt of jokes — we were the guys who rub cream on people and prescribe steroids. Perceptions of dermatology have changed as we’ve gotten involved in more of the complex diseases. We handle psoriasis and a variety of autoimmune diseases with complex, serious medications,” Dr. Greenberg said.

A Publication of the American Academy of Dermatology | Association

DERMATOLOGY WORLD // July 2019 31
The Journal of the American Academy of Dermatology (JAAD) is turning 40 this month! Dermatology World talks with JAAD Editor Dirk M. Elston, MD, to discuss the evolution of the journal and what the future may hold for the publication.

1. Dermatology World: JAAD launched 40 years ago this month. How did JAAD get its start and what was the impetus behind establishing an Academy journal?

Dr. Elston: The Academy recognized the explosion of knowledge in our field and the need for a key journal that would serve our members’ needs and keep them on the cutting edge of scientific advances. [Check out the first issue of JAAD at www.jaad.org/issue/50190-9622(05)1X7001-3.]

2. Dermatology World: Health care has evolved tremendously in the last several decades. What does the editorial board do to ensure that JAAD stays on top of the latest scientific advances in dermatology?

Dr. Elston: The editorial board represents a broad range of expertise in our field. We focus on advances in the field as well as data regarding what dermatologists find most useful. We also look at what sessions sell out most quickly at the Academy Annual Meeting, what articles are being cited, and which are being downloaded most often. When a hot, evolving topic is identified, we invite experts in the field to submit proposals for key review or CME articles to cover the topic. We offer expedited review for key clinical trials and now make most JAAD content available in the form of unformatted, uncorrected proofs within about a week of acceptance to make information about new advances readily available.

3. Dermatology World: In addition to staying up to speed on the latest scientific advances in dermatology, what has JAAD done to ensure that it also keeps up with changes in the overall health care landscape?

Dr. Elston: JAAD’s mission is to help the practicing dermatologist improve patient outcomes. Our focus is on the practicing clinical dermatologist and their need for concise, informative articles that have a direct impact on patient care. Our goal is to present key advances in the field in a useful clinical context [i.e., What does it mean and how does it change clinical practice?]. We are also the Academy’s vehicle for dissemination of guidelines of care and evidence-based position statements to guide clinical practice. The journal also focuses on the “game changers” — articles that had a profound effect on how we manage patients and how current advances have added to our knowledge.

4. Dermatology World: Many physicians have indicated that they are strapped for time. How has JAAD adapted over the years to meet the needs of the busy dermatologist?

Dr. Elston: Dermatologists are busy. When they invest precious time in a journal, they want real return on their investment. We have introduced key points bullets for CME articles, structured abstracts, and capsule summaries to reinforce the key messages of each article and emphasized the impact of each author’s work on clinical practice. We also invite brief commentaries from leaders in the field to interpret the findings and note what changes they will make in their own practices as a result of the new knowledge. Emily Altman, MD, has also helped us launch a successful virtual JAAD Journal Club. Special editors help us capsize key advances through social media and JAAD content is now available through a growing variety of electronic platforms.

5. Dermatology World: What do you think the future holds for JAAD?

Dr. Elston: The journal is constantly evolving to meet the changing needs of our members and to take advantage of evolving technology. We want to publish the key advances in medical, surgical, and pediatric dermatology most relevant to all practicing dermatologists, and we help interpret those advances, so they have the greatest impact to improve patient care.

Most dermatologists still want to read a paper journal, but also love their smartphones. We are developing bar codes that will make articles come to life with video and enhancements of value to readers.

The journal also serves as an important resource to dermatologists with a repository of many of the best images in dermatology. We are working to make them more accessible to improve education in our field. New features include clinical, surgical, and technology pearls as well as Letters to the Ethicist, and we are launching a new “controversies” section that will address some of the most difficult clinical topics in our field.

Medical knowledge is growing at an accelerated pace, and the JAAD will be there to keep dermatologists at the cutting edge of our field and to help put all that knowledge into context so we can provide the best care for our patients.
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Going green

BY VICTORIA HOUGHTON, MANAGING EDITOR

Dermatology World talks to Sandra Marchese Johnson, MD, from Johnson Dermatology in Fort Smith, Arkansas, about the green practice that she and her husband, Brad Johnson, MD, opened in 2006.

Q DERMATOLOGY WORLD: Tell me about your practice
Dr. Sandra Johnson: My husband and I built our medical facility and opened our practice in 2006. We have three board-certified dermatologists — which includes my husband and myself — a board-certified dermatopathologist, a physician assistant, and two nurse practitioners. On average, we see about 3,500 patients per month.

Q Why did you decide to seek LEED certification for your facility?
Dr. Johnson: My husband was a physics major in college, and he really wanted to make a statement with our new practice. When we started, we wanted to be earth-conscious in our new building — I wanted to use geothermal and have a small carbon footprint on the environment. Our architect and our builder went to high school with my husband and both are LEED-accredited and were really excited about these green initiatives in our new practice. They kept those aspects in mind when we started to develop the plans. Just as we got to the building stage, we realized that if we just added a few more points, we could go for LEED certification, so we decided to take it a step further and try to get certification. We were the first medical clinic in the state of Arkansas to be LEED certified.

Q Can you describe some of the key LEED characteristics of your practice and why you chose them?
Dr. Johnson: We knew what big items we wanted, and our architect and builder helped us decide which smaller items would make sense to add. We decided that we wanted to design a building to look like a barn. The architect designed a silo on the side of the barn to collect rain water and we use that rain water to flush the toilets. It was a pretty design element but also a functional one. My son, who was 10 at the time, and I really liked this flooring that looked like hardwood flooring at a showroom, but it was recycled vinyl planks, so we chose that and that brought us another LEED point. You also get a lot of credit for using local supplies. It was easy for us to get our stone locally so there weren’t a lot of transportation costs when bringing the stone to our place. Also, supporting local is important to us, so it made sense.

Q From soup to nuts, how long did it take to build your LEED-certified facility?
Dr. Johnson: It took about 18 months to design and build. Adding the LEED certification did not add a lot of time to our construction timeline.

Q Building a LEED-certified building can be more costly than building a non-LEED facility, but in the long run, is there the potential for cost savings?
Dr. Johnson: There’s a high price tag to get that LEED certification. Since we’d already made all of those decisions in the building that we wanted any-
way, to be greener, we thought it was worth paying that extra fee to get this certification. It would kind of be like doing your residency without taking your boards. You might as well get the certification.

If you want to get the most return on your investment, going for the LEED certification probably doesn’t make good financial sense. If you want to make a statement as a dermatologist who’s environmentally conscious, that’s a non-tangible benefit that you really can’t measure. When we were building, we knew we wanted to build as energy- and earth-conscious as possible. Doing those things really did not add more expense but really has saved us a lot in costs. We more than tripled our building size, but less than doubled our electric bill. They did a lot of design elements to save on electricity, such as using motion sensors, so the lights go off if you’re not in the room. We have geothermal energy and all our heat and air units are on timers.

Q Are you still looking for ways to be “greener” in your practice?

Dr. Johnson: We are! We recycle. For example, we melt down our sharps whenever we can and put them in the regular trash rather than contributing to the medical waste. We also use electronic medical records, as most people do. There is still a lot of waste of paper and we are looking for ways to decrease the use of paper at our clinic. Using the patient portal is helping us a lot with that. Some patients are reluctant to use it. However, it has been a really good environmental feature and offers a cost-savings to us. In general, being green is something that continues to be important to us.

Q If a physician — who already has a practice or works in an institution and can’t build from the ground up — wants to go green, what tips would you offer?

Dr. Johnson: Be aware of your paper use. See if you can put your outlets, lighting, heat, and air on a timer. If possible, investing in a smart thermostat is a good idea. Don’t heat or cool an empty building. Also, living the example more than just saying you support green efforts is one thing physicians can do. Walk to places instead of driving. Recycle your utensils in the office. I use real plates and silverware instead of paper plates and products, and we wash those to decrease the amount of trash.

Q How has having a LEED-certified building affected your patients?

Dr. Johnson: I think for most of our patients, it’s a really good way to communicate and start a dialogue. We also built a clinic that I think is very pleasing to the eye. It feels very homey with that barn feel. Driving up to it, you feel comfortable and I think that’s created a sense of calmness for our patients. People appreciate the fact that they can go to a nice medical facility and it doesn’t cost any more money, and they know that we’re invested in the community and also invested in our patients. 

For more information on LEED certification and accredited architects and builders, visit https://new.usgbc.org/leed.
As states have taken measures to decriminalize marijuana in the medical and recreational context, many physicians are examining the potential benefits of cannabis use for their patients, including for certain skin conditions. Stepping into the medical marijuana arena comes with risks, however. Physicians who intend to prescribe must understand the nuances of federal and state laws governing medical marijuana use. Likewise, physicians should consider how their practices will address the rise in marijuana use by both patients and employees alike.

The legal landscape
Federal law regarding marijuana remains unchanged: It is still categorized as a Schedule I controlled substance, and therefore cannot be prescribed, or used personally. During the Obama presidency, the Department of Justice issued a memorandum removing marijuana enforcement as a priority for federal enforcers. This memorandum was later rescinded by then-Attorney General Jeff Sessions, JD, in early 2018. Today, a physician prescribing marijuana could risk revocation of their DEA registration, and possible prison time.

At the state level, however, the landscape has shifted dramatically. In 1996, California became the first state to allow marijuana for medical use. Since then, dozens of additional states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have passed similar laws (see map). Many of these laws share certain common features. They generally permit physicians to “recommend” the use of marijuana for medical use in treating specific, chronic conditions. The use of the term “recommend,” or other similar words, is meant to distinguish the physician's act from that of “prescribing,” specifically to avoid potential federal penalties. Although the specific conditions for which medical marijuana may be recommended vary from state to state, the list often includes glaucoma, HIV/AIDS, cancer, seizure disorders (usually including epilepsy), muscle spasms, ALS, multiple sclerosis, muscular dystrophy, or terminal illnesses. Physicians planning to recommend the use of medical marijuana should carefully research their state’s qualifying conditions or obtain the advice of knowledgeable counsel.
States that have passed medical marijuana legislation

Visit [www.webmd.com/a-to-z-guides/qa/what-us-states-have-legalized-medical-marijuana](http://www.webmd.com/a-to-z-guides/qa/what-us-states-have-legalized-medical-marijuana) for more information. The precise number of states cited may vary, depending on how one defines "legalization." For example, Iowa and Georgia are not on the list, but permit the use of cannabidiol oils, which are derivatives of marijuana.

Take the pledge!

Are you an ethical dermatologist? Let the world know.
Take the pledge and learn more at [www.aad.org/form/ethicspledge](http://www.aad.org/form/ethicspledge).
Some states also give greater leeway to physicians to recommend the use of marijuana at their own discretion, beyond the list of conditions specified in state law. For example, Maine permits a physician to recommend medical marijuana based solely on the physician’s professional opinion that the patient will benefit from its use. The District of Columbia, which has also decriminalized the personal, non-medical use of marijuana, defines “qualifying medical conditions” for the recommendation of medical marijuana as “any condition for which treatment with medical marijuana would be beneficial, as determined by the patient’s authorized practitioner.” By contrast, Virginia permits a physician to certify a patient for the use of medical marijuana “for treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use,” but limits the type of marijuana that can be recommended to cannabidiol (CBD) or THC-A oils only.

Finally, several states have legalized the recreational use of marijuana, such as California, Washington, and Colorado. Other states have “decriminalized” the use and/or possession of marijuana but vary in the details of what the law permits as well as applicable penalties, if any.

**Cannabis and dermatology**
Dermatologic conditions rarely appear on state lists of qualifying medical conditions for medical marijuana. Many states include cancer (which could include skin cancer) as a qualifying medical condition, but do not specify skin cancers, and may further limit recommendation for only terminal or end-stage cancers, creating a potential grey area for dermatologists. Georgia permits the use of low THC oil for a variety of conditions, including epidermolysis bullosa.

Some studies suggest that medical cannabis is helpful in treating atopic dermatitis (AD) or psoriasis. State laws typically do not include either condition, however, meaning that dermatologic recommendation of medical marijuana may only be appropriate in states like Maine or in the District of Columbia, which give physicians broader latitude in recommending medical marijuana for their patients. To further complicate matters, marijuana-based treatment for AD or psoriasis usually involves a topical cream, which may conflict with some state laws that require only the use of certain oils (e.g., Virginia, Georgia). Thus, dermatologists may be prevented from recommending a more effective treatment.

**Additional concerns**
There are more concerns beyond simply navigating the legal risks associated with recommending the use of medical marijuana. Physicians must also consider the implications both of their own staff using medical marijuana, or even their own personal use.

Physicians considering personal use of marijuana — either for medical or recreational reasons — should carefully consider whether their employers have policies prohibiting such activity. Similarly, medical staff bylaws may require drug testing as a condition of maintaining privileges. At the very least, physicians should consult with their employers and heads of medical staffs to find out what is permitted, and whether exceptions can be made. Likewise, they may want to consult with state medical licensure boards (or knowledgeable counsel on their behalf) to determine the board’s position on marijuana use by a physician.

Physicians who operate their own practices should similarly consider the risks of permitting employees — especially clinical staff — to use marijuana, either medically or recreationally. Even if the employee is not actively impaired when interacting with patients, laws permitting marijuana usage are recent enough that the standard of care in the medical community is unlikely to have changed. This, in turn, could raise potential malpractice implications if a patient is harmed by an employee who uses marijuana. In the coming years, standards may change, as malpractice cases directly address such use, but until that point, employers are operating without clear guidance, and may instead choose to err on the side of caution by prohibiting even otherwise legal marijuana use. Physicians considering such policies should also consult an attorney to determine whether state laws protect employees from discrimination based on medical marijuana use.

**Conclusion**
Marijuana use is likely to increase in the coming years, as more states allow for its medical and/or recreational use. Physicians considering recommending marijuana to their patients should carefully examine applicable state laws to know their own requirements. Likewise, physicians should consider how marijuana use will impact their own practices, or their work in hospital settings. Consulting with knowledgeable legal counsel will help in this regard. dw

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In 2017, Warren Heymann, MD, addressed the growing use of cannabinoids in medicine. Visit aad.org/dw and search “cannabinoid” to read his commentary.
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#DermTwitter

@ a glance

Dermatologists harness the twittersphere for clinical discussion, patient education, and more
Among the now 321 million Twitter users currently on the platform, a core group of dermatologists have carved out their own growing niche. This online community, otherwise known as #DermTwitter, has come together to form its own online journal club to exchange clinical insights, discuss emerging research, and yes, post the occasional meme.

Following a larger trend in medicine, this journal club — @DermatologyJC — follows in the footsteps of other specialties such as oncology, rheumatology, and dermatopathology, among others, to harness the platform as a truly “open access” discussion forum. As the medical community’s discourse continues to trend toward the digital, #DermTwitter pioneers and enthusiasts talk this month with Dermatology World about social media’s potential as a tool to:

• Share clinical insights
• Connect and collaborate with colleagues in and outside of dermatology
• Improve public health literacy and debunk harmful messaging
Twitter trendsetters

Despite the larger medical community’s embrace of Twitter (#medtwitter), dermatology has had a slower start on the platform. “It’s true, dermatology has a limited presence on Twitter, especially compared to fields that seem to be actively using it, like emergency medicine and pathology,” said David Harker, MD, [@HarkerDavid] a dermatology resident at the University of Texas Southwestern Medical Center, who discovered Twitter during his fourth year of medical school. Initially tweeting tips for succeeding on board exams and advice about medical school, Dr. Harker noticed his dermatology-focused tweets were extremely popular. “The attention they got made it apparent I was filling a space that was still relatively empty. I also found, surprisingly, that corny jokes that would only draw groans in person were re-tweet rockets on Twitter,” he said. “Now I find people often follow me initially for the humor but stay for the derm pearls!” With more than 5,000 followers on the platform, Harker is part of a still relatively small but mighty community of dermatologists utilizing the platform to engage with each other and the public.

Roxana Daneshjou, MD, PhD, (@RoxanaDaneshjou) also saw a gap in the online dermatology space, prompting her to launch the @DermatologyJC journal club last April. “I used to live-tweet conferences and started following a lot of physicians when I started residency, most of them outside dermatology,” she said. “Oncology, rheumatology, even dermatopathology has a pretty large presence on Twitter with their own journal clubs.” Now, the group virtually “meets” once a month at the same date and time to discuss a specific study selected either by Dr. Daneshjou or other members. Participants can join the discussion by including the group’s designed hashtag (#DermJC) in their follow-up questions and comments. “The way that it works is we post what the paper that month will be ahead of time, and then on the third Wednesday of the month, at 9:00 pm Eastern, people will log on, and introduce themselves with the hashtag included,” explained Dr. Daneshjou. “So then on Twitter when you click the hashtag, you can follow all the latest tweets in the discussion.”

While between 10 to 20 users tune in each month for discussion, Dr. Daneshjou said participation is growing as awareness of the journal club builds among new and future dermatologists. “Right now, it’s primarily academic faculty and residents, although we’ve definitely had a few people who are in private practice also,” she said. “Recently I talked to some medical students who had wanted to participate but didn’t realize it was ok for them to. So we’ve had more medical students participating as well.”

Although the medical dermatology community on Twitter remains relatively small, the space is poised for growth, suggested Steven Chen, MD, MPH, (@DrStevenTChen) assistant professor of dermatology at Harvard Medical School. “I think it has rapidly changed over the last year in terms of the number of people joining the conversation,” he said. “There are people who are more about telling jokes, and people who are on Twitter purely to talk about research. There are also people who are there mainly to teach, and that’s what really hooked me in.”

Follow the AAD on Twitter

Keep up with the latest from the AAD by following @AADmember on Twitter. Want to hear directly from AAD President George Hruza, MD, MBA? Follow @AADpresident.

Sharing clinical knowledge

Fans of #DermTwitter praise the platform not only for its ability to facilitate open discussion — but also for broadening access to emerging research and trends within the field. “I might give a lecture to a single department of 30 to 50 people at grand rounds, or speak at the AAD Annual Meeting to a room of 300 people, but on Twitter it can amplify those talks to thousands,” said Misha Rosenbach, MD, (@MishaRosenbach) associate professor of dermatology and internal medicine at the University of Pennsylvania. Beyond opening doors to a vastly wider audience, Twitter also has the capacity for more direct and candid discussion with researchers. “The journal club has been a really interesting experience because you can engage with the study authors — or as an author myself of one of the studies @DermatologyJC previously discussed — I could hear questions and realize what our paper did a good job versus a not-as-good job of explaining to readers,” he adds.

Adewole Adamson, MD, MPP, (@AdeAdamson) dermatologist and assistant professor of internal medicine at the University of Texas at Austin, agrees that newfound
access to study authors is one of the key parts of @DermatologyJC’s appeal. “During discussion, sometimes patients and trainees chime in, but what I think is most amazing is when the authors themselves are commenting about their study. You can engage in real-time with folks. You can post screenshots from the paper being discussed, or links to other articles to bolster the discussion,” he said. “I think Twitter is probably the ideal platform for the exchange of ideas.”

Beyond clinical discussion, Twitter has also proved to be a useful way for dermatologists to exchange practical applications of new findings, said Allison Larson, MD, (@AllisonLarsonMD) assistant professor of dermatology at Boston University School of Medicine. “We have both academic and community practice providers in the #DermTwitter community, so there are a number of people who go beyond the evidence in the article to say, ‘How are people using this? Are you incorporating this, or using that?’ We get very quickly down to the nitty-gritty reality of what each of us are doing and why,” she said. “The neat thing is that we each take care of a different patient population with different needs, and it’s really helpful to be able to compare and contrast how each person is incorporating the evidence into their practice, and it helps us all to think about what we could be doing better for our patients.”

Despite Twitter’s reputation for having an occasionally shaky relationship with the truth, #DermTwitter participants say that internal vetting among physicians helps keep the conversation on track. “You can certainly try to make stuff up, but the nice thing about Twitter is that it kind of polices itself,” explains Dr. Chen. “Other physicians are going to come and correct you on the things you miss, so there’s certainly pressure to give out good information because people will call you out on it.”

**Education for non-dermatologist physicians**

Dr. Chen has also had success with Twitter as a tool for amplifying key dermatology learning to a variety of different audiences including non-dermatologist physicians and the general public. “I realized there was this need for dermatology education for the rest of #medtwitter that I could help fill in,” he said. Dr. Chen, who is board-certified in internal medicine and dermatology, began composing “tweetorials” on different topics initially aimed at providing internists or hospitalists with key information about common inpatient dermatologic diseases. “The first one I ever did was on Stevens-Johnson syndrome that was really geared toward hospitalists, trying to teach them what to look for in the event of a ‘derm emergency,’” he said. “I got an outpouring of interest from the internal medicine community. I’ve created a bunch now, some of which are

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**LIVE TWEET RESPONSIBLY**

While using Twitter during conferences (like the AAD Annual or Summer Meeting) can be a great way to share highlights and pearls from sessions in real-time, it also poses a new set of challenges when it comes to social media etiquette. Share and discuss meeting content responsibly on social media by following these key guidelines:

- Use the official meeting hashtag (such as #AAD2019) so speakers and other attendees can locate and engage with your posts
- Identify the speaker’s name and affiliation to give due credit
- Do not post pictures of slides without permission from the speaker
- Do not post pictures or slides with identifiable patient photos on them
geared toward internists, others toward medical students, and still others for dermatology residents. Much of what I put together for the non-dermatologist is with an intent to emphasize the wide scope of dermatology and why involving a board-certified dermatologist might be in their patient’s best interest. Put another way, I want our colleagues in #medtwitter to recognize when it’s time to ask a dermatologist for help.”

Dr. Adamson, who also utilizes tweetorials to educate other physicians, and the public, recently received national media attention this May when CNN took note of his popular tweetorial explaining a recent JAMA study on the safety of four common sunscreen ingredients (doi:10.1001/jama.2019.5586). “This provocative study in JAMA deserves a tweetorial,” explained Dr. Adamson, who used the format to help followers make sense of “the controversy and discuss sunscreen in general.”

Dr. Chen sources images for the tweetorials through free online databases, such as DermNetNZ.org, and said that overall the response to them has been robust. “I find it a very rewarding way to educate a broader audience. If I get up and give a talk, maybe there are 50 people there, and half of them are eating lunch — you don’t know how much is getting through,” he said. “Whereas the last tutorial I tweeted out on cellulitis had more than 30,000 impressions. You’re just really expanding the exposure of your teaching, and hopefully, educating others about the importance of dermatology in the house of medicine.”

**Bite-sized learning**

While Twitter’s original 140-character limit is no more (expanded in 2018 to a verbose 280 characters), the platform is still known for being notoriously short-form. However, according to its fans, the brevity of the platform is an advantage, rather than a detriment. “While the brief nature of tweets may seem a limitation, I think it just hones your writing ability, and allows you to consume bite-size, easily digestible pearls of medical knowledge as papers are discussed or clinical points outlined,” said Dr. Harker. “I find myself frequently saying in clinic, ‘So I saw this paper discussed on Twitter...’”

Dr. Chen agrees that being able to convey critical information in just a few tweets is ideal for the audience of busy physicians he’s trying to reach. “I like Twitter because it’s a very novel way to teach,” he said. “It’s a great way for the learner to get these little nuggets of information, and you can read through the whole thing in maybe five minutes. Twitter can also be really interactive; you can add polls; people can answer questions; you can make it more entertaining by adding gifs, or high-yield by citing literature.”

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**Social media in medicine**


**Connecting with other physicians**

“From the dermatology perspective, it’s great to be able to connect with other academicians to see what people are working on, and what research has caught other people’s attention,” said Dr. Larson, who indicated that the platform has actually generated several collaborative research projects. “Collaborations typically happen with people at your institution or neighboring institutions. You don’t always know who’s doing what elsewhere, but with Twitter, you can find out and form collaborations that aren’t limited by geography.”

Outside of the specialty, the journal club has helped foster connections with other members of the medical community that the average dermatologist might not otherwise engage with. “The really neat part for me is all the interactions we have with other specialties,” said Dr. Daneshjou. “We actually did a joint journal club with nephrology discussing a paper that looked at immunosuppression in renal transplant patients, and the risk of skin cancer in those patients. Nephrologists and dermatologists probably don’t talk that often in real
life, but that’s another big thing that drew me to Twitter, because once you graduate from medical school and go into residency, you don’t have as many opportunities to interact and learn from other specialties.”

Dr. Rosenbach agrees. “It’s been a wonderful way to connect with dermatologists at other institutions, and other medical specialists around the world. I have had some discussions on Twitter that I would never have been able to engage in without the medium, such as regarding residency applications and USMLE scores, with folks from different subspecialties that actually prompted a suggestion for an upcoming session that will take place at the Association of Professors of Dermatology meeting this fall.”

It is for this reason that Dr. Adamson said, “I’m like an evangelist when it comes to Twitter, especially to all the trainees and young faculty I interact with. For me personally, it was one of the most important decisions I made professionally. People think I’m nuts for saying that, but I’ve been able to talk with journalists, collaborate with people at different institutions, and take part in joint journal clubs with specialists in other fields. I would encourage folks, especially trainees, to get on Twitter and join the conversation because it gives you one-on-one access to some really awesome academic dermatologists.”

Educate the public

While the internet is rife with health misinformation, members of the #DermTwitter community see the platform as an opportunity to improve public health literacy. “This is one area where dermatologists could provide such valuable contributions,” said Dr. Harker. “The internet, and Twitter in particular, is fraught with misinformation about skin disease and the promotion of useless or even potentially harmful skincare products. Fortunately, more dermatologists seem to be recognizing the value of Twitter and are helping #DermTwitter become a force to become reckoned with.”

Dr. Rosenbach is slightly more cautious, however. “I think #medtwitter and #DermTwitter could absolutely help educate the public. Unfortunately, misinformation machines are often more robust. See for example, the online debate about vaccinations and the power of online anti-vaxx groups,” he explained. Dr. Chen agrees. “The hard part with Twitter is that everyone’s voice is equal. There’s nothing that grades which tweet is more accurate, and there are a lot of voices on Twitter that are spreading messages that are less than positive, some of which are just incorrect,” he said. “However, I think we as a community of medical-trained, board-certified dermatologists can do our part to raise awareness of the science behind the things we do, so we can try to move the needle in whatever way we can toward the truth and better health for our patients.”

Dr. Adamson, who frequently engages with his more than 2,500 Twitter followers on both research-focused and more broadly public-facing topics, said, “I think people are susceptible to soundbites and clickbait. If you don’t have dermatologists involved in what’s getting out there in social media — which is where a lot of people get their information — then I think we’re doing a disservice to our specialty because we have a lot of valuable information and insights we can share with the public.”

JOIN JAAD JOURNAL CLUB

If Facebook is your social media outlet of choice, you can still participate in an online journal club discussion. Join the JAAD Journal Club at www.facebook.com/groups/JAADJournalClub/.
No two dermatologists are alike? I beg to differ.

Dermatologists are an exceptional bunch. From melanoma, to alopecia areata, to onychomycosis, we treat a massive number of skin, hair, and nail diseases. Our members’ interests may include cosmetic procedures, Mohs surgery, complex medical dermatology, dermatopathology, and/or pediatric dermatology. We also practice in a variety of settings — from solo private practice to academic institutions, integrated medical systems, multispecialty groups, or private equity-backed practices among others. While we are all part of this one great specialty, one might think that no two dermatologists are alike. However, I would argue that we are more alike than we are different, in that we all care about doing what’s best for patients. When we come together as a specialty, we accomplish great things.

I can think of many examples in recent history that prove my point. Last year we learned that the dermatology delegation to the AMA House of Delegates (HOD) was on the brink of losing some of its representation in the HOD. Regardless of your sub-specialty within dermatology, or if you are in a private practice or academics, your concerns are represented at the national level through the Academy’s delegation and the Dermatology Section Council at the AMA HOD, so full dermatology representation in the HOD is a must for us. The Academy put out a call to members asking them to help dermatology retain its full representation in the AMA by joining or renewing their AMA membership. You heard our call and took action. As a result, we recently learned that dermatology has retained its representation in the HOD. Thank you for your support and for coming together to help us achieve this great success.

In addition to solidifying our voice in the house of medicine, as many are aware, dermatologists have been working with the United States Pharmacopoeial Convention on its revisions to Chapter 797 on compounded sterile preparations in the office. The Academy joined forces with some of our sister societies — the American College of Mohs Surgery, the American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery — along with the American Medical Association, to work with USP on the chapter revisions. As a unified force, we met with the USP several times to stress the importance of access to buffered lidocaine for dermatology patients to reduce pain of anesthesia, and the need for physicians to prepare buffered lidocaine ahead of patient visits to facilitate access and avoid interruption of longer procedures such as Mohs surgery.

The Academy, in lockstep with these other dermatology societies, also adopted a joint position statement, in record time, on how lidocaine should be safely buffered and prepared in-office, and we are now working together with USP on safety studies to demonstrate the safety of buffered lidocaine. A lot of collaborative work has gone into addressing this critical issue, and I believe that our collective efforts will make a difference. While not yet fully resolved, I am cautiously optimistic.

These are just a few examples that demonstrate that when dermatologists put their heads together, there’s no telling how much we can accomplish. Therefore, the Academy’s new strategic plan will prioritize ‘unity of the specialty’ as one of its strategic goals, which we will strive to reflect in all of the Academy’s initiatives and programs. In an interview with Dermatology World Weekly, my fellow Board member, Seemal R. Desai, MD, gives a comprehensive overview of how “unity of the specialty” impacts our members. Read it at www.aad.org/dw/dw-weekly/unity-in-dermatology-starts-with-putting-patients-first.

At the end of the day, while we all have our own clinical interests, and practice in different subspecialties and practice settings, I would argue that we are more alike than we are different, and when we unify, anything is possible. dw
Recognizing the increasing presence of augmented intelligence (AuI) in medicine, and dermatology in particular, the Academy has adopted a position statement that addresses AuI and its role in medicine.

In the position statement, the American Academy of Dermatology Association indicated its support for AuI that enables the delivery of high-quality patient care by enhancing the physician/patient relationship, stating that focusing on artificial intelligence’s assistive role reinforces the synergy that results when human intelligence — or in-person physician care and expertise — is combined with machine learning technology.

The position statement also provides a framework for future directions in the development of AuI including education, privacy issues, and advocacy, stating, “Effective and ethical development and implementation of AuI will require continuous engagement, education, exploration of privacy and medical-legal issues, and advocacy.”

**What is the Academy doing to address the increasing development of augmented intelligence in medicine?**

*Dermatology World digs into an issue that is affecting the specialty and discusses the Academy’s key activities to address and advocate on the issue.*

Want to learn more about the Academy’s position statement on AuI?

- Read the Academy’s full position statement on augmented intelligence at [www.aad.org/Forms/Policies/ps.aspx](http://www.aad.org/Forms/Policies/ps.aspx).
- Read more from Justin Ko, MD, chair of the Academy’s Ad Hoc Task Force on Augmented Intelligence in *Dermatology World Weekly*, where he discusses the challenges and opportunities ahead with AuI at [www.aad.org/dw/dw-weekly/augmented-intelligence-position-statement](http://www.aad.org/dw/dw-weekly/augmented-intelligence-position-statement).
I’m retiring and want to sell my practice. Does the Academy have any resources to help?

Yes! We offer the following resources to assist AAD members who are considering closing their practices:

- The AADA’s Practice Management Center breaks down:
  1. How to value your practice, with a detailed explanation of how to calculate EBITDA (Earnings Before Interest, Taxes, Depreciation, and Amortization)
  2. What to consider before selling your practice to a private-equity backed group
  3. 5 essential contract tips

Get these resources and more at www.aad.org/selling-your-practice.

- Consult the Academy’s newly revised Valuing, Selling, or Closing a Dermatology Practice Manual for tips on how to evaluate your practice’s worth, key strategies for a successful sale, and advice on meeting requirements for record retention, staff or patient notification, legal, and accounting. For more information, visit store.aad.org/products/8000.

Moving or closing practices? Here’s what you need to know.

The Academy’s manager of practice management, Faiza Wasif, MPH, offers a comprehensive checklist to help you keep track of all the details involved with closing or moving practices. Read more at www.aad.org/dw/monthly/2018/december/moving-or-closing-practices-heres-what-you-need-to-know.

The Hill 90D Dermatology Chair offers an impressive list of features compared to other models and with quality you’d expect from a fourth generation company. Electric height, power lift-back, manual adjustable foot section, adjustable headrest and up to 600 lb. lift capacity are all standard. Add options like electric tilt and foot sections, removable armrests, contour cushions and matching stool to make the 90D the perfect solution for your practice.

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1-877-445-5020
www.HillLabs.com
The American Academy of Dermatology Nominating Committee seeks nominees for the offices of President, Vice President, Board of Directors, and Nominating Committee Member Representative (West Region). For the 2020 AAD Election the president-elect and vice president-elect candidates will participate in the following activities:

- President-elect and vice president-elect:
  - town hall during the Annual Meeting in Denver
  - post-election videochat interview with successful candidates

- President-elect:
  - pre-election videochat interview
  - five (5) minute speech on March 22 during the Annual Business Meeting

Submit nominations / Complete nominee materials / View reference materials
www.aad.org/aadnominations

### REQUIREMENTS

**President-elect**
- Must have served 1 year on Board of Directors
- Fellow in good standing
- 4-year commitment
- Must divest
- Term begins close of 2021 Annual Meeting

**Vice President-elect**
- Must have served 1 year on Board of Directors
- Fellow in good standing
- 3-year commitment
- No divestment
- Term begins close of 2021 Annual Meeting

**Board of Directors**
- Fellow in good standing
- 4-year commitment
- No divestment requirement
- Terms begins close of 2021 Annual Meeting

**Nominating Committee Member Rep.**
- 2-year commitment
- Must be from Western Region
- Term begins close of 2020 Annual Meeting

The Administrative Regulation on Nomination and Election Procedures requires that nominees submit all required materials to the Nominating Committee no later than Oct. 1.

For more information, contact the AAD Executive Office at callfornominations@aad.org or (847) 240-1046.

### NOMINATING COMMITTEE

<table>
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<tr>
<th>Name</th>
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<tr>
<td>Dirk M. Elston, MD, FAAD</td>
<td>Chair</td>
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<td>Robert T. Brodell, MD, FAAD</td>
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<td>Wilma F. Bergfeld, MD, FAAD</td>
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<td>Robert D. Durst Jr., MD, FAAD</td>
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<td>Marc D. Brown, MD, FAAD</td>
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<td>Kevin M. Crawford, MD, FAAD</td>
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<td>Mark Lebwohl, MD, FAAD</td>
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### UNAUTHORIZED MEMBER ACTIVITIES

No member of the American Academy of Dermatology shall directly contact any member of the Nominating Committee regarding nominees under consideration. Any lobbying of committee members may eliminate the nominee from consideration by the Nominating Committee.

No nominee, slated nor write-in candidate[s], may engage in any campaign activities prior to the official announcement of the slate of candidates on February 25, 2020. Both slated and write-in candidates should discourage others from campaigning on their behalf prior to the slate announcement. Violation of this rule may result in disqualification of the candidate.
Apply today for Academy leadership programs

In order to encourage dermatologists to take leadership roles in their specialty going forward, the Academy is seeking applicants for three leadership programs in 2020.

Leadership Forum

The 2020 Leadership Forum will bring together aspiring leaders in dermatology with experienced mentors to enhance their communication and leadership skills. The event will take place May 1–3, 2020, at the Eaglewood Resort near Chicago. Aspiring leaders will engage in an interactive program with colleagues and Academy leadership, and will learn critical competencies for physician leaders, including self-assessment and leveraging innate skills. It is open to dermatologists in both private-sector practice and academic settings. The Academy will provide travel and lodging expenses, as well as on-site meals for the Leadership Forum. Applications will be open July 1 through Oct. 1, 2019. For more information on the 2020 Leadership Forum, visit www.aad.org/LeadershipForum.

Academic Dermatology Leadership Program

The Academic Dermatology Leadership Program is facilitated by the Academy to provide physicians in academic settings the resources to meet the unique challenges of life in academia. A total of 18 Academy members will be chosen to participate in this highly selective program, which includes informative sessions at both the annual and summer AAD meetings, participation in the 2020 Leadership Forum, and opportunities to connect with an experienced mentor. This program requires a year-long commitment of between five and eight hours per month in addition to the on-site sessions. Applications will be open from July 1 through Oct. 1, 2019. For more information on the Academic Dermatology Leadership Program, visit www.aad.org/ADLP.

Advanced Leadership Forum

The Academy also offers an Advanced Leadership Forum designed for mid-career level dermatologists. The event will take place May 1–3, 2020, at the Eaglewood Resort near Chicago, in conjunction with the Leadership Forum. Applications are open to all dermatologists, especially those with a particular interest in developing leadership skills that are transferrable to both practice and advocacy settings. Eligibility requirements include the member being 10 years out of residency training or six years past Leadership Forum attendance. Applications will be open from July 1 through Oct. 1, 2019. For more information on the Advanced Leadership Forum visit www.aad.org/AdvancedLF.

Last chance to register for the 2019 AADA Legislative Conference

Registration for the 2019 AADA Legislative Conference, Sept. 8-10, in Washington, D.C., at the Willard Inter-Continental hotel, is still open at www.aad.org/advocacy/legislative-conference. The Legislative Conference is dermatologists’ premier opportunity to learn about issues and legislation that could affect the specialty’s future, receive expert advice on how to deliver messages to legislators, and help advance the specialty’s legislative priorities by meeting directly with members of Congress and their staff. Don’t wait: Registration will only be open until Aug. 9.

The program will contain policy-focused breakout sessions — designed to offer an in-depth understanding of the issues participants will present to Congress on the final day of the Conference. Break-out sessions will involve didactic discussions and hands-on training from a panel of health policy experts, AADA staff, and experienced member advocates, which will cover all aspects of the legislative process. Additionally, the Conference offers a mentoring program that matches new advocates with an AADA leader to help guide them through their Capitol Hill experience. The AADA will schedule all the Capitol Hill meetings and provide background materials and briefing information so you can be fully prepared to meet with your members of Congress.

Read more about the conference and check out the speakers and agenda for the event at www.aad.org/legislative-conference. - SUSIE DUMOND

Leaves policy on AAD/A meeting conduct

At the March 2019 Academy Board of Directors meeting, the Board approved a member conduct policy to ensure a professional and collegial environment for Academy/Association (AAD/A) meetings and other activities. View the policy at www.aad.org/Forms/Policies/Uploads/Members/GP-%20-%20Conduct%20at%20AAD-A%20Meetings%20and%20Other%20AAD-A%20Activities.pdf.
AADA Board approves position statement on augmented intelligence

The American Academy of Dermatology Association Board of Directors approved a position statement on augmented intelligence at its May 18 meeting. The AAD Board approved a position statement on “dermatology residency and fellowship training nomenclature exclusivity for U.S. based dermatology residents and/or fellows.” Those position statements are available at www.aad.org/Forms/Policies/ps.aspx. Learn more about the augmented intelligence position statement in a recent DW Weekly article at www.aad.org/dw/dw-weekly/augmented-intelligence-position-statement.

The Academy Board also approved edits to the administrative regulations on conflict of interest disclosure and on appropriate use criteria. It converted the Diversity Task Force into the Diversity Committee and sunset the Member Recognition Committee, moving its programs to the Council on Member Services. The AADA Board converted the Grassroots Advocacy Workgroup into the Grassroots Advocacy Task Force.

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• https://clinicaltrials.gov/ct2/show/NCT03703310
FULL-TIME FACULTY

Brown Dermatology is recruiting full-time faculty for the 2020 academic year. Candidates must be board-eligible/board certified in dermatology, and eligible for appointment at Brown at the level of Assistant Professor, Associate Professor, or Professor. We seek enthusiastic general and procedural dermatologists looking to build and further their careers in a highly supportive environment! We are the only academic dermatology service in the State of Rhode Island, and the largest group providing comprehensive dermatologic care in the region extending to Southern Massachusetts and Northern Connecticut. Our patient-mix is broad, transcending general dermatology and complex medical and procedural dermatology. We take pride in our growing dermatopathology service and our expanding Division of Pediatric Dermatology. We are also extremely proud of our faculty who lead community-outreach programs regionally (Rhode Island Free Clinic) and internationally (Jordan and Kenya). There are myriad teaching opportunities available to faculty across two dermatology residency training programs in the State (Rhode Island Hospital and Roger Williams Medical Center) and through advanced fellowships in development, e.g., Dermatology-Rheumatology/Complex Medical Dermatology Fellowship. The Clinical and Translational Research Program within the Department provides core services to all faculty including support with study design and biostatistics, IRB application preparation and submission and grant submissions. Our clinical trials unit is growing rapidly and highly supportive of faculty interested in leading trials.

Located in Providence, the historic ‘creative capital’ of Rhode Island, Brown University was founded in 1764 and is an Ivy League university offering a world class college, graduate school, medical school, school of public health, and school of engineering. Affiliated with multiple area hospitals within Lifespan and in other systems, including Care New England (Memorial Hospital of RI, Women & Infants Hospital) and the Providence VA Medical Center, we offer a large variety of patient care and research opportunities. Faculty will receive appointments from Brown University’s Warren Alpert Medical School and Rhode Island Hospital/Hasbro Children’s Hospital/Miriam Hospital.

Interested candidates should send a brief letter of interest and curriculum vitae to Abrar A. Qureshi, MD, MPH, Professor and Chair, Department of Dermatology, Warren Alpert Medical School and Rhode Island Hospital/Miriam Hospital via katarzyna_lada@brown.edu.

EOE/M/F/Vets/Disabled

FULL-TIME FACULTY with SURGICAL EXPERTISE

The Department of Dermatology at the Warren Alpert Medical School of Brown University is recruiting full-time faculty with surgical expertise for the 2020 academic year. Candidates must be board eligible/board certified in Dermatology, have completed a fellowship in Mohs micrographic surgery, and be eligible for appointment at Brown at the level of Assistant Professor, Associate Professor, or Professor. We seek enthusiastic surgical dermatologists looking to build or further their careers in a supportive environment. Brown has an established multidisciplinary partnership involving collaboration from the Departments of Dermatology, Oncology, Radiation Oncology, Plastic and Reconstructive Surgery, Head and Neck Surgery and Dermatopathology. An interest in cosmetic dermatology and lasers can also be accommodated. The Department has a strong research core in dermatoepidemiology and biostatistics that has fostered substantial advances in the field. Teaching of residents and medical students and research interests, including clinical trials, are encouraged.

Located in Providence, the historic ‘creative capital’ of Rhode Island, Brown University was founded in 1764 and is an Ivy League university offering a world class college, graduate school, medical school, school of public health, and school of engineering. Affiliated with multiple area hospitals within Lifespan and in other systems, including Care New England (Memorial Hospital of RI, Women & Infants Hospital) and the Providence VA Medical Center, we offer a myriad of patient care and research opportunities. Faculty will receive appointments from Brown University’s Warren Alpert Medical School and Rhode Island Hospital/Hasbro Children’s Hospital/Miriam Hospital.

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Dermatology Associates of Lancaster is looking for BC/BE general dermatologists, FT or PT and a Mohs surgeon. Great opportunity to join a 7-physician and 3 mid-level provider office. Dermatopathology and Mohs surgery available on site as well as cosmetics, laser, and phototherapy. Lancaster is a vibrant city with a growing cultural downtown. Contact Marcia Gephart, Practice Manager at (717) 509-5698 or mgephart@dermlanc.com.

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BC Dermatologist wanted for skin cancer screenings 1 day per month in Concierge practice. Saturdays best. Must have CT license and independent malpractice insurance. Could evolve into full time for right applicant in CT or Westchester. No aesthetics. Email conciergemdofct@gmail.com.

GREENVILLE, MISSISSIPPI
Great opportunity for FT dermatologist. Contact Karey, (866) 488-4100 or email inquiries to dermatologist@mydermgroup.com.

RENO, NEVADA
Associate Opportunity. Contact Karey, (866) 488-4100 or email inquiries to dermatologist@mydermgroup.com.

CHEVY CHASE, MARYLAND
Partnership available. Established practice. Contact Karey, (866) 488-4100 or email inquiries to dermatologist@mydermgroup.com.

MONTROSE, COLORADO
Part time opportunity for 2 days/wk. Contact Karey, (866) 488-4100 or dermatologist@mydermgroup.com.

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Phone: (847) 240-1770
The doctor will see you...soon?

By Emily Margosian, Assistant Editor

As efforts to improve access to dermatologic care remain ongoing (Read Dermatology World’s 2017 feature “Access Granted” at www.aad.org/dw/monthly/2017/october/access-granted for strategies to broaden patient access), how long can the average patient expect to wait to see a dermatologist? According to 2017 AAD Practice Profile Survey data, dermatology wait times vary according to practice setting and patient type. Multispecialty and academic groups have the highest wait times, with new, non-emergency patients waiting on average up to 60 days for an appointment. Dermatology groups and solo practices had lower wait times, with new, non-emergency patients waiting on average up to 30-40 days for an appointment.

Across all patient types, new, non-emergency patients experience the highest wait times, with more than 29% waiting more than four weeks for an appointment on average. Whereas established, non-cosmetic surgical patients have some of the best wait times, with 59% able to see their dermatologist in two weeks or less. For a more detailed breakdown of dermatology wait times according to patient type see the chart below.

---

Estimated wait time by patient type

- **36 DAYS**
  - New patient, non-emergency

- **21 DAYS**
  - Established patient, non-emergency

- **26 DAYS**
  - New patient, non-cosmetic surgical

- **16 DAYS**
  - Established patient, non-cosmetic surgical

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