Dermatologists undaunted by INDOOR TANNING industry’s claims

Under-18 bans, public education campaigns move forward
Break the Cycle of Inflammatory Rosacea With Oracea®

The only FDA-approved oral treatment—
Formulated for an effective anti-inflammatory response

Oracea® is the #1 ROSACEA BRAND among dermatologists2

Important Safety Information
Oracea® is indicated for the treatment of only inflammatory lesions (papules and pustules) of rosacea in adult patients.

In clinical trials, the most common adverse events reported were nasopharyngitis/pain, gastrointestinal upsets, hypertension, and nasal congestion/sinusitis. Oracea® should not be used to treat microbial infections, and should be used only as indicated. This drug is contraindicated in people who have shown hypersensitivity to any of the tetracyclines, and, like other tetracycline drugs, may cause fetal harm when administered to a pregnant woman. Oracea® should not be used during pregnancy, by nursing mothers, or during tooth development (up to the age of 8 years). Although photosensitivity was not observed in clinical trials, Oracea® patients should minimize or avoid exposure to natural or artificial sunlight.

All contraindications, warnings, and precautions associated with tetracyclines must be considered before prescribing Oracea®. The efficacy of Oracea® beyond 16 weeks and safety beyond 9 months have not been established.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.

**INDICATIONS AND USAGE**

**ORACEA** is indicated for the treatment of only inflammatory lesions (papules and pustules) of rosacea in adult patients. The usage of **ORACEA** differs from that of doxycycline used to treat infections. To reduce the development of resistant bacteria as well as to maintain the effectiveness of other antibiotic drugs, **ORACEA** should be used only as indicated.

**CLINICAL PHARMACOLOGY**

**Pharmacokinetics**

**ORACEA** capsules are not bioequivalent to other doxycycline products.

**CONTRAINDICATIONS**

**ORACEA** is contraindicated in persons who have shown hypersensitivity to doxycycline or any of the other tetracyclines.

**WARNINGS**

**Teratogenic effects:** 1) Doxycycline, like other tetracycline-class antibiotics, can cause fetal harm when administered to a pregnant woman. If any tetracycline is used during pregnancy or if the patient becomes pregnant while taking these drugs, the patient should be informed of the potential hazard to the fetus and treatment stopped immediately.

**CONTRAINdications:**

**ORACEA** should not be used during pregnancy (see PRECAUTIONS: Pregnancy)

2) The use of drugs of the tetracycline class during tooth development (last half of pregnancy, infancy, and childhood up to the age of 8 years) may cause permanent discoloration of the teeth. Therefore, these drugs should not be used in these patients unless other drugs are not likely to be effective or are contraindicated.

3) All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in tibia growth rate has been observed in premature human infants given tetracycline in doses of 25 mg/kg every 6 hours.

**Pseudomembranous colitis:**

This diarrheal disorder may occur following antibiotic therapy, especially tetracycline therapy. The above criteria should be considered in patients who present with diarrhea during or after use of antibacterial agents, especially tetracyclines.

**Gastrointestinal effects:**

The following adverse reactions have been observed in patients treated with **ORACEA** for various indications (see PRECAUTIONS: Gastrointestinal effects).

**Photosensitivity:**

Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Although this was not observed during the duration of the clinical studies with **ORACEA**, patients should be warned to avoid exposure to the sun or ultraviolet light. Skin and oral photoproduction may be reduced by wearing protective clothing and using sunscreen preparations.

**Photosensitivity:**

Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Although this was not observed during the duration of the clinical studies with **ORACEA**, patients should be warned to avoid exposure to the sun or ultraviolet light. Skin and oral photoproduction may be reduced by wearing protective clothing and using sunscreen preparations.

**Pseudomembranous colitis:**

This diarrheal disorder may occur following antibiotic therapy, especially tetracycline therapy. The above criteria should be considered in patients who present with diarrhea during or after use of antibacterial agents, especially tetracyclines.

**Hypersensitivity reactions:**

Urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, serum sickness, and rarely, erythema multiforme major have been reported. Hypersensitivity reactions may occur following topical administration as well as oral administration. Photosensitivity is discussed above. (see CLINICAL PHARMACOLOGY).

**Microbiology**

**DOSAGE AND ADMINISTRATION**

**ORACEA** is indicated for the treatment of adults with moderate to severe inflammatory lesions (papules and pustules) of rosacea. The recommended daily dosage of **ORACEA** for the treatment of rosacea is 1 capsule (50 mg) orally once daily in the morning for 12 weeks.

**DOSAGE AND ADMINISTRATION**

**ORACEA** is indicated for the treatment of adults with moderate to severe inflammatory lesions (papules and pustules) of rosacea. The recommended daily dosage of **ORACEA** for the treatment of rosacea is 1 capsule (50 mg) orally once daily in the morning for 12 weeks.

**OVERDOSAGE**

In case of overdose, discontinue treatment, treat symptomatically, and institute supportive measures. Doxycycline is excreted in the urine and may be removed by dialysis. No specific antidote is known.

**ADVERSE REACTIONS**

**Gastrointestinal events** have been reported rarely. Rare instances of eosinophilic and esophageal ulcerations have been reported in patients receiving the capsule forms of the drug. Patients should be instructed to discontinue the drug if esophageal symptoms occur.

**Renal toxicity:**

Risks of **ORACEA** use in renal impairment include altered serum concentration and increased systemic exposure to tetracycline. Therefore, in patients with moderate to severe renal impairment, dosage adjustment is not necessary. The incidence of diarrheal disorder is not increased in patients with renal impairment. In case of overdosage, discontinue medication, treat symptomatically, and institute supportive measures.

**Hepatotoxicity:**

Hepatotoxicity has been reported rarely.**
DEAR READERS,

Did you know that April is named for Aphrodite, the goddess of love and beauty?

The name of this month certainly fits in Philadelphia, since it is such a lovely time of the year. My garden shows its first signs of awakening with spring bulbs coming into their glory. The milder weather usually lets me return to the outdoor world, limited only by the frequent showers. And as I do, I am struck by the newness of it all. Despite having experienced many a spring, I find that each year is as delicious as ever. I especially looked forward to the spring’s arrival this year after having my taste buds whetted by being in San Diego in March. Suspect that I’m not the only one. It was a very successful meeting for me ... I enjoyed seeing many of you, and of course attending the lectures too. Hope that you also found it rewarding.

We start this month with another of our new columnists, Gilly Munavalli, MD, MHS, who will be writing for us on various technology topics. He talks to us about how to utilize your personnel in the world of the electronic health record. We all got good at the hand-off of paper charts, passing the often-storied tomes as a part of the passage into the exam room. But now re-learning that dance, so that it works effectively and efficiently in the digital age, is critical to each of us. Delegation of tasks is still possible, but electronic linkage of notes has become the new paradigm, and understanding the possible role of scribes vs. medical assistants is important. Hope that you like this new column and find it useful in your practice.

Spring also gives us a chance to take a new look at health care in Britain in our debuting international column. Each year we will be getting a chance to explore dermatologic care in three other parts of the world ranging from Europe to Asia to South America and Africa. We need to join forces with our brethren all over the world to figure out how to meet the needs of patients with skin disease. I found it really interesting to read about the evolving role of dermatologic specialist nurses in England, and to see how dermatologists there are using these nurses to manage the patient load. Their role as a bridge between primaries and the dermatology practices is especially intriguing, with these nurses often serving as the liaison for patients returned to the referring physicians and providing continuing clinical advice to these practices. While it would certainly be fun to travel to each place to add my two cents to these pieces, I know that we’ll all learn a lot hearing about dermatology around the world. Our next stop will be Brazil, so stay tuned.

Don’t limit your reading though to just these two. I personally loved reading the piece about tattoos. Didn’t surprise me to read that 40 percent of millennials are sporting these embellishments. For sport sometimes during a long day, I’ll ask patients why they chose their particular tattoo. Strikes me that it often was a fairly impulsive decision, or at least so they say. But the numbers are truly growing with people from grandmas to hipsters all sporting a personal statement. I’m just hoping my three millennials don’t surprise me with body art of their own. As the numbers are truly growing with people from grandmas to hipsters all sporting a personal state-

Enjoy your reading!

Gilly A. Munavalli, MD, MHS

DEPUTY EXECUTIVE DIRECTOR
Lakshmi Albu, BSN, ANP-BC

PUBLISHER
Eileen Murray, CAE

EDITOR
Lara Lowery

MANAGING EDITOR
Katie Domanowski

STAFF WRITER
Ronald A. Heinrics, CAE

DESIGN MANAGER
Ed Wantuch

EDITORIAL DESIGNER
Theresa Oliver

 Printed in U.S.A. Copyright © 2012 by the American Academy of Dermatology Association, 930 E. Woodfield Rd., Schaumburg, IL 60173-4729
Phone: (847) 330-0230 Fax: (847) 330-0050

MISSION STATEMENT: Dermatology World is published monthly by the American Academy of Dermatology Association. Through insightful analysis of the trends that affect them, it provides members with a trusted, inside source for balanced news and information about managing their practice, understanding legislative and regulatory issues, and incorporating clinical and research developments into patient care.

Dermatology World® (ISSN 10602445) is published monthly by the American Academy of Dermatology and AAD Association, 930 E. Woodfield Rd., Schaumburg, IL 60173-4729. Subscription price $48.00 per year included in AAD membership dues. Non-member annual subscription price $108.00 US or $120.00 international. Periodicals Postage Paid at Schaumburg, IL and additional mailing offices.

POSTMASTER: Send address changes to Dermatology World®, American Academy of Dermatology Association, P.O. Box 4014, Schaumburg, IL 60168-4014.
"It’s not an attack on the indoor tanning industry. It’s a concerted effort to help the public better understand how to protect themselves from the ravages of UV exposure.”

COVER STORY
DERMATOLOGISTS UNDAUNTED BY INDOOR TANNING INDUSTRY’S TACTICS
Under-18 bans, public education campaigns move forward
BY RUTH CAROL

20
WHICH WAY?
Physicians detail the considerations leading more of them to choose employment over independent practice
BY JOHN CARRUTHERS

26
REBELLION AND REMORSE
More Americans getting — and getting rid of — tattoos
BY JAN BOWERS

depts
02 FROM THE EDITOR

04 CRACKING THE CODE
Appropriate use of modifier 58.

05 ROUNDS
Drug shortages, ICD-10 delay.

06 ACTA ERUDITORUM
What is the best way to treat severe atopic dermatitis?

08 TECHNICALLY SPEAKING
Who should enter what info into your EHR?

10 IN PRACTICE
Dermatology in the United Kingdom.

33 FROM THE PRESIDENT

34 ACADEMY UPDATE
Election candidates announced, more.

36 ACCOLADES

40 FACTS AT YOUR FINGERTIPS
Advertising for dermatology practices.
DIRK M. ELSTON, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Elston, who serves as director of the Ackerman Academy of Dermatopathology in New York, has represented the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

I removed an atypical melanocytic lesion, but the margin was involved and I brought the patient in a week later for a re-excision of the site. Can I use modifier 58, even though the staged excision was not planned in advance?

Yes. Modifier 58 serves two major functions — it indicates a planned staged excision, and can also be used when the patient requires further excision because of a positive margin.

Modifier 58 indicates a staged or related procedure or service by the same physician during the postoperative (global) period. For most excisions, the global period is 10 days. There is a zero-day global period for a biopsy or shave, and a 90-day global period if an adjacent tissue transfer was performed. (Please note that an adjacent tissue transfer already includes excision of the lesion, so the initial excision would not be reported separately. The subsequent excision would be reported).

Appropriate uses for modifier 58 include:
- Reporting a staged procedure planned at the time of the original procedure.
- Reporting a staged procedure that is more extensive than the original procedure.
- Reporting definitive therapy following a diagnostic surgical procedure that included a global period (note: biopsy and shave have a zero-day global period).
- Reporting a second or related procedure during the postoperative period. This includes re-excision for a positive margin.

Inappropriate usage:
- Appending the modifier to services described in CPT as involving multiple sessions.
- Reporting the treatment of a complication related to the original surgery that requires a return to the operating room.
- Reporting an unrelated procedure during the postoperative period.

Remember that a 10-day global period begins at midnight after the procedure is performed. A 90-day global period starts at midnight the day before. When the staged or related second procedure is performed, the clock starts all over again (i.e: A new postoperative period begins at midnight after the second procedure).

Examples:

Correct use of modifier 58:
A patient undergoes excision of a squamous cell carcinoma (116xx) with a discussion by the physician and the patient that after histologic examination, there may be a need to re-excite the margins should they come back positive. The histologic examination report comes back stating the margins are positive, and the physician re-excises the lesion one week after the initial surgery. The subsequent procedure was related to the first procedure, even though it was not planned in advance. As it occurred during the 10-day global period, modifier 58 should be appended.

Correct use of modifier 58:
A planned staged excision is performed for a medium-sized congenital nevus. If the second stage is performed during the 10-day global period, modifier 58 should be appended.

Incorrect use of modifier 58:
A patient undergoes excision of a basal cell carcinoma. Several days later, he has to return to the operating suite to evacuate a large hematoma. Modifier 58 is not appropriate in the case of a return to the operating room because of a surgical complication. The correct modifier is 78.

Incorrect use of modifier 58:
A patient undergoes excision of a basal cell carcinoma. Seven days later, an unrelated abscess has to be incised and drained. The second procedure occurred during the global period, but was unrelated to the initial procedure. It would be inappropriate to report the procedure with modifier 58. Instead, it should be reported with modifier 79 (unrelated surgical procedure performed during the global period).

Incorrect use of modifier 58:
A patient undergoes biopsy of a basal cell carcinoma. Several days later, he returns to have the lesion excised. A biopsy has a zero-day global period, so it would be inappropriate to append modifier 58. No modifier is needed in this situation. dw
Concerns about drug shortages put pressure on FDA, Congress

Dermatologists across the country have reported shortages of a variety of treatments to the American Academy of Dermatology Association, including lidocaine 1 percent, fluocinolone/hydroquinone/tretinoin, bleomycin, and tetracycline. Oncologists recently sounded a similar alarm regarding methotrexate, a common cancer treatment that is also used for patients with psoriasis, which attracted the attention of the New York Times to the issue.

The AADA has communicated the concerns of members to both the Food and Drug Administration and Congress. The FDA has approved a foreign source to stave off the methotrexate shortage, and it has developed a list of actions it can take to address the larger problem of shortages, including asking manufacturers to notify the FDA of potential supply disruption and establishing a database to collect and analyze shortage information. The FDA has also indicated that it lacks the authority to require companies to provide such notification. Committees in both houses of Congress have conducted hearings about drug shortages, and have released a number of legislative bills to expand the FDA’s authority to require early disruption notification and require additional studies to identify long-term steps to mitigate shortages of vital drugs.

More information about the drug shortage issue, including the AADA’s letters to the FDA and Congress, is available at www.aad.org/member-tools-and-benefits/aada-advocacy/regulatory-affairs/drugs-and-devices. To inform the AADA about drug shortage issues you are facing, contact Amanda Grimm at agrimm@aad.org. - RICHARD NELSON

D.C. delays benefit dermatologists

Congress stops Medicare payment cut for 2012, HHS promises ICD-10 compliance extension

TWO DELAYS ANNOUNCED IN LATE FEBRUARY will offer dermatologists and their practices a bit of breathing room regarding the ICD-10 transition and the level of their Medicare payments, though there is work yet to be done on both issues in Washington, D.C.

On Feb. 14, Marilyn Tavenner, the acting administrator of the Centers for Medicare and Medicaid Services, said that her agency would reconsider the Oct. 1, 2013 compliance date for the ICD-10 code set transition. She told attendees at an American Medical Association conference that she wanted to work with them to implement ICD-10 in a way that would achieve its goals while recognizing physician concerns about the transition. A new compliance date has not yet been set. Resources to help dermatologists with the ICD-10 transition are available on the Academy’s website at www.aad.org/member-tools-and-benefits/practice-management-resources/coding-and-reimbursement/icd-10.

Later the same week, congressional negotiators agreed to legislation that extended the existing two-month fix for the Medicare payment formula, along with extensions of the payroll tax cut and unemployment benefits. While the extension puts a 32 percent Medicare payment cut in play for 2013, it also ensures that dermatologists will see level payments in 2012. The American Academy of Dermatology Association continues to advocate for a permanent fix to the flawed formula and expressed disappointment that Congress did not achieve that fix, noting that “the constant threat posed by the current unsustainable and unstable payment structure creates a tremendous burden on our small businesses, the staff that we employ in our practices, and the patients who we serve.” - RICHARD NELSON
What is the best way to treat severe atopic dermatitis?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with M.E. Schram, MD, PhD, about her recent Journal of Clinical Allergy and Immunology article, “A randomized trial of methotrexate vs. azathioprine for severe atopic eczema.”

Q&A

DR. VAN VOORHEES: Let’s start by having you tell us a little bit about how you came to start studying severe atopic dermatitis? Aren’t there alternative therapies for these patients? Why did you choose to study methotrexate and azathioprine?

DR. SCHRAM: My PhD research was primarily directed at atopic dermatitis (AD), a chronic inflammatory skin disorder with an increasing (high) prevalence. Some patients are severely affected, which means that they do not respond to intensive topical treatment or phototherapy. AD can result in impairment of skin function and poor sleep and it has a high social burden.

Frequently used options for systemic treatment of AD include cyclosporine and systemic corticosteroids. Although these have proven efficacy, many patients have contraindications for cyclosporine or discontinue treatment because of ineffectiveness or side effects (Acta Derm Venereol 2007; 87:100-11). Moreover, long-term use of cyclosporine raises concerns of nephrotoxicity. Systemic corticosteroids are used frequently to suppress exacerbations, although high-level evidence is lacking. Medium- to long-term treatment with prednisolone is relatively contraindicated because of the cumulative effect of the side effects. Additionally, both treatments may cause a rebound effect.

In our perspective, more treatment options for severe AD are needed. Long-existing and relatively cheap disease-modifying anti-rheumatic drugs have been shown to be of some benefit in part of the patients with AD. Two of those drugs are methotrexate and azathioprine.

Two randomized controlled trials (RCTs) comparing azathioprine with placebo showed that azathioprine was significantly superior to placebo in the

DR. SCHRAM: Let’s begin with your study design. How many patients were studied? How did you dose these medications in the study?

DR. VAN VOORHEES: This study was an investigator-initiated, single-blind, parallel-group (ratio 1:1), randomized controlled trial evaluating efficacy, safety, and quality of life with methotrexate versus azathioprine over a 12-week period and a 12-week follow-up period.

Randomization, efficacy assessment, and statistical analysis were blinded. Forty-five adult patients with severe AD were screened and 42 patients were randomized to receive either methotrexate or azathioprine. In total, 52 percent of the patients were male, the mean age was 40 years, and the mean duration of eczema was 36 years.

Treatment with methotrexate was initiated at 10 mg/wk in a single oral dose. Dose escalation with 2.5 to 5 mg per scheduled visit was allowed with a maximum of 22.5 mg/wk. Patients also received 5 mg of folate one day after methotrexate intake. Azathioprine was initiated at 1.5 mg/kg/day in a single dose, and the dosage could be escalated at each visit with 0.5 mg/kg/day until a maximum of 2.5 mg/kg/day was reached. The dosages could be decreased according to protocol in case of abnormal findings on physical examination, laboratory markers, and/or adverse events. After the first 12 weeks, dosages in responders were reduced to find the optimum dosage. To illustrate this, mean dose of methotrexate at week 12 was 20 mg/wk and 17.5 mg/wk at week 24. Mean dosage of azathioprine was 2.2 mg/kg/d at week 12 and 2.1 mg/kg/d at week 24.

DR. VAN VOORHEES: How did the two drugs compare in terms of their efficacy in treating severe adult atopic dermatitis? What percentage improvement was seen with methotrexate versus azathioprine?

DR. SCHRAM: There were no significant differences between methotrexate and azathioprine in all the efficacy outcome parameters we measured at week 12 and 24.

At week 12, mean SCORing Atopic Dermatitis index (SCORAD) in the patients in the methotrexate group showed a relative reduction of 42 percent (P < 0.001). SCORAD scores in patients randomized to the azathioprine group showed a relative reduction of 39 percent (P < 0.001). The P value for the absolute difference between the groups is 0.89.

DR. VAN VOORHEES: Was there a difference in percentage of patients in the two groups who achieved mild disease or improvement in quality of life scores?

DR. SCHRAM: No, there was no statistically significant difference between the groups for the percentage of patients achieving at least mild disease on the physician global assessment; 75.0 percent in the methotrexate group versus 68.2 percent in the azathioprine group.

For measuring quality of life, the mean Skindex-17 score was used. Patients in the methotrexate group experienced a relative reduction on the Skindex-17 of 26 percent, in the azathioprine group of 20 percent. There was no statistically significant difference (P= 0.65).

DR. VAN VOORHEES: Was there a difference in adverse events in those treated with either agent?

DR. SCHRAM: Infections, gastrointestinal adverse events, and increased liver enzyme levels occurred in equal proportion in both groups (P= 0.66). Abnormalities in blood count (mostly lymphocytopenia) were statistically significantly more frequent in the azathioprine group (P = 0.002). Three (15 percent) patients in the methotrexate group had an exacerbation of their eczema during the study compared with two (9 percent) patients in the azathioprine group. No severe and serious adverse events occurred.

DR. VAN VOORHEES: Your pilot study suggests that these drugs may come to play a more significant role in the treatment of severe atopic dermatitis. Have you planned additional larger studies to further clarify this?

DR. SCHRAM: A five-year follow up study is currently being undertaken to address long-term safety in this patient group. The two-year data will be analyzed soon. dw
Electronic health records (EHR) are a great Trojan horse for many of us. This gleaming trophy promises to aid us in achieving the pinnacle of office efficiency and government compliance. We willingly bring it into our offices, eager to harness its raw technological power to make short work of our seemingly never-ending task to document, document, document. But the trap door in the underbelly conceals an invading force of cryptic templates, diagrams, formatting, permissions, and even technical support. Soon the very productivity we sought to optimize can become shrouded in uncertainty and inaccuracy.

The truth of the matter is that the advent of EHRs has, for better or worse, been thrust upon us, in the form of a government mandate designed to standardize the process of capturing patient encounter data in our office. Whether this is some conspiracy designed to analyze our practice habits, judge our medical proficiency/efficiency, or just give us gray hair, our fate has been set before us. We must learn to co-exist with the beast, tame it, and teach it to serve our needs. Although we can all agree conceptually that EHR may be a good idea, when the rubber hits the road and we are trying to deliver patient care at the bedside, how does this really fit in without slowing us to a snail’s pace?

CAPTURING DATA

Once the software is in place, attention turns to figuring out the best way to capture everything that happens in a patient encounter. It is very difficult, if not impossible, to document the array of complaints seemingly universally prefaced by “As long as you are here.”

Resist the temptation to do it yourself. Your staff can help, as long as you know the rules. Most of us have someone in the room at all times during a patient encounter; we might as well utilize them to convert the patient’s words into electronic format. We must first teach and then
NEW NAFTIN® Cream 2%
(naftifine HCl)

Twice as Strong
Half as Long

NAFTIN® Cream 2%
Once a Day for 2 Weeks

NEW NAFTIN® CREAM 2%
(Naftifine HCl)

Once a day for 2 weeks

Please see brief Prescribing Information on back.

www.NAFTIN.com
**NEW NAFTIN CREAM 2% (Naftifine HCl)**

Once a Day for 2 weeks

**Important Safety Information**

In clinical trials with NAFTIN® Cream 2%, the most common adverse reaction (≥1%) was pruritus.

**Indication**

NAFTIN® (naftifine hydrochloride) Cream 2% is an allylamine antifungal indicated for the treatment of interdigital tinea pedis, tinea cruris, and tinea corporis caused by the organism *Trichophyton rubrum* in adult patients ≥18 years of age.

---

**Rx ONLY**

**INDICATIONS AND USAGE:** NAFTIN (naftifine hydrochloride) Cream, 2% is indicated for the treatment of: interdigital tinea pedis, tinea cruris, and tinea corporis caused by the organism *Trichophyton rubrum* in adult patients ≥18 years of age.

**CONTRAINDICATIONS:** None.

**WARNINGS AND PRECAUTIONS:** If irritation or sensitivitivy develops with the use of NAFTIN (naftifine hydrochloride) Cream, 2% treatment should be discontinued. Patients should be directed to contact their physician if these conditions develop following use of NAFTIN (naftifine hydrochloride) Cream, 2%.

**Information for Patients:**

1. NAFTIN (naftifine hydrochloride) Cream, 2% is for topical use only. NAFTIN (naftifine hydrochloride) Cream, 2% is not intended for intravaginal or ophthalmic use.

2. If irritation or sensitivity develops with the use of NAFTIN (naftifine hydrochloride) Cream, 2% treatment should be discontinued and appropriate therapy instituted. Patients should be directed to contact their physician if these conditions develop following use of NAFTIN (naftifine hydrochloride) Cream, 2%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Long-term studies to evaluate the carcinogenic potential of NAFTIN (naftifine hydrochloride) Cream, 2% have not been performed.

**Pregnancy:** Pregnancy Category B. There are no adequate and well-controlled studies of NAFTIN (naftifine hydrochloride) Cream, 2% in pregnant women. Because animal reproduction studies are not always predictive of human response, NAFTIN (naftifine hydrochloride) Cream, 2% should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when NAFTIN (naftifine hydrochloride) Cream, 2% is administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in pediatric patients have not been established. The number of pediatric patients ≥12 years of age studied were too small to adequately assess safety and efficacy.

**ADVERSE REACTIONS:** In clinical trials with NAFTIN (naftifine hydrochloride) Cream, 2% the most common adverse reaction (≥1%) was pruritus.

NAFTIN (naftifine hydrochloride) Cream, 2% is manufactured for Merz Pharmaceuticals, LLC, Greensboro, NC 27410

NAFTIN is a registered trademark of Merz Pharmaceuticals, LLC.
properly utilize our trained staff to do the yeoman’s work of data capture, which will allow us to face our patients sans electronic barriers.

Again, though, we must be aware of the rules. In the conventional, paper world, there are guidelines as to who can record certain aspects of the patient encounter, and these guidelines extend to the electronic arena as well. Many Medicare carriers and some other insurers virtually mandate that the history of present illness be captured by the physician or non-physician provider (NPP) directly, and not via the use of a medical assistant or other ancillary staff. From my perspective, it really shouldn’t matter who captures the data, as long as it is reviewed and verified in the presence of the patient and interpretations and conclusions drawn (from this data) are done by the physician or NPP. But be aware that your EHR will indicate who was logged in and entering data, leaving a clear trail any auditor could follow if you are suspected of circumventing the rules.

**USING A SCRIBE**

A scribe is an individual who is present during the physician’s performance of a clinical service and documents (on behalf of the physician) everything said during the course of the service. A scribe must not be seeing the patient in any clinical capacity or interject his or her own observations or impressions. I was taught to use scribes to document my spoken words on paper while in the patient rooms. This allowed me to focus my attention into eye-to-eye, face-to-face contact with the patient, while seated. Studies have shown this seems to lengthen the perceived appointment time in the patient’s eyes, reinforcing the fact that you are indeed listening to their concerns. In a heavy-traffic, high-volume specialty such as dermatology, this can make the difference between a return visit and losing a patient.

In our office, EHR has not changed this scribing strategy. Our providers endeavor to “prescribe to scribe.” All EHR software packages are required to have authentication at the user level, and to provide a background electronic audit trail. Medical assistants can log in and capture most of the standard pertinent review of systems and history of present illness, as an enumerated list, within predesigned templated forms. These forms may or may not be provided by EHR companies and even with existing forms, it can take an inordinately large amount of time and resources to customize templates to one’s individual workflow. This can be a great source of frustration and cost for physicians and their staff (in terms of their time), as they seek to electronically recreate their paper environment. Thankfuly, the bulk of template design is a one-time deal, with tweaking taking far less time to perform.

**PATIENT PORTALS**

Conversely, patient portals can lessen the workload and are becoming more mainstream and “must-have” features in EHR packages. These portals can be integrated into practice websites easily and drive a steady flow of traffic to those sites. Patients log on securely from a browser in the comfort of their own home and complete/update review of systems, medications lists, and even brief, informal HPI via pre-designed online forms. Portions of this information are automatically imported into the patient’s notes (the physician must attest to having reviewed them) for the day of the encounter. Some (such as medications) must be manually verified and matched to a standardized list before being accepted as part of the medical record.

While it is easy to hand off paper charts between assistants and physicians for completion, electronic charts are not so easily transferred. Two individuals with different logins cannot typically write into the same patient chart simultaneously due to back-end database limitations. In our office, assistants have certain pre-assigned user rights, which only allow them to record up through the HPI. The physical exam and the assessment/plan are only editable by the physician. The workflow is designed such that as the physician prepares to enter a room and selects that specific patient chart for review, the assistant is automatically kicked out of the chart. Alerts are present to keep untimely log-offs from occurring, but essentially all that is recorded is constantly being saved. This also has advantages, for example, in the event that wireless connections fail.

EHR packages that support different hardware platforms for data entry really can shine here. For instance, the assistant can utilize a swivel-screen laptop to tap/type their portion of the exam, containing most of the prose, whereas the physician can utilize an iPad to tap out the more predictable physical findings and diagnosis. The chart is only complete when the physician closes the note with an electronic signature. Assistants do not have the ability to electronically sign a note, although there are fields designated to allow them to identify themselves as the scribe. Assistants also do not have the ability under their own login to assign codes and perform billing. These services are performed by the physician and may be automatically suggested (with override capability) by the software itself, based on completed bulleted items. Billing is not transmitted and posted until the chart is electronically signed. This may involve a review by a billing specialist prior to posting.

In summary, recognize EHR for what it is...a tool and a means to an end. It is still very important to tailor your workflow to optimize your contact time with the patient. This can best be accomplished by hiring, training, and utilizing technology-proficient assistants at the point of care. **dvw**
As dermatologists in the United States ponder how their specialty may change as the provisions of 2010’s health system reform law go into effect, they may cast their eyes to the United Kingdom, whose system many critics of the law point to as an example of the sort of medicine Americans can anticipate. Three dermatologists from the United Kingdom shared their thoughts on the pros and cons of their system with Dermatology World — and their perspective suggests that dermatologists can find different ways to thrive inside a system that focuses more on primary care — or outside of it, as patients can choose to pay for care on their own and see non-National Health Service (NHS) providers. Thriving within such a system may require some American dermatologists to relate to general practice physicians in a different way than they are currently accustomed to, though — while the existence of dermatology nurses in the UK is perhaps unsurprising to their American counterparts, the fact that they sometimes practice in primary care offices and help triage patients to dermatologists may surprise.

FREE FOR ALL
All three British dermatologists began their discussion of the pros of their country’s national health system by noting that care is free for patients. Roderick Hay, MD, said, “Everyone can see a doctor without charge and whatever their condition. If they are chronically ill, a child, or over 60 years of age they can obtain medicines free — otherwise they pay a standard fee per item. All areas of the country are covered equally for medical care; there is the same access to health care in cities and rural areas.”

Susan Burge, MD, noted that the system also features strong care coordination, with a single physician who knows any given patient’s history and oversees treatment. Christopher
Griffiths, MD, agreed. “Primary care is highly respected,” he said, “as is the expertise that resides within the NHS in general. Our emergency care is probably second to none.”

The British system offers physicians different incentives than the American one, Dr. Burge noted. “There is no financial incentive to do procedures or bring back patients repeatedly as all NHS doctors have a salary paid by the hospital (along with good pensions, holidays, and study leave).”

CHOICES LIMITED
All is not roses, of course. As Dr. Burge explained, the National Institute for Health and Clinical Excellence (NICE) recommends treatments that should be funded by the NHS on the basis of the best evidence. While this leads to evidence-based care, it also leads, she said, to “some variability in availability of expensive treatments,” as the Primary Care Trusts in each region determine what treatments should be offered given the health needs of their particular population.

This can make a big difference when treating some dermatologic conditions, Dr. Griffiths said. “There are restrictions around prescribing biologic therapies for psoriasis. Eligibility criteria are dictated by NICE guidelines and approved by local Primary Care Trusts. Thus, patients with severe psoriasis must meet stringent criteria before they are deemed suitable for management with biologics.” Dr. Hay noted that the responsibility for making a case for a particular therapy for a particular patient can fall to the physician. “Our government has endeavored to make balancing cost versus benefit the responsibility of physicians rather than administrators,” he said. “In my practice we use potentially highly expensive anti-virals and some antifungals and there is often an argument with the central purchasing unit of the hospital pharmacy; so far we have usually won.”

These encounters may sound familiar to American dermatologists accustomed to debating coverage with insurers. So, too, is Dr. Burge’s concern about the fact that NHS does not cover cosmetic treatment. “Where should one draw the line? For example, in our area, we do not treat vascular birthmarks in adults with laser surgery. The NHS only funds laser surgery for facial port wine stains in children (up to age 18).”

REFERRALS RARE
While physicians may see their treatment options limited by cost-control measures, patients, too, have their choices limited under the British system — particularly regarding specialist care, Dr. Hay said. “Our contracting system involves every patient consulting a general practitioner before seeing a specialist,” he said, and the funding scheme by which hospitals (and the specialists who work in them) to whom GPs might refer are paid creates a perverse incentive not to refer, he added, because the Primary Care Trusts which purchase on behalf of GPs may retain unused funds.

Unlike most American dermatologists, UK dermatologists are among the specialists at the hospital. “Dermatologists are based in departments in hospitals (secondary care) alongside other medical and surgical specialties,” Dr. Burge said, “and do not work in isolation in offices.”

With only 350 dermatologists in a country with a population of more than 62 million, GPs must see most skin disease cases for the system to function, and they do. “Most patients with skin disease are managed in primary care; indeed, it is estimated that 15 percent of a GP’s workload is accounted for by management of skin disease,” Dr. Griffiths said. “Paradoxically, most GPs have very little training in dermatology,” he added — though all medical students have some dermatology education. Dr. Hay noted that 85-90 percent of skin disease cases are seen in general practice, and referred on only if problems arise with diagnosis or management. As a result, Dr. Griffiths said, “dermatologists in the UK have a more complex caseload than their counterparts in the U.S. and management of warts and mild acne, eczema, and psoriasis would be unusual.” Problems, he said, arise “when financial pressure is exerted on practices; they are less willing to refer and patients may have to resort to private consultations in order to see a dermatologist. However the articulate patients can usually obtain a referral — the problem is with those who are less fortunate.”

In an initiative that may remind some U.S. dermatologists of the burgeoning number of physician assistants and nurse practitioners working with them, Dr. Griffiths noted that the UK — which does not have PAs — has seen the empowerment in recent years of dermatology specialist nurses, who play a large role in the management of chronic skin diseases. “Nurses are now taking biopsies and performing laser practice,” he said. Dr. Burge said the training of nurses to excise skin tumors...
has increased efficiency at Oxford, where she also noted that dermatology nurses run their own clinics for patients with acne, eczema, and psoriasis. All of those nurses work in the same secondary-care setting as dermatologists and can consult with them as necessary. Nurses also help with triage of patients who may need subsequent care after an initial visit with a dermatologist, Dr. Hay said. “We try to discharge patients back to their referring doctor and increasingly utilize specialist nurses to liaise with the practice for continuing advice — these in turn will, where appropriate, arrange for the dermatologists to see patients again.” Meanwhile, Dr. Griffiths noted that some nurses in primary care settings have enough expertise in managing skin disease to provide education about topical therapies and their application.

COMPETITION AND WAIT TIMES
After they are referred to a dermatologist, patients in the UK face the same things American patients do: A wait. “Wait times to see a consultant dermatologist are long in some parts of the country,” Dr. Griffiths said. However, he noted that there has been significant improvement in this area. “Waiting lists are significantly less than they were 10 years ago. For a routine appointment in 2011 the wait was less than eight weeks. In 2000 there were waits for almost a year in some parts of the country!”

Patients who do not want to wait eight weeks for NHS care do have the option of seeking care outside the system. “There is considerable concern in the UK about competition from independent providers of health care,” Dr. Griffiths said. Partly, he said, this is because “there is no provision for cosmetic dermatology on the NHS; dermatologists who provide this service do so in private practice.” Similar to the U.S., he said, there is significant competition from non-dermatologists for delivery of cosmetic dermatology services, including dentists, GPs, gynecologists, and others.

ABOUT THE CONTRIBUTORS
Susan Burge, MD, is in a National Health Service academic practice based in the Oxford University Hospitals and sees primarily pediatric and medical dermatology patients. Christopher Griffiths, MD, is in academic practice with the Dermatology Centre in Greater Manchester. Roderick Hay, MD, is in a hospital-based and private practice after spending most of his career as a clinical academic. dw
Bio-Oil® is a skincare oil that helps improve the appearance of scars, stretch marks and uneven skin tone. It contains natural oils, vitamins and the breakthrough ingredient PurCellin Oil™. For comprehensive product information and results of clinical trials, please visit bio-oil.com. Bio-Oil is the No.1 selling scar and stretch mark product in 11 countries. $11.99 (2fl.oz.).
DERMATOLOGY WORLD
April 2012

BY RUTH CAROL, CONTRIBUTING WRITER

Dermatologists undaunted by INDOOR TANNING industry’s claims

Under-18 bans, public education campaigns move forward

The Indoor Tanning Association (ITA) may be prohibited from making false health and safety claims about indoor tanning by a settlement with the Federal Trade Commission (FTC), but that isn’t stopping the industry from pursuing other strategies to promote this $5 billion business. (It isn’t stopping individual operators from making false statements about tanning’s risks to potential customers, either — see sidebar, p. 17, for details.)

Those strategies include criticizing study findings, downplaying the link between tanning bed use and the increased incidence of melanoma, claiming that indoor tanning produces vitamin D, and suggesting hardship for small businesses.

The indoor tanning industry will use any tactic it can to promote and preserve indoor tanning for people, and young people, in particular, said Bruce A. Brod, MD, clinical associate professor of dermatology at the University of Pennsylvania School of Medicine in Philadelphia. "The bottom line is for every one of those points there is good hard data to refute it,” noted Allan Halpern, MD, chief of dermatology at Sloan-Kettering Cancer Center in New York. >>
Dermatologists undaunted by indoor tanning industry’s claims

MISREPRESENT DATA, BLAME OTHERS
The tanning industry often tries to discredit study findings that suggest indoor tanning increases the risk of skin cancer. Tanning salon owners opposed to a proposed ban on tanning for minors sent a letter to a state senator claiming to have strong evidence that false information had been provided to the state legislature to promote passage of a bill to ban minors from indoor tanning. They singled out for criticism the International Agency for Research on Cancer (IARC) 2009 report, which found that first exposure to tanning beds before the age of 35 increases an individual’s lifetime risk of melanoma by as much as 75 percent; the ITA used a similar tactic at the Food and Drug Administration’s March 2010 hearing to consider modifying the classification of indoor tanning beds. The ITA argued that a meta-analysis, such as the IARC study, is a flawed methodology. But Henry W. Lim, MD, chairman and C.S. Livingood chair of the department of dermatology at Henry Ford Hospital in Detroit, who attended and testified at the hearing, noted that several other studies have since been published — in Cancer Epidemiology, Biomarkers & Prevention, the International Journal of Cancer, and the American Journal of Epidemiology — and all conclude that exposure to indoor tanning increases one’s risk of developing skin cancers. All of these studies have looked exclusively at the use of indoor tanning beds, so the ITA can’t argue that dermatology-supervised phototherapy is included, Dr. Lim added.

Blaming sunscreens for increased melanoma is another common strategy. It’s true that some earlier studies have questioned whether sunscreen use is associated with an increase in melanoma, Dr. Lim said, but these studies evaluated first-generation sunscreens, which had good UVB protection, but lacked UVA protection. Most of today’s sunscreens have both good UVA and UVB protection, he noted.

TOUT HEALTH BENEFITS
The ITA maintains that vitamin D production is a positive side effect of indoor tanning and notes a potential epidemic of vitamin D deficiency in North America. Dermatologists argue that the ITA overplays the potential health benefits of vitamin D. “The key point about vitamin D is that you don’t need ultraviolet light to get it,” said Martin A. Weinstock, MD, PhD, professor of dermatology and epidemiology at Brown University in Providence, R.I. Vitamin D can be obtained more reliably through diet and supplements, neither of which is associated with carcinogenic risk. Plus, these options are cheaper than indoor tanning.

The indoor tanning industry’s argument is further undermined by the fact that it started using primarily UVA-emitting light bulbs when confronted with growing evidence that UVB rays are carcinogenic and cause burns. The industry argues that today’s tanning beds emit almost exclusively UV A light, said William D. James, MD, director of the residency program, Paul Gross Professor, and vice chair in the department of dermatology at the University of Pennsylvania Health System in Philadelphia. However, UVA is not the wavelength that produces vitamin D. Moreover, the skin can convert only so much vitamin D from UV light and it happens quickly, Dr. Brod said, so getting excessive amounts of any kind of UV light doesn’t translate into higher vitamin D levels.

CLAIM BUSINESS HARDSHIP
Additionally, the ITA argues that regulation of the indoor tanning industry will cause small businesses to close. This argument was emphasized in New York, according to Liz Dears Kent, executive director of the New York State Society of Dermatology and Dermatologic Surgery and senior vice president for legislative and regulatory affairs for the Medical Society of the State of New York. This is similar to the owners of restaurants and bars who claimed that they would lose customers and be forced out of business if a smoking ban was put into effect, she said. That didn’t happen and neither will tanning salons be put out of business should this bill become law, Kent added.

Using this same argument, the ITA has urged Congress to repeal the 10 percent tax on indoor tanning services enacted as part of health system reform. Some anti-UV tanning advocates have suggested that indoor tanning facilities can grow their spray-on tanning services as a reasonable and safe way to sustain their business.

SUPPORT LEGISLATION
The dermatology community combats efforts of the indoor tanning industry primarily by supporting the passage of state laws to ban indoor tanning for minors or restrict its use while educating the public about the known health risks associated with UV radiation exposure from indoor tanning.

To date, 36 states regulate the indoor tanning industry in some way. During the last several years, tanning bills have been introduced in approximately half of the states across the country, said Kathryn Chandra, assistant director of state policy for the AADA. She expects roughly that many to be introduced in 2012, as well.

Young people care more about being tan for the prom than getting melanoma when they’re 50.

We’re losing that battle.

We need to make tanning uncool.
The difference between legislation introduced in years past and this year is that many of the current proposals call for a ban on indoor tanning for individuals under the age of 18. “We’re seeing more states calling for an under-age ban whereas previously new legislation was for parental consent,” said Dr. Brod, who attributes this shift largely to California, which became the first state to prohibit anyone under 18 from using indoor tanning beds as of Jan. 1. “California is often the frontrunner on legislative initiatives,” he added. When dermatologists are trying to get tanning legislation passed in their respective states, they can let legislators know that California has a law banning minors from using tanning beds. That gets the attention of legislators,” Dr. Brod said.

This difference is also a reflection of the growing scientific evidence, including growing evidence in animal models and human studies that tanning is an addictive behavior. “That’s becoming a very powerful message,” Dr. Lim said. Dr. Weinstock summed up that message: “By preventing children from indoor tanning, you prevent them from becoming addicted to it,” he said. “By the time these minors are 18 years of age, their judgment may be more developed and they may choose not to tan when they get older.”

The message is getting stronger, but credit is also due to those who have been pushing for better laws for years, according to Dr. James. “It takes a while to gain momentum,” he said. “Previous efforts have made inroads that brought this issue to the forefront for legislators.”

Each state, however, will have its own political realities to overcome, warned Ann Haas, MD, who testified before multiple committees of both houses in advance of the California bill’s passage. “What defeats these bills is politics. Things happen for political reasons, not necessarily merit,” she said. The only way to know the political inner workings is by hiring a lobbyist. “You need a lobbyist because dermatologists don’t have the time or political knowledge to do this,” Dr. Haas said. The lobbyist for the California Society of Dermatology and Dermatologic Surgery worked tirelessly with both CalDerm and the bill’s other cosponsor, the AIM at Melanoma Foundation, to get it passed, she said.

In New York, the political reality is that the small business concern is a significant threat to passage of an under-18 ban. Legislators, in particular senators from upstate New York, need to be assured that these businesses have alternative options that they can offer, Kent said.

Even as states enact laws, lack of enforcement is an issue. Including more enforcement language and building in funding mechanisms to allow for conducting routine annual inspections and levying penalties for violations can help. For instance, Dr. Brod explained, in some states, parental consent laws do not require the consenting parent

**CONGRESSIONAL COMMITTEE LOOKS AT TANNING INDUSTRY CLAIMS**

Dermatologists have heard anecdotes for years about what indoor tanning salons tell potential customers regarding the risks and benefits of tanning. A report released Feb. 1 by the Democratic minority of the House Energy and Commerce Committee confirmed what many dermatologists have long suspected — customers are not hearing the truth about tanning from salons.

The committee’s investigation consisted of contacting more than 300 tanning salons around the country, including at least three in every state, and asking each salon about the benefits and risks of indoor tanning and how frequently customers could use tanning beds. Investigators found that:

- 90 percent of salons said tanning did not pose a health risk.
- nearly 80 percent said tanning would have health benefits for a fair-skinned teenage girl — several said it would prevent cancer.
- about 75 percent of salons allow daily tanning, though the FDA recommends limiting indoor tanning to three visits the first week.

“The results of this investigation point to the need for policymakers to increase regulation of indoor tanning devices to help protect the health and safety of our young people,” the American Academy of Dermatology said in a statement following the report’s release. “This report demonstrates that when asked direct, simple questions about the safety of indoor tanning, the industry willfully misleads potential customers, putting their health in jeopardy.”

The full report is available online in the Academy’s State Advocacy Toolkit on indoor tanning, along with a fact sheet on indoor tanning, documents to use in meetings with legislators, and templates for communicating with the media on the issue. Visit www.aad.org/member-tools-and-benefits/aada-advocacy/state-affairs/advocacy-toolkit. — RICHARD NELSON
to prove that he/she is the parent. “The language can be strengthened to require the parent to show identification and to stay on site as opposed to providing a note that can easily be forged,” he said. A look at New Hampshire, where there was an attempt to overturn the parental consent law because of a lack of funding, points to the importance of incorporating funding mechanisms in proposed bills. If the regulations had both licensing fees and financial penalties, states could set up systems that were financially self-sufficient, Dr. Halpern said.

ENLIST OTHERS

Overall, more dermatologists are taking an active role in getting legislation passed and they are becoming more savvy in doing so, Dr. Brod said. Instead of starting from scratch, they are using model legislation drafted by the AADA and working with other advocacy organizations, including the American Society for Dermatologic Surgery Association, other state medical societies, and other specialty societies, including pediatrics. In some states, dermatologists are trying to build relationships with the Department of Health, reasoning that if the health department supports passage of a bill, it will be more inclined to enforce a law.

But it’s not just dermatologists taking a more active role. “We are seeing more state medical societies, which represent all medical specialties, supporting indoor tanning legislation,” Dr. Brod said. Some medical specialty groups have used their capitol visits, which are extremely important because they get media coverage, to advocate for indoor tanning legislation, something pediatricians did last year in Pennsylvania, he added.

As a core member of the National Council for Skin Cancer Prevention, the AADA knows the value of working with other skin cancer stakeholder groups. Many of the 50 organizations that comprise the council have been very vocal in supporting tanning legislation across the country. In California, the state medical society, medical specialty associations, and nurses organizations all played a major role in getting the under-18 ban passed, Dr. Haas said.

The American Cancer Society – Cancer Action Network was instrumental as a grassroots organization. Similar collaborative efforts have been ongoing in New York, Kent said, adding that, “All of medicine needs to be united in this effort.”

Besides the AADA, probably the most vocal is the American Academy of Pediatrics, which last year issued a policy statement supporting a ban on tanning bed use by minors. “Pediatricians have taken a strong stand, and we would like to have more physicians and medical professionals come out with that kind of statement,” noted Dr. James, who is a past president of the AAP. The Academy continues to reach out to other specialists, such as ophthalmologists and plastic surgeons, who see the effects of chronic UV light in their respective patients.

Many believe that passage of the Tanning Bed Cancer Control Act, which calls for the FDA to examine the classification of indoor tanning beds, would also serve to support state-based legislation. Reclassification might lead to a youth ban as well as the ability to enforce warning signs, implement labeling recommendations included in the Tanning Accountability and Notification Act, which became law in 2007, and encourage more enforcement of state regulations, Dr. Brod said. The AADA continues its efforts on Capitol Hill to add more members of Congress to the list of cosponsors of the federal bill that was reintroduced last year.

PROVIDE PUBLIC EDUCATION, AWARENESS

In addition to supporting passage of tanning legislation, the primary goal of the dermatology community has been to raise public awareness and provide education about the risks of tanning in general and the use of tanning beds in particular, Dr. Halpern said. “It’s an attack on the indoor tanning industry. It’s a concerted effort to help the public better understand how to protect themselves from the ravages of UV exposure.”

Dr. Weinstock likened the dermatology community’s efforts to those involved in reducing tobacco consumption. When the Surgeon General’s report on tobacco was published in 1964, it created an opportunity to educate the public about the perils of smoking and led to the tobacco industry being prohibited from making claims that smoking was healthy. Similarly, the FTC settlement with the ITA and the multitude of studies linking indoor tanning to the increase in skin cancers have laid the groundwork for public education about tanning, he said.

But passing tanning legislation would enhance this drive for public education and awareness, Dr. Halpern said, because the current lack of regulation can be interpreted by the public to mean that indoor tanning is not that dangerous. “Legislation not only impacts public perception, but has the potential to directly impact behaviors through the enforcement of regulations,” he added. “[But] even if enforcement is lacking, having the legislation still accomplishes a great deal in terms of setting the proper tone for public education.”

Next on the agenda is to change the public’s perception about having a tan. “The truth is that young people care more about being tan for the prom than getting melanoma when they’re 50,” said James M. Spencer, MD, a Florida dermatologist and chair of the American Academy of Dermatology’s Melanoma/Skin Cancer Committee. “We’re losing that battle. We need to make tanning uncool.” Dr. Weinstock concurs. “We need to change glorification of the tan so that a larger variety of skin tones would be considered attractive,” he said. That is why public education must address both cultural norms and health concerns. These messages must be targeted to various demographics and use a variety of media to reach the different audiences, Dr. Lim added.

Dermatologists are undaunted by the ongoing battle they face. “This won’t be easy and it won’t go away anytime soon,” Dr. Spencer concluded. “We have our work cut out for us, but we’re in it for the long haul.”
Now patients can spend less time thinking about their scars and more time seeing results.

New Mederma® Advanced Scar Gel—the first and only 1X daily scar therapy.

- From the #1 doctor recommended brand in scar care
- More convenient application, better patient compliance, better results
- Clinically shown to improve scar softness, redness, texture and overall appearance
- Subjects saw a 36% greater improvement in the overall appearance of their scar after 8 weeks vs. untreated scars (P<0.01)

More information at mederma.com

©/®/™ 2012 Merz Pharmaceuticals, LLC
WHICH WAY?

Physicians detail the considerations leading more of them to choose employment over independent practice.
In the current climate of ever-growing health care systems and increasingly complicated regulatory mandates, an increasing number of physicians — both established doctors and those just leaving training — are electing to practice medicine as employees, rather than as independent practitioners. Being an employee can mean many things — becoming a professor of dermatology at an academic center, or an employee at a large dermatology group, or a dermatologist within a multispecialty practice. Whatever the setting, though, a greater share of dermatologists, especially younger ones, are finding themselves enamored of the benefits of life as an employed physician.

EMPLOYMENT TRENDS
In a sweeping survey-driven report published in May 2011, consulting group Accenture detailed the steadily declining numbers of physicians who practice independently. According to the survey, the number of physicians defined as “truly independent” — those running their own private practices, working outside of hospitals, large groups, or health care systems — has been declining at a steady rate of around 2 percent per year, even as the total number of overall physicians has increased. Moreover, Accenture predicts a 5 percent annual drop by 2013.

In dermatology, the Academy’s 2009 Dermatology Practice Profile Survey found that 39.6 percent of practicing dermatologists practice solo, 40.5 percent practice in a single-specialty dermatology group practice, 8.9 percent practice in multi-specialty practices, and 8.0 percent practice in an academic setting. Comparing those results to the Academy’s most-recent survey of young physicians and residents suggests a stark contrast between dermatology’s present and its future. Only 5.3 percent of residents plan to practice solo, and only 13.0 percent of young dermatologists (within eight years of residency) currently practice in that setting. Young dermatologists practice in academia at a rate of 24.7 percent, and 29.6 of residents plan to enter that setting. >>
WHICH WAY?

While numbers from the Academy’s survey show that dermatologists still trail behind other specialists in practice consolidation, they do seem to be slowing down in their efforts to set up solo practice and instead have been migrating toward single-specialty mid-size group practices, according to William Brady, the Academy’s senior manager of practice management resources.

“This doesn’t mean that the solo derm practice model is becoming extinct. Many have explored other career options before deciding to go it alone,” Brady said. “Largely, it comes down to both objective and subjective factors — entrepreneurial spirit, risk tolerance, sense of autonomy, professional goals, local competition, and insurance climate, with some states more attractive for sustaining the solo dermatology practice model.”

As the business side of providing medical care has become increasingly codified, many physicians find themselves without the time, specialized expertise, or desire to navigate the financial and regulatory minefield of opening a private practice. The ability to focus only on practicing medicine, free of administrative concerns, has led Kaiser Permanente to see a marked uptick in employment inquiries in the past year, according to dermatologist Jeffrey Benabio, MD.

“I can tell you that we don’t have any openings at the moment for dermatology. We’ve got a waiting list of people contacting us and my chief saying they’d like to work for us,” Dr. Benabio said. “I’ve only been here for five years, but this is definitely a new trend. We’re seeing a lot of people who are in private practice who would like to get in, but we just don’t have any room.”

Las Vegas dermatologist Lucius Blanchard, MD, who runs 30 dermatology offices in five states, has witnessed this trend firsthand, and said that the vast majority of young physicians he encounters have a desire to start out their medical careers as an employee, rather than an employer. He attributes the trend to forces in the marketplace. Young physicians, he said, face tremendous difficulties in start-up, such as getting loans from banks in the current economy, negotiating with major payers alone, and navigating the ever-changing current of state and federal regulation.

“I think almost all of the young doctors that we talk to now — and we’re constantly recruiting — want to be employed physicians. Nobody recently coming out wants to open their own practice.” Dr. Blanchard said. “You look at all the challenges, weighed against the advantages of coming into an established practice with no cash outlay and money coming in from the first month. To most people, that’s much more attractive. People want to go where they can have a lifestyle and exchange a little money for security. It’s easier than entering into all the financial obligations of your own practice.”

**BENEFITS OF EMPLOYMENT**

As a specialty, dermatology is well known for striking an agreeable work/life balance for its practitioners. In much the same way, joining a large group or system affords tangible lifestyle benefits that come with eliminating many of the most common stresses of the private practice owner. Geisinger dermatologist Christen Mowad, MD, said that one of the biggest benefits of her work situation is the disappearance of many month-to-month worries under the umbrella of her employer. While she still indirectly pays the cost of such provided benefits as malpractice insurance, Dr. Mowad said that having it taken care of in the background of her daily practice is a convenient attribute of employment with a health system.

“I don’t have to worry about paying my malpractice, life, and disability insurance. All of that comes as a benefit through the institution. I don’t have to worry about billing, hiring and firing, and the day-to-day management headaches,” she said. “It really allows you to be free of those concerns and concentrate on patient care and teaching. For some people, they prefer the independence to make those decisions and have control of the finances. That wasn’t me.”

Dr. Benabio expressed a similar sentiment, adding that the organizational philosophy at Kaiser was a very significant factor in his choosing that institution from among a host of potential employers.

“My initial interest in Kaiser came from its care model. It really allows you to just focus on medicine,” Dr. Benabio said. “How many patients I’m seeing, am I making enough money, are my employees happy? I don’t have to worry about that. There are no reimbursement questions in particular, as any contract questions are out of my hands. It’s never a concern.”

Likewise, Dr. Mowad and many dermatologists with a pronounced interest in teaching or research have chosen the institutional benefits of joining a large academic organiza-
tion — notably the advantage of nearby colleagues with an interest in continued education and unusual cases.

“The real reason I went [to Geisinger] was to stay in an academic center where I would have the ability to do research and teach residents. But practicality-wise, it’s nice to have those comrades to bounce things off of. We practice side by side, and we get sent a lot of difficult cases because we’re a tertiary care center. If one of my colleagues sees somebody who’s complicated, we often call everyone into the office to put our heads together and see who has any ideas,” Dr. Mowad said. “Teaching the residents is really a lot of fun. They keep you current by asking questions. It’s a little bit more work, but it’s perhaps the main reason that I chose an institution with a residency program.”

An ample supply of colleagues, Dr. Benabio and Dr. Mowad said, also allows for a great deal more flexibility in taking time away from work for overseas medical trips, professional meetings, or vacations. Kaiser’s flexible scheduling, Dr. Benabio said, has given him the ability to work only four days a week.

**POTENTIAL DRAWBACKS**

While the security of an institution allows for a certain ease in practicing medicine, it also comes with a host of administrators to whom physicians must answer. While his opinions on treatment don’t often clash in any meaningful way with that of his institution, Dr. Benabio said, he’s always aware that should something arise, he won’t have the final say on a patient or scheduling matter.

“I work for a big company, so I can’t always just do what I want. I do have the final say on patient care, but not on my schedule or scope of practice,” he said. “Though I can’t say that very often I come across something that I’d like to do that I can’t with respect to my schedule or scope of practice.”

**BOTH SIDES OF THE FENCE**

Las Vegas dermatologist Lucius Blanchard, MD, has explored both sides of the employer/employee divide since completing his fellowship in 1978. He joined a private practice run by two dermatologist partners, and shortly afterward bought out both of their stakes. He expanded the operation to a handful of offices and sold eight years ago to a health system, staying on as an employee. Not long after, the company began having financial troubles, and Dr. Blanchard found himself buying a system of 30 offices and 25 employee physicians. The pathology lab he also operates requires him to hold licensure in six states. Having seen both sides, he shared a number of his personal observations on the pros and cons of employment and employing.

- **On the personality required of a successful owner:**
  “If you have the drive, then owning your own practice is one of the most exciting, rewarding, frustrating things you’ll ever do, especially when you’re young and ambitious. It’s a matter of personality. It takes a bit of an entrepreneurial spirit and some risk-taking in your genes to be an employer.”

- **On the additional time management skills required as an owner:**
  “One of my requirements, whether it’s running a dermatology business, or one of the other businesses I’m involved in, is that there has to be a manager to run the day to day. And you have to manage them, of course, but I always keep in mind that my main job is always seeing patients. Some doctors want to be administrators or CEOs. Me, I’ve always enjoyed the patient experience. I have a rule, we don’t have any meeting that lasts over an hour. I work probably 12-15 hours a day. Maybe 12 of those are seeing patients, and an hour’s worth of administrative time, five and a half days a week.”

- **On the differences in medical management since his first stint as an owner:**
  “When I was an owner the first time, the business side of medicine was simple enough that I could understand and manage it. When I came back the second time, there’s no way I could have a full understanding of everything involved. Not only has regulation increased significantly, especially for practices operating in multiple states, but the process of negotiating contracts is much more involved than when I started as an owner. Now, instead of calling up a payer and making a deal, you’ve got to have statistics, cost analysis, and everything about every payer. It’s a lot more technical analysis of a thing that I used to be able to do myself. That’s been the biggest change.”

- **On the responsibility inherent in ownership:**
  “When people ask me, I tell them that I wake up every morning knowing that I have to make enough money to pay 450 people and rent on 30 offices. If you don’t make that, you’ve got to cover it yourself.”
WHICH WAY?

In addition, many institutional physicians have long dealt with the general assumption that they make less money because they’re not seeing the potential profits of being in practice for themselves.

“Traditionally, institutions and academic centers make less money,” Dr. Mowad said. “We are reimbursed well, however, so I choose this situation understanding that private practice people might potentially make more money.”

LOOKING FORWARD

Given the current climate, Dr. Benabio, Dr. Mowad, and Dr. Blanchard all predict a continued move toward more physicians becoming employees. Dr. Benabio, who sampled different practice scenarios extensively during training, said that being employed by a large organization offers a combination of lifestyle and medical focus that many physicians find extremely attractive.

“I had an open mind during training. I had an opportunity to work at Kaiser when I was a resident, which was helpful, but I also worked in a number of private practices, including some pretty well-known cosmetic practices in Orange County and Los Angeles, to get a sense for what it would be like with my work and lifestyle,” Dr. Benabio said.

“Based on all the information I had from those experiences, I made the decision to work here. It was nice to have those experiences and make a decision that I was truly free to make.”

In addition, Dr. Mowad said, younger physicians tend to gravitate toward facilities that can provide the best equipment and opportunities to stay on the cutting edge. Smaller practices, she said, simply can’t match the resources offered by larger organizations.

“Working for Geisinger has allowed our practice to have state-of-the-art computers and equipment with no direct cost to me. I’m not having to take money out of my practice to pay for EHR, e-prescribing software, or new hardware — all of which are becoming mainstays in every practice. The institution has spent significant dollars, and I’ve benefitted from that,” Dr. Mowad said. “Weighing that with the direction that medicine is moving, we’re going to see much more of a trend of physicians being employed.”

While the ultimate results of health system reform are yet undetermined, it’s clear that for at least the near future, more new and established physicians will be pondering the concept of becoming an employed physician. dw

PROS AND CONS

Whether it’s making the decision about where to start one’s career or contemplating whether a change of practice would be beneficial, it’s vital to consider all the elements involved and how they interact with a practitioner’s preferences and experiences. The Academy’s practice management staff detailed the strengths and potential pitfalls of the different practice scenarios dermatologists are most likely to consider.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Potential pitfalls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting a practice</td>
<td>Complete autonomy and entrepreneurial freedom, as well as high patient demand in many areas of the country.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Joining a small single-specialty group</td>
<td>Shared patient responsibility, income predictability, and expense sharing.</td>
</tr>
<tr>
<td></td>
<td>Professional camaraderie and the potential to coordinate care.</td>
</tr>
<tr>
<td></td>
<td>Can expand market share and increase scope of services.</td>
</tr>
<tr>
<td>Joining a multispecialty group</td>
<td>Greater care coordination and reliable in-house referrals.</td>
</tr>
<tr>
<td></td>
<td>High degree of coverage flexibility and professional camaraderie, with income predictability.</td>
</tr>
<tr>
<td></td>
<td>Good potential to diversify services in-house.</td>
</tr>
<tr>
<td></td>
<td>Capitation and risk-sharing continue to advance as prominent strategies while the government pushes the ACO model.</td>
</tr>
</tbody>
</table>
Reach Your Patients on the Internet
Anywhere, Anytime, Any Device

Your New Website Live in Just Hours

- Easy & fast website launch—we handle everything!
- Pre-designed layouts and editable pre-written Web page content
- Mobile site available for smartphones and tablets
- Start getting found online by new patients immediately

Save $500
Call for details

24/7 communication with new, referred and existing patients
Patient education available from any device, including mobile
New patient forms & appointment requesting all accessible from website

888.506.1286
www.AADDermsOnline.org
Rebellion and Remorse

More Americans getting—and getting rid of—tattoos
What do Ötzi the Tyrolean Iceman and Tokidoki Barbie have in common? Tattoos — lots of them. The 57 tattoos that were found on the mummified remains of Ötzi, who lived in the Alps near the border of Austria and Italy about 5,300 years ago, were created with fireplace soot, according to a study in the *Journal of Archaeological Science* (2009;36(10):2335-2341). Because several of the tattoos appear over typical acupuncture points for treating back and leg pain, researchers believe they may have had more of a therapeutic than a decorative purpose. In contrast, the tattoos adorning Tokidoki Barbie, who also sports pink hair and leopard print leggings, are purely decorative, a nod to fans of the Japanese-inspired lifestyle brand.

Although the tattooed Barbie raises the ire of some parents, it also points to a growing acceptance of body art as a legitimate form of self-expression, particularly among younger Americans. “Tattoos are far more prevalent than they were 20 years ago, and there are far more in the current younger generation than there are in people 50 and over,” said Scott A. Norton, MD, MPH, staff dermatologist at Georgetown University and chief of dermatology at Children’s National Medical Center. And just as more tattoo parlors are springing up to serve a growing market, tattoo removal clinics are proliferating as well. While removal is often practiced by non-dermatologist physicians (and even by non-physicians in some states), it is dermatologists who are advancing the science of tattoo lightening, as evidenced by recent studies using Q-switched and picosecond lasers. >>
FROM MARGINS TO MAINSTREAM

The modern history of tattoos dates back to the 18th century Pacific island voyages of Captain James Cook and a handful of other European explorers, according to Dr. Norton, who maintains a strong anthropological interest in the topic. “The word ‘tattoo’ is a pan-Polynesian word meaning ‘to tap,’” he noted. “As Cook and his crew stopped on the islands of Polynesia and Melanesia, they observed an abundance of tattoos and saw that they were not simply decorative, but also conveyed essential information about the individual and his or her place in society. Cook’s scientist and a few of the sailors got tattoos, and when they returned to England, the whole concept of having tattoos became quite exotic, associated with these Eden-like South Sea islands.” As time went on, the concept of having tattoos became more prevalent among lower socioeconomic classes in Europe and were associated with the “marginalized populations” throughout the 19th century, Dr. Norton said.

Similarly, Americans with tattoos in the early 1900s were widely regarded as part of a “fringe population” with unsavory reputations: prostitutes, circus sideshow performers, and the like, Dr. Norton remarked. “All that changed with World War I, when very respectable people went off to war and came back with tattoos. The same thing happened in World War II; we can say that much of our greatest generation obtained tattoos as a memento of their experiences in the war.” But tattoos also remained popular among certain fringe elements, such as white supremacist groups. “Law enforcement groups recognized certain designs as pretty obvious markers of antisocial behavior and created a field guide to these tattoos,” Dr. Norton explained. “In the late 1980s, the Department of Defense issued a directive prohibiting the enlistment of soldiers with particular hate-based markings.”

Tattoos among women in the military caught the attention of an Army nurse who would become a leading expert in the sociology of tattoos. “Around 1989, as I was performing a lot of physicals, I began to see tattoos on enlisted women and officers,” said Myrna Armstrong, EdD, RN, professor emerita at the Texas Tech University Health Sciences Center School of Nursing. “I was so surprised, and the more I talked to them, the more interested I became in the phenomenon of women getting tattoos.” Ten years later, Dr. Armstrong and a few of her colleagues at Texas Tech formed a small research group “looking at sociology, religion, studies for decision-making, complications, and trends” relating to tattoos (and more recently, body piercing).

TWENTY-FIRST CENTURY TRENDS

Tattoos can easily be observed on business professionals, college students, parents and grandparents, as well as on athletes, entertainers, bikers, and military personnel. In some areas, tattoo parlors have morphed into upscale studios with spa-like ambiance. But the increase in tattoos among the general population is difficult to document precisely. The most recent nationwide survey of tattoo prevalence, published in the Journal of the American Academy of Dermatology (2006;55(3):413-21), found that 24 percent of the 500 respondents (aged 18 to 50) had a tattoo, and 65 percent had considered getting one. Co-authored by Anne E. Laumann, MBChB, and Amy J. Derick, MD, the study examined the association of tattoos with age, sex, level of education, jail time, and recreational drug use. Respondents with tattoos were also asked about local medical problems within two weeks of getting tattooed, and about the impact of their decision on work and social settings. Among the key findings:

- Half of respondents with tattoos had multiple tattoos, and younger respondents were more likely to have more than one.
- Men were slightly more likely to have tattoos (26 percent) than women (22 percent).
- Thirty-six percent of respondents born between 1975 and 1986 had tattoos, compared with 24 percent of those born between 1964 and 1974, and 15 percent of those born between 1953 and 1963.
- Recreational drug use and the current or past high consumption of alcohol was significantly more common among the tattooed than the nontattooed.

TATTOOS IN THE DERMATOLOGY OFFICE

Body art may be gaining acceptance in the workplace, but many dermatology practices forbid their employees from displaying visible tattoos, said Rhonda Holloway, president of the Association of Dermatology Administrators and Managers. “There are no guidelines set by our organization, though we have hosted speakers at our annual meeting who have addressed the issue. In the world of dermatology it’s a practice-by-practice choice,” Holloway said. “I certainly have gone into other [non-dermatologist physicians’] offices and seen employees with tattoos. But in our practice, and in those I’ve had this discussion with, the feeling is that when you’re in the business of promoting healthy skin, we as a physician’s office should not be promoting tattoos, just as we would not promote tanning.”

Holloway manages a Shreveport, La. practice with seven dermatologists and 50 employees. She compared the no-tattoo policy with the requirement for wearing a uniform, and said she makes both very clear to job applicants during the interview. “You have to be very upfront with them at the very beginning,” she insisted. “We don’t discriminate against people with tattoos, but our policy is that if you have a tattoo, it may not show when you’re working in the office. That normally means that you have to wear long sleeves, or socks, or whatever it takes. So far, that’s worked very well for us.”
• No one had had a tattoo removed, although 17 percent had considered it.

“It is clear that people of lower socioeconomic class and people who have been in jail for three days or more are more likely to have tattoos,” said Dr. Laumann, who is professor of dermatology and chief of general dermatology at Northwestern University’s Feinberg School of Medicine. Her findings also indicated that the more highly educated respondents were far less likely to have tattoos than those who did not finish high school. Some notable exceptions are profiled in a book cited by Dr. Norton. Published in 2011, Science ink: Tattoos of the science obsessed, by acclaimed science writer Carl Zimmer, features more than 350 color photographs of tattoos worn by scientists and scholars, including those depicting Darwin’s finches, the uranium atom, physics equations, and the neural network of the brain.

A 2010 Pew Research Center report on the “Millennials” (those between ages 18 and 29 at the time of the survey) found that nearly 40 percent have tattoos — a higher percentage than in the youngest group surveyed by Dr. Laumann in 2004 — and about half of those with tattoos have two to five. In a study of college students and tattoos, published in the Journal of Psychosocial Nursing (2002;40(10):20-29), Dr. Armstrong cited a “tattoo renaissance in people of all ages, social classes, and occupations.” She noted that despite the physical risks, which include infections and transmission of blood-borne diseases such as hepatitis B and C, tattoos remain popular among college students (19 percent of students in her study had tattoos, which she called “the highest recorded amount in a civilian group”). Dr. Laumann pointed out that an acceptance of body art may now start in childhood. “All young people I know take their children to parties, and the child comes home with a temporary tattoo,” she said. “Mom thinks it’s alright — you’ve told that child that decorating the skin is OK. That never would have happened at a party when I was a child.”

“We know that one of the reasons people obtain body art is that it makes them feel good, feel special and unique,” Dr. Armstrong said. “It’s so interesting to step into the lobby of a tattoo parlor and see who’s there. It’s a cross section of individuals, from the 15-year-olds to the 60-year-olds. But it’s important not to lump them together; the people with one tattoo aren’t like the ones with five. We have found that the higher the amount of tattoos or piercings, the higher the risk of deviant behavior, such as marijuana use and cheating on exams.”

While Dr. Armstrong has written extensively about the risks of infection and hepatitis associated with tattoos, she said the incidence of these complications is difficult to quantify. “You would have to test the individual before and after they went into the studio to establish tattooing as the cause of hepatitis, and we have no data on a direct link,” she said. “Infection will usually occur during the procedure, either from the artist, from the individual, or from a previous individual. For all the tattoos created, I believe there have been very few problems with infections, especially as compared to body piercings.” Consumer
TAKING IT OFF
While tattoos may be entering the mainstream of society, they are not universally accepted, particularly in the workplace environment (see sidebar). In a study examining the motivations for tattoo removal, published in Archives of Dermatology (2008;144(7):879-84), the authors note that women “had experienced significantly more negative comments and stigma problems in public, workplace, or school settings than had the men with tattoos. Problems with clothes were also significant and led them to use cosmetics, creams, and adhesive bandages to cover their tattoos.” For many, the symbols of their individuality and identity had become a barrier to fitting into a corporate culture.

Tattoo removal with lasers was revolutionized in the 1980s when R. Rox Anderson, MD, professor of dermatology at Harvard Medical School and director of the Wellman Center for Photomedicine, developed the theory of selective photothermolysis as applied to the Q-switched ruby laser.

“He basically figured out that different colors preferentially absorb different waves of laser energy, so each color could be targeted by a specific wavelength,” said Allan Izikson, MD, a dermatologist in private practice who conducts clinical research at the Wellman Center. “He also found that for optimal destruction of pigments, the duration of the laser pulse has to be less than the thermal relaxation time of the target — that’s the amount of time in which a particle loses half its heat.”

Modern conventional laser therapy for tattoo removal may involve the use of different lasers to achieve the optimal wavelengths, Dr. Izikson said. Results of the treatment will depend on a number of factors, including whether the tattoo was done by an amateur or professional (the latter is more difficult to remove); whether it is a new or an old tattoo; and the color and chemical composition of the ink. While the laser treatments can lighten tattoos significantly, some pigment is likely to remain. In addition, the treatments are expensive, require multiple visits, and can be painful. “It’s important to understand the capacities of the technology and also the limitations,” Dr. Izikson said. “And you have to know how to speak to patients realistically about expectations. That’s paramount.” (See sidebar, p. 29.)

Recent research conducted in Greece and supervised by Dr. Anderson may lead to better results with fewer treatment sessions. Greek dermatologists treated 18 tattoos on 12 adults. Each tattoo was divided into two approximately equal parts, which were randomized to receive either conventional therapy (a single treatment pass) or four consecutive passes separated by 20-minute intervals (called the “R20” method). A Q-switched alexandrite nanosecond laser was used for both groups. With the R20 method, 61 percent of the sites cleared completely. Among the tattoos treated with conventional therapy, none cleared completely, and lightening was much less than with the R20 method. On a self-assessment questionnaire, 97 percent of subjects said they would recommend the R20 treatment to others. (The study has been accepted for publication by the JAAD.)

“The principal of R20 is very sound, and has a lot of foundation in biology and science,” Dr. Izikson said. “But of course, the only way to find out if it works on a mass scale is to do it on all kinds of colors and tattoos.” In his own research at the Wellman Center, Dr. Izikson tested the concept with fewer treatment passes and a different laser. “We took an ultrafast laser, in the picosecond range, and treated one part of the tattoo with one pulse and another part with two pulses separated by 20 minutes,” he explained. “We repeated the process one month later, and again after another month. We wanted to see if we could replicate the same kind of efficacy as the four treatments per session. And we did see some improved lightening, not quite as dramatic as with the four treatments. We’re still waiting for the final results at the three-month follow-up. But the patients were pretty happy with the results; some of these tattoos almost completely went away.”

Not surprisingly, laser tattoo removal is a booming business. A recent article in the Washington Post (“Rethinking the ink: Laser tattoo removal gains popularity,” Dec. 8, 2011) quotes an entrepreneur who took a two-week course to become a certified laser specialist, invested $90,000 in equipment, and now operates out of an office building. Regulations regarding who can operate a laser vary by state; Dr. Izikson noted that in New York it must be a physician but not necessarily a dermatologist. “You can have an opinion one way or the other, but I believe the patient who cares about getting the best results should probably go to the professional who’s best trained to do the procedure, who understands the limitations of the technology, and can medically manage the side effects,” he said. "Dev"
Upcoming CME Activities

Annual Clinical Symposium – Dermatologic Surgery: Focus on Skin Cancer

Memorial Day Weekend, May 24-27, 2012
Sheraton Wild Horse Pass Resort & Spa – Chandler, Arizona

Top experts in the field will provide updates on a wide range of dermatologic surgery and Mohs surgery topics. Separate interactive panels will discuss appropriate repair strategies for a variety of surgical wounds and innovative approaches to melanoma treatment. Both Mohs and non-Mohs cases will be featured in the microscope laboratory. Mohs nursing staff, technicians and other Mohs support personnel will increase their knowledge of skin cancer treatment and develop a greater appreciation for their unique roles in supporting high quality dermatologic care.

AMA PRA Category 1 Credit Available

Save the Date!

Closure Course and Fundamentals of Mohs Surgery

November 5 - 7, 2012 – Closures Course for Dermatologists

Course prerequisite is basic experience in cutting and sewing skin, and program is designed to take dermatologists to the next level of dermatologic surgery practice. This is an intense 2-day experience in closure considerations for the surgeon with a primary interest in closing surgical defects. It will feature practical techniques, site specific discussions, and numerous reconstruction “pearls,” based upon presenters’ extensive derm surgery experience.

November 8 - 11, 2012 – Fundamentals of Mohs Surgery for Dermatologists and Mohs Technicians

Developed as a comprehensive introduction to Mohs surgery, the course provides an overview of Mohs indications, mapping techniques, office set-up and instrumentation, and interpretation of Mohs histopathology. Instruction in key concepts is facilitated by lectures, “pearls” discussions, interactive Q&A sessions, video microscope demonstrations, and challenging microscope electives. The Mohs technician program will feature hands-on training in Mohs laboratory techniques and incorporate important safety and regulatory guidelines and updates. A high faculty-to-student ratio helps ensure rapid skill development and advancement, and allows for discussion of critical troubleshooting techniques relative to tissue processing and slide preparation.

AMA PRA Category 1 Credit Available

For additional information regarding ASMS educational activities, membership opportunities, and patient resources, please contact:

Novella Rodgers, Executive Director
American Society for Mohs Surgery
5901 Warner Avenue, Box 391
Huntington Beach, CA 92649-4659
Tel: 800-616-2767 or 714-379-6262
Fax: 714-379-6272
www.mohssurgery.org
execdir@mohssurgery.org
They’re never too young to learn sun-safety!

The See SPOT CD is the perfect tool to educate children on sun-safety and skin cancer detection and prevention. Children will enjoy learning sun-safety with the activities, coloring sheets, and word finds offered in the See SPOT CD.

Broken into four age specific groups (grades K-2, grades 3-5, pre-teens and teenagers, and adults), the See SPOT PowerPoint™ presentations are sure to grab the attention of any audience.

Visit the AAD store at www.aad.org/store or call (866) 503-SKIN (7546).

If you were in San Diego for the Annual Meeting, you could not have missed the launch of SPOT Skin Cancer™, the Academy's new public awareness campaign designed to educate the public about skin cancer prevention and detection. The campaign's distinctive logo and bright colors were all over the convention center — and we are looking for your help to make a similar impact when we launch to the public starting on Melanoma Monday, May 7.

The goal of SPOT Skin Cancer is a goal we as dermatologists, in our day-to-day work and as an Academy, have long committed ourselves to: preventing and detecting skin cancer. As its tagline (Prevent. Detect. Live.) suggests, SPOT will help the public to understand that skin cancer is, in fact, easy to prevent: Simply seek shade, cover up, and wear sunscreen. SPOT will also reinforce the fact that skin cancer is easy to detect — our potential patients need only look for new or changing spots on their skin. And if they do spot something that is changing, itching, or bleeding, SPOT will urge them to see a dermatologist.

How can you help make SPOT a success? First, spread the word. Use the Academy’s SPOT-branded resources, which will include the SpotSkinCancer.org website. (Linking to this site from your own practice website will help enhance recognition of the campaign.) Second, get involved by volunteering your time and expertise to help others prevent and detect skin cancer. (Many of you already do this as part of the Academy’s skin cancer screening program — I hope SPOT will inspire more of you to join your colleagues in this valuable volunteer effort.) Third, support SPOT Skin Cancer by donating to the Sustaining Fund or purchasing SPOT items, which will include t-shirts, wristbands, and water bottles with the SPOT logo on them; the funds we raise will be used to educate the public about the importance of skin cancer detection and prevention.

You and the Academy will not be alone in promoting the goals of SPOT Skin Cancer. Our goal is to orchestrate a broad-based, comprehensive campaign that brings together numerous partners in the fight against skin cancer. We will seek SPOT partners among our existing corporate partners, other for-profit companies, state and subspecialty dermatology societies, the media, and the public. We imagine they will be impressed by the positive data we have collected through focus testing of adult men and women, which indicated resounding support for a skin cancer initiative of this nature. The name, logo, and colors we are using have also been tested and refined to have maximum impact.

SPOT Skin Cancer will bring together under one visual identity the many programs the Academy already has in place, including the skin cancer screening program, our skin cancer-focused PSAs, and our Shade Structure Grant program.

While we are currently funding all of these activities ourselves, the additional attention and funding we expect SPOT to attract will offer us the opportunity to explore new programs to enhance our public education efforts related to skin cancer detection and prevention.

SPOT Skin Cancer will be launched to the public on Melanoma Monday, May 7, as part of National Melanoma/Skin Cancer Prevention and Detection Month®. To learn more and sign up to play your part, visit www.SpotSkinCancer.org.

Of course, we can’t forget our other missions and as this is an election year, SkinPAC needs your help. Remember, if we hit the $1 million mark my head, excluding lashes and brows, can be shaved onstage at the summer meeting by the highest donor or donors. I, of course, am not worried. I wear hats. dw
International scholarships to 2013 Annual Meeting available

POSTER EXHIBIT AND REGISTRATION SCHOLARSHIPS make it possible for young dermatologists from around the world to attend the Academy’s Annual Meeting each year. Information about scholarships for the 71st Annual Meeting, being held March 1-5, 2013 in Miami Beach, Fla., appears below. (Previous scholarship recipients are not eligible.)

POSTER EXHIBIT SCHOLARSHIPS
Applicants must be from developing countries as defined by the World Bank and within three years of completion of their dermatology residency training at the time of the Annual Meeting. The scholarship includes a registration waiver, free admission to one post-graduate ticketed session (subject to availability of space), and a stipend. There is a limit of two scholarships per country. Applicants must be endorsed by an officer of their national dermatologic society and must submit a poster abstract. Applications are due July 31, 2012.

REGISTRATION SCHOLARSHIPS
Scholarships are offered to dermatologists from all countries except the U.S. and Canada and are limited to two recipients per country. Recipients will receive a meeting registration waiver and free admission to one post-graduate ticketed session course (subject to availability of space). Successful candidates must have adequate funds for travel and housing, and should be able to understand spoken English. Applicants must complete and submit an application and officers of national dermatologic societies must complete and submit a nomination form through the website. Applications and nominations are due Sept. 1, 2012.

For more information about either scholarship, visit www.aad.org/education-and-quality-care/awards-grants-and-scholarships or contactCoura Badiane, international affairs specialist, at cbadiane@aad.org or (847) 240-1241.

– COURA BADIANE

Academy Executive Director announces retirement

Ronald A. Henrichs, CAE, has announced his retirement as the Academy’s Executive Director and CEO effective June 5.

“I have been anticipating retirement for a while, and it is with careful consideration that I have decided to spend more time with my family and to pursue the next phase of my life, including my passion for sailing and diving.”

Henrichs’s contributions during his nearly eight-year tenure include strategic planning, growth of the scientific meetings, expanded advocacy initiatives, enhanced membership services/support, and expanded specialty positioning activities.

“In my time as CEO, I have had the privilege to work with members and staff to advance the specialty and to further the growth of the Academy. Our accomplishments are myriad, and the AAD’s reputation as a premier medical specialty society has never been more prominent.”

New AK public education campaign tells public: “Listen To Your Skin”

THE AMERICAN ACADEMY OF DERMATOLOGY and LEO Pharma have joined together to educate Americans that sunburns and premature aging are not the only indications that skin has been damaged by UVR exposure. LEO Pharma and the Academy have partnered to launch Listen To Your Skin, a campaign aimed at raising awareness about the consequences and symptoms of cumulative sun damage, including actinic keratosis (AK) and skin cancer.

“The Academy is proud to work with LEO Pharma on the Listen To Your Skin campaign,” said Academy President Daniel M. Siegel, MD. “We hope Listen To Your Skin will raise awareness of how to prevent and detect sun damage and encourage the public to visit a dermatologist when appropriate.”

The foundation of the campaign is an educational website where visitors can discover more about AK and sun damage, view photos of AKs and skin cancers, and find out how to check their skin. Encourage your patients to visit www.listentoyourskin.org and learn more about sun damage.

The non-branded campaign debuted in mid-February with a national media relations effort. AAD member Ellen Marmur, MD, is serving as the campaign’s spokesperson. This month, Dr. Marmur is participating in a nationwide media tour to discuss the results of a consumer survey on attitudes about skin health and relationships, and to encourage the public to prevent and detect sun damage.

LEO Pharma is also supporting the Dermatology A to Z section on AKs on aad.org and will support the next printing of the Academy’s AK pamphlet.

– MISSY LUNDBERG

– COURA BADIANE
AAD election candidates
Votes due April 16; visit www.aad.org/election to vote

**PRESIDENT-ELECT**

Brett M. Coldiron, MD  Suzanne M. Connolly, MD

**VICE PRESIDENT-ELECT**

Elise A. Olsen, MD  Lisa A. Garner, MD

**BOARD OF DIRECTORS**

Paul A. Storrs, MD  Howard B. Pride, MD  Robert T. Brodell, MD  Wendy E. Roberts, MD  Amy McMichael, MD  Linda Susan Marcus, MD  Julie A. Hodge, MD, MPH  George J. Hruza, MD, MBA

**NOMINATING COMMITTEE MEMBER REPRESENTATIVE**

Dan McCoy, MD  C. William Hanke, MD, MPH

Are you ready to vote? Scan this image with your smartphone or iPad and vote now! (QR app required)

---

**DATEBOOK**

**WHAT’S COMING UP**

**APRIL 1**  ABD pediatric dermatology subspecialty exam applications due for October exam. See www.abderm.org.

**APRIL 8**  Camp Discovery volunteer applications due. See www.aad.org/forms/CampDiscovery-VolunteerApplication/Default.aspx.

**APRIL 16**  2012 AAD election closes. See www.aad.org/election.

**MAY 7**  Melanoma Monday, See www.SPOTSkinCancer.org.

**MAY 17**  Coding Surgical Repairs, Transfers, and Grafts – Oh My! webinar. See www.aad.org/webinars.

**JUNE 6**  Everett C. Fox, MD Lectureship nominations due. See www.aad.org/namedlectureships.

**AUG 15**  Summer Academy Meeting in Boston.

**SEPT 20**  Update your Modifier 59 Knowledge webinar. See www.aad.org/webinars.
Dermatologist puts practice on hold for Army

Newport Beach, Calif., dermatologist Dore Gilbert, MD, found himself at a crossroads in early 2009. He’d built a successful medical practice and established a close family, but remained fixated on one thing left undone. Hoping to set things right in his mind and serve his country, Dr. Gilbert applied to the U.S Army Medical Corps in 2009. He recently returned from a deployment in Afghanistan.

Dr. Gilbert pulled out of committing to the Army in 1983. The deployment requirements, he said, proved a bit too much for his situation. “If you got called up at the time, you were gone for a year,” Dr. Gilbert said. “I had a new practice and a new home, and had I joined, I’d probably have lost both. I couldn’t put my wife in that situation. We had two little kids at home and one on the way.”

By 2009, Dr. Gilbert had expanded his practice to include an associate and raised his children, including a son in the Marines. The time felt right to revisit the Army Medical Corps. “I’d always felt bad about backing out, but I believed and I still believe that it was the right decision at the time. But when my youngest son joined the Marine Corps, it got me thinking about it again,” he said. “All my kids were grown, my practice was matured, and it would be a good time if I was ever going to do it to look into enlisting.”

He called a recruiter, who told him to get his application in as quickly as possible: at 59, he was one year shy of the cutoff for doctors. Dr. Gilbert became a physician in the reserves at age 60. The challenge of basic training, he said, was considerable. “Usually the mental challenge of basic training is more difficult than the physical, but at my age both were pretty difficult,” he said. “I lost about 30 pounds. It looked as if someone had Photoshopped my face onto another body.”

Following his completion of basic training, Dr. Gilbert served a deployment in Afghanistan. “I know that I contributed to the soldiers that I was re-connecting with that as my example.”

“I was lucky to have good mentors and a lot of opportunities for volunteer work.”

• Since 2008, Dr. Carlos has worked extensively with Carrie Kovarik, MD, one of her mentors during residency at the University of Pennsylvania, to bring quality dermatology education to medical students in countries around the world.

• “My father was a physician, and he always spent a lot of time volunteering and taking care of others. I grew up with that as my example.”

• In August 2009, Dr. Carlos traveled to Monrovia, Liberia, which was just beginning the rebuilding process after years of violent unrest. She and Dr. Kovarik gave 20 hours of lectures on dermatology and dermatopathology to the medical students at John F. Kennedy Hospital.

• “Everything had been bombed and gutted, but they had kept the medical school open. The United Nations was still on the ground, and there was a very precarious feeling in the country.”

• In addition, Dr. Carlos has traveled to the University of Costa Rica to lecture with Dr. Kovarik on dermatopathology for Mohs surgery, developed case-based dermatology lectures in Lima, Peru, and has worked in Botswana as a volunteer as part of the AAD Resident International Grant program.

• “A big part of why I love this is learning — meeting these wonderful people and exchanging information. Whenever I’ve come back to the U.S., I feel like I’m re-focused on why I went into medicine.”

To nominate a physician, visit www.aad.org/membersmakingadifference.
ALBUQUERQUE, NEW MEXICO
Well established solo derm practice. Working 3 days a week. Medical, surgical, and cosmetic. Lease up for renewal in August. Will stay 6-12 months if needed. Price to depend on valuation to be done if serious interest. (505) 417-3787.

MANHATTAN
General/Cosmetic derm practice with small spa and office condo space in prime location. Ideal as solo or group practice; great deal; owner financial possible. Email: a2352099@pol.net.

NEW YORK, NEW YORK
32 year-old well respected solo Park Avenue dermatology practice with large referral base for sale. Mix of medical and cosmetic dermatology. Could easily be expanded to offer more cosmetic and surgical procedures. Email: mtderm@aol.com.

OREGON
Mehm surgeon/dermatologist contemplating retirement in 6-18 months. Practice offers a combination of Mohs, reconstruction, lasers, cosmetic and general derm. Productive PA and a loyal staff. Located blocks from Portland, Oregon, land of biking, hiking, beautiful scenery and a relaxed lifestyle. Principals only. Please respond to pgoodkin11@aol.com www.GoodSkinMD.com.

TEXAS

HOUSTON, TEXAS
80% + private pay practice. Can double income with use of laser, fillers, & surgeries being referred out. Be independent from Managed Care! Email to houstonermsale@yahoo.com.

**PRACTICES FOR SALE**

**PRACTICE FOR SALE OR LEASE**

ELIZABETHTOWN, KENTUCKY
36 YEAR ESTABLISHED FUNCTIONING PRACTICE.

Critical need for a dermatologist in growing area near Ft. Knox. Tremendous potential. Office is a 2-story converted home on 2/3 acre of commercial land on main traffic route, across from hospital with a Human Resource center located 10 miles from office containing a large federally employed population. Turn key operation with experienced staff. Located 40 miles south of Louisville, Kentucky on I-65. Call or email to discuss generous terms. Available at (877) 769-6327; derma@windstream.net or (423) 821-8230; jmgalex@epbf.com.

**PROFESSIONAL OPPORTUNITIES**

St. Petersburg, Florida - Immediate Position Available on Florida’s Beautiful Gulf Coast:

Immediate position available for a full or part time BE/BC general/cosmetic dermatologist to assume an existing busy dermatology practice within a large multispecialty group. This opportunity includes working alongside a full time Mohs Surgeon and comes with an unlimited potential for growth. An interest in dermatopathology is a plus. Expected annual income is based on productivity and is competitive. Office is moving to a brand new state-of-the-art facility in 2013.

Interested candidates should contact Kelli Drayton at: kelli.drayton@baycare.org or (727) 502-4176.

**CLINICAL DERMATOLOGIST OPPORTUNITIES**

Geisinger Health System is looking for full-time or part-time Clinical Dermatologists to join our very active and growing Dermatology Department at Geisinger Medical Center (GMC) in Danville, PA and Geisinger Wyoming Valley (GWW) Medical Center in Wilkes-Barre, PA.

Geisinger’s Dermatology Department offers a friendly, collegial work environment that allows physicians to create a balance between individual practice and resident teaching while pursuing clinical opportunities in specific areas of interest. Research and publication are not required but opportunities abound. The region boasts exceptional quality of life with a low cost of living and excellent public and private school systems. Our practice sites are surrounded by several universities, offering cultural and athletic events. Both Danville and Wilkes-Barre are within a few hours drive of New York City, Philadelphia and Washington, D.C.

Geisinger offers a very competitive salary and benefits package beginning on the first day of hire.

For more information or to apply for this position, please contact Lori Surak, Professional Staff Recruiter, at 1-800-845-7112 or ljsurak@geisinger.edu.
PROFESSIONAL OPPORTUNITIES

SOUTHERN ARIZONA
Starting salary $750,000

TUCSON, ARIZONA
Leading dermatology practice specializing in adult, pediatric, & cosmetic dermatology and laser & skin surgery (e.g., Mohs) seeks experienced BC/BE general dermatologist to grow with our exceptional team of five providers and 20 support staff. A highly competitive salary & benefit package with partnership potential awaits the ideal candidate. Please submit a CV and letter of interest to Rachel Chánes at rchanes@pimaderm.com. Please visit pimaderm.com for more info.

BOULDER, COLORADO
Established Mohs/Cosmetic dermatology practice seeks exceptional BC/BE dermatologist. State-of-the-art office, excellent staff, established EHR, outdoor activities abound. Guaranteed salary and incentives. Please submit a CV and letter of interest to jschnieder.db@ gmail.com or fax to (303) 442-2696.

FLORIDA
Southeast Treasure Coast Florida. 2-1/2 Days/week, BC/BE Dermatologist. Salary plus bonus & Benefits. Send CV to rakjak1@gmail.com.

SOUTHEAST FLORIDA
Practice looking for part or full time general dermatologist for two of its Palm Beach County locations. Fax resume to (888) 650-7801.

MIAMI, FLORIDA
Mohs Surgeon Needed
Fellowship trained Mohs surgeon sought for 2 days per month. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgrou.com. www.mydermgrou.com.

SOUTHERN NEW JERSEY
Great opportunity for BC/BE dermatologist in Medford, NJ. Beautiful community near Philadelphia, PA and Cherry Hill, NJ. Well-established busy dermatology practice in a brand new facility, with associated medical spa. Opportunity for competitive salary, benefits, and practice ownership. FT/PT position available. Email inquiry to CV to Becky@accentderma.com.

NEW HAMPSHIRE
Mohs Surgeon Needed

WELLESLEY, MASSACHUSETTS
Board certified or board eligible dermatologist for dynamic, busy practice. Flexible full time or part time. www.krausserdm.com. Email CV to Maureen@krausserdm.com.

CONCORD, MASSACHUSETTS
An opportunity for a part or full time Dermatologist to join a group of six Board Certified Dermatologists in a professionally run practice with Dermatopathology, Mohs, Dermatology Certified Nurse Practitioners, Medical Aesthetics, and consulting facial plastic surgeon. The opportunity would allow a highly qualified dermatologist to practice with numerous laser and light sources, electronic health records, and a excellent support staff in a collegial practice in attractive Boston suburbs or resort area of New Hampshire with opportunity for competitive salary, benefits and practice ownership.
For more information, please contact: Glenn Smith, MHA; Administrator and Chief Operating Officer, at (978) 610-3701 or email to gsmith@apderm.com.

NEW YORK
Wallstreet and Park Avenue offices of established plastic surgeon is seeking a BC/BE general dermatologist to join practice or rent space. Please contact Gigi at (212) 744-9400 or info@donaldrolandmd.com.
NEW YORK
Laser & Skin Surgery Center of New York has an immediate opportunity for a full time clinical position in our active laser and related technologies research program. The physician will have an opportunity to participate in clinical trials involving new and evolving treatments for a wide variety of medical and cosmetic conditions. Publication and lecturing opportunities should be numerous. Dermatology training is preferred prerequisite, but not essential. Salary will be commensurate with experience. Interested candidates should contact mail@laserskinsurgery.com for consideration.

SOUTHEAST FLORIDA
Starting salary $750,000

ROCHESTER, NEW YORK

TUCSON, ARIZONA
Starting salary $750,000

MIAMI, FLORIDA
Mohs Surgeon Needed
Fellowship trained Mohs surgeon sought for 2 days per month. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgrou.com. www.mydermgrou.com.

PRINCETON, NEW JERSEY
• Well-established practice looking to expand
• Vibrant university town close to Philadelphia & Manhattan
• State-of-the-art facility opened in July 2010
• Competitive salary & benefits
Contact Jayme at (609) 924-7690 www.princetondermatology.com

SAVE! the DATE
August 15-19, 2012
Boston, Mass.
www.aad.org/meetings-and-events
PeaceHealth is a Washington-based not-for-profit Catholic healthcare system with seven medical centers, critical access hospitals, medical groups and laboratories in Alaska, Washington and Oregon. Founded by the Sisters of St. Joseph of Peace, PeaceHealth employs more than 14,000 caregivers and has consistently received national recognition for innovations in patient-centered care, patient safety and healthcare technology and cost efficiency.

PeaceHealth offers an employment model with a comprehensive benefit package including excellent retirement and health coverage, vacation, CME allowance, malpractice coverage, tail insurance, sign-on bonus, relocation and educational loan reimbursement.

**General Dermatologist – Eugene, OR**

We are seeking a full-time BC/BE general dermatologist with experience in medical and surgical dermatology. We offer a busy state-of-the-art facility shared with one MOHS Surgeon.

**General Dermatologist – Longview, WA/Portland, OR**

PeaceHealth, in conjunction with the Division of Dermatology at Oregon Health & Science University (OHSU), is recruiting a General Dermatologist. This unique OHSU employed with faculty appointment opportunity is based 4 days in Longview and 1 day at OHSU with no call responsibilities.

For more information, visit www.peacehealth.org or contact Carol Shea at (360) 414-7867, cshea@peacehealth.org

Sanford Clinic Dermatology is looking to add a BC/BE Dermatologist to its current group of 7 physicians. An interest in Pediatric Dermatology would be a plus. 4.5 work week. Competitive two-year guarantee with Enhanced Physician Benefit plan. No State Income Tax and Relocation Allowance.

The City of Sioux Falls is one of the fastest growing areas in the Midwest, currently totaling over 180,000 in the greater Sioux Falls area. Sioux Falls, the largest city in the state, balances an excellent quality of life, a strong economy, and a safe, clean living environment.

Darla Horton, MBA, CPHQ, FASPR
Physician Placement Associate
darla.horton@sanfordhealth.org
Phone: (605) 328-6994 or (866) 312-3907
ADVERTISING FOR DERMATOLOGY PRACTICES

New patients sometimes have to wait several weeks for an appointment with a dermatologist. But that doesn’t mean that dermatology practices can neglect advertising to ensure that potential patients know to call them when they need treatment for their skin, hair, and nails.

How are dermatology practices advertising? According to the American Academy of Dermatology’s most-recent Member Needs Assessment Survey, conducted late in 2011, the phone book is still the most popular way to advertise to patients. The results reflect responses from 941 Academy members. - RICHARD NELSON

Most-used media for advertising

*Figure based on write-in answers from respondents who selected “Other” — this was not an option offered to respondents.
She only completed 40% of your treatment plan.

Wouldn’t you rather she complete 100% now?

86% of Dermatologists reported that every month they have patients modify their treatment plans due to cost. You can avoid this by offering the CareCredit® card to every patient, along with other payment options, during your fee discussions.

CareCredit builds the cost of your care into the patient’s monthly budget, and is ideal for those getting cosmetic procedures or dermatologic procedures with high deductibles. Think of it as your patient’s beauty card they can use to pay every time they visit your practice.

Plus, it’s great for your practice because you can avoid the hassles and stress of billing and collections. You get paid within 2 business days, regardless whether the patient delays or fails to pay.

To enroll at no cost today call 866-247-3049 ext. 2

1 2010 Dermatology Market Study, Hiner & Partners, Inc.  
* Subject to credit approval  
† Subject to Representations and Warranties in the CareCredit Acceptance Agreement for Participating Professionals.  
©2012 CareCredit
Innovation.
Chart on an iPad
like you would on
paper with NexTech's
Native iPad App!

One Powerful Software Solution - Fully Integrated

Fully Integrated EMR, Practice Management, & Marketing Software

Customizable: We adapt to your patient flow, not a “cookie cutter” software solution

Innovative: Native iPad App (coming soon) & 3D EMR Diagrams

100% US Based support & development

Immediate “Out of the Box” Implementation with the ability to customize and use NexTech right away

Stability: 15 years and 7,000 providers

Bi-Directional Lab Integration: with many labs

Certified to Support Meaningful Use: Many NexTech clients have already received their first stimulus check

Contact us today to find out why NexTech is the true leader in Dermatology Software!

NexTech EMR & PM
Designed for Dermatology

www.nextech.com • websales@nextech.com • (866) 857-7809