Most important election ever?

Parties make different promises about health care’s future, but some changes have bipartisan backing.
For the treatment of moderate to severe plaque psoriasis for up to 4 weeks in adults

The right delivery for a standout performance

With its unique formulation, Clobex® (clobetasol propionate) Spray, 0.05%, contains the only class 1 steroid that can be used for up to 4 weeks¹-⁴

- An average of 80% of patients were clear or almost clear at week 4 in two pivotal Phase III trials (n=120)²

- On average, patients rated CLOBEX® Spray a 9.1 out of 10 for ease of application (n=44)⁵†

*From two randomized, vehicle-controlled clinical trials that were designed to assess the efficacy of CLOBEX® Spray (n=120) or vehicle spray (n=120) in patients with moderate to severe plaque psoriasis for up to 4 weeks. Patients were evaluated on their Overall Disease Severity.²

†From a 4-week, randomized study comparing efficacy, safety, quality of life and patient satisfaction with CLOBEX® Spray BID (n=44 per protocol) vs Taclonex® (calcipotriene 0.005%/betamethasone dipropionate 0.064%) Ointment QD (n=49 per protocol) in patients with moderate to severe plaque psoriasis. Dosing was according to approved labeling for each product, with a maximum dosage of 50 g/week for CLOBEX® Spray and 100 g/week for Taclonex® Ointment (n=93 per protocol). In the patient-reported satisfaction survey, patients rated their responses on a scale of 1 through 10 (1 being the worst, 10 being the best).²,³

Important Safety Information

Indication: CLOBEX® Spray, 0.05% is indicated for the topical treatment of moderate to severe plaque psoriasis affecting up to 20% body surface area in adults 18 years of age or older. Adverse Events: In controlled clinical studies, the most common adverse reactions (> 2%) were burning, pruritus, nasopharyngitis and upper respiratory tract infection. Local adverse reactions may occur more frequently with the use of occlusive dressings. Warnings/Precautions: Clobetasol propionate has been shown to suppress the HPA axis at the lowest doses tested. Treatment should be limited to 4 weeks. The total dosage should not exceed 50 g (59 mL or 2 fl oz) per week. Do not use more than 26 sprays for each application or more than 52 sprays in 1 day.

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.

Please see adjacent page for brief summary of Prescribing Information.
BRIEF SUMMARY
This summary contains important information about CLOBEX [KLO-bex] Spray, 0.05%. It is not meant to take the place of your doctor’s instructions. Read this information carefully before you start using CLOBEX Spray. Ask your doctor or pharmacist if you do not understand any of this information or if you want to know more about CLOBEX Spray. For full Prescribing Information and Patient Information please see the package insert.

WHAT IS CLOBEX SPRAY?
CLOBEX Spray is a prescription corticosteroid medicine used to treat adults with moderate to severe plaque psoriasis that affects up to 20% of the body’s skin surface. CLOBEX Spray is for use on the skin only (topical).
- CLOBEX Spray should only be used for the shortest amount of time needed to treat your plaque psoriasis.
- Do not use more than 26 sprays for each application or more than 52 sprays in 1 day.
- You should not apply more than 59 mL (2 fluid ounces) of CLOBEX Spray to your skin in 1 week.

You should not use CLOBEX SPRAY:
- on your face, under arms (armpits), or groin area
- if you have thinning of the skin (atrophy) at the treatment site
- to treat rosacea or perioral dermatitis (a rash around the mouth)

WHO IS CLOBEX SPRAY FOR?
CLOBEX Spray is for use in adults 18 years of age or older. Use in people under 18 years of age is not recommended because safety has not been established and because numerically high rates of HPA axis suppression were seen with other clobetasol propionate topical formulations.
Do not use CLOBEX Spray for a condition for which it was not prescribed. Do not give CLOBEX Spray to other people, even if they have the same symptoms you have. It may harm them.

WHAT SHOULD I TELL MY DOCTOR BEFORE USING CLOBEX SPRAY?
Before you use CLOBEX SPRAY, tell your doctor if you:
- have a skin infection. You may need medicine to treat the skin infection before you use CLOBEX Spray.
- plan to have surgery.
- have any other medical conditions.
- are pregnant or plan to become pregnant. It is not known if CLOBEX Spray will harm your unborn baby.
- are breast-feeding or plan to breast-feed. It is not known if CLOBEX Spray passes into your breast milk. Talk to your doctor about the best way to feed your baby if you use CLOBEX Spray.

Tell your doctor about all of the medicines you take, including prescription and non-prescription medicines, vitamins, and herbal supplements. Especially tell your doctor if you take other corticosteroid medicines by mouth or use other products on your skin that contain corticosteroids.
Ask your doctor or pharmacists if you are not sure.

WHAT SHOULD I AVOID WHILE USING CLOBEX SPRAY?
• CLOBEX Spray is flammable. Avoid heat, flames or smoking while applying CLOBEX Spray to your skin.

WHAT ARE THE MOST COMMON SIDE EFFECTS OF CLOBEX SPRAY?
CLOBEX SPRAY can pass through your skin. Too much CLOBEX Spray passing through your skin can shut down your adrenal glands. Your doctor may need to do blood tests to check for adrenal gland function while you are on CLOBEX Spray.

The most common side effects with CLOBEX Spray include:
• burning at treated site
• upper respiratory tract infection
• runny nose
• sore throat
• dry, itchy, and reddened skin

If you go to another doctor for illness, injury or surgery, tell that doctor you are using CLOBEX Spray. Tell your doctor if you have any side effect that bothers you or doesn’t go away. These are not all of the possible side effects of CLOBEX SPRAY. For more information, ask your doctor or pharmacist.

You are encouraged to report negative side effects of prescription drugs to the FDA at www.fda.gov/medwatch or call 1-800-FDA-1088. You may also contact GALDERMA LABORATORIES, L.P. AT 1-866-735-4137.

HOW SHOULD I USE CLOBEX SPRAY?
• Use CLOBEX Spray exactly as your doctor tells you to use it.
• Your doctor should tell you how much CLOBEX Spray to use and when to apply it.
• CLOBEX Spray is for use on skin only. Do not get CLOBEX Spray near or in your eyes, mouth, or vagina.
• You should not use CLOBEX Spray on your face, under arms (armpits), or groin area.
• Apply CLOBEX Spray 2 times each day.
• Apply only enough CLOBEX Spray to cover the affected skin area. Rub in gently.
• Wash your hands after using CLOBEX Spray.
• Throw away any unused CLOBEX Spray.
• Do not bandage or cover your treated areas unless your doctor tells you to.
• Tell your doctor if your skin condition is not getting better after 2 weeks of using CLOBEX Spray. Your doctor may tell you to apply CLOBEX Spray to certain areas of your skin for up to 2 more weeks if needed. You should not use CLOBEX Spray for more than 4 weeks unless your doctor tells you to. This can increase your risk of serious side effects.

WHERE SHOULD I GO FOR MORE INFORMATION ABOUT CLOBEX SPRAY?
• Talk to your doctor or pharmacist
• Go to www.clobex.com or call 1-866-735-4137

GALDERMA LABORATORIES, L.P., Fort Worth, Texas 76177 USA
Revised: March 2012

References:
There is a sentence in this month’s story about our online reputations that really resonated with me.

A nationwide survey of all Internet users found that while only 4 percent of users posted a review of a physician online, 80 percent of users (which translates to 59 percent of all U.S. adults) seek health information online, whether it’s reading the experiences of others, watching medical-related videos, or finding others with similar medical concerns.” How is it that 4 percent talk and 80 percent of us listen?

Truthfully I can’t remember a single time that I ever posted a review about anything. Even survey requests which come by the hour about almost everything seem burdensome...is there an entity in the ICD-10 list for survey fatigue? So I really shouldn’t be surprised about the power of those who take the time to do what I don’t. It is remarkable, though, how we all read those limited number of reviews and take them to heart, basing our decisions on them. Positive reviews are easy. Always fun to hear someone write that we were so caring or our office staff was so helpful. But it is even more critical to understand how to handle the less-than-complimentary ones in our technological age. I think that the approach outlined in our piece — acceptance and adjustment — makes good sense. Realizing that people will make comments both good and bad online for the entire world to see is the first half of the equation. The second half is taking the information and utilizing it to make our practices better.

I hope that you find our piece on national politics of value. No matter whether you are a political junkie or a novice, this election season will be critical for medicine...change is clearly coming regardless of the outcomes. Jack Resneck Jr., MD, tells us that some of these changes will mostly likely be the same no matter who is elected. For other issues such as Medicare payment reform, the future of IPAB, and tanning regulation, the future is murky. The results of this election therefore will be critical to our practices. We trust that you’ll find our dermatology-focused perspective of interest.

My other favorite piece this month is on photography. Being able to utilize cameras in our practices has seemed so simple in the past. Take a picture, print it out, file it in the patient’s chart — all done. However, as offices become computerized, the potential to incorporate these pictures in the patients’ charts has become compelling, but also increasingly complicated. Photo capturing and photo storage are the new buzzwords. This is really going to help you sort out all the tools and technologies that are available whether you use an EHR or not.

Don’t want to leave you with the impression I was not a fan of the other stories this month. My other favorite piece this month is on photography. Being able to utilize cameras in our practices has seemed so simple in the past. Take a picture, print it out, file it in the patient’s chart — all done. However, as offices become computerized, the potential to incorporate these pictures in the patients’ charts has become compelling, but also increasingly complicated. Photo capturing and photo storage are the new buzzwords. This is really going to help you sort out all the tools and technologies that are available whether you use an EHR or not.

Don’t want to leave you with the impression I was not a fan of the other stories this month. There is a piece on when to use the 25 modifier vs. the 57 modifier, a very timely piece on military derm, as well as one on the considerations of hiring physician extenders. Lots to chew on.

Enjoy your reading.
“Given that it has support for some of its issues on both sides of the aisle, dermatology must maintain a bipartisan advocacy stance.”

**features**

**COVER STORY**

**MOST IMPORTANT ELECTION EVER?**

Parties make different promises about health care's future, but some changes have bipartisan backing

*BY RICHARD NELSON*

**26**

**FIVE-STAR PRACTICE, ONE-STAR REPUTATION?**

Fair or not, online reviews may be the first thing a potential patient sees about a dermatologist

*BY JOHN CARRUTHERS*

**32**

**MILITARY DERMATOLOGISTS TREAT TROOPS, PROVIDE HUMANITARIAN MISSIONS ABROAD**

*BY RUTH CAROL*

**depts**

**02**

**FROM THE EDITOR**

**04**

**CRACKING THE CODE**

When do I use the 57 modifier instead of the 25 modifier?

**08**

**ROUNDS**

Compensation report, meaningful use stage 2 criteria, more.

**10**

**ACTA ERUDITORUM**

Do TCIs cause lentigines with prolonged use?

**12**

**TECHNICALLY SPEAKING**

Dermatologists have options for storing and accessing photos in their records.

**16**

**IN PRACTICE**

Considerations when adding a physician extender.

**38**

**FROM THE PRESIDENT**

**40**

**ACADEMY UPDATE**

President shaves head, more.

**44**

**ACCOLADES**

**48**

**FACTS AT YOUR FINGERTIPS**

Camp Discovery makes memories.
When do I use the 57 modifier instead of the 25 modifier?

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.

Modifier 57 indicates a separately identifiable evaluation and management (E/M) service related to the decision to perform surgery; Medicare further defines surgery as a procedure with a 90-day global period. Modifier 25, on the other hand, indicates that on the day of a minor procedure (one with a 10-day global period), the patient’s condition required a significant, separately identifiable E/M service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed.

According to Medicare, modifier 57 indicates that an E/M service resulted in the initial decision to perform surgery, either the day before or the day of a major surgery. Private payer policies may vary; while some payers prefer modifier 25 whenever an E/M service is billed on the same date as another service, you should confirm the policies of your local private payers.

To determine the global period for major surgeries, count one day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery. To determine the global period for minor procedures, count the day of surgery and the appropriate number of days immediately following the date of surgery.

In both these cases, the E/M service is provided by the same physician, either the day before or the day of a major surgery (modifier 57) or on the day of a minor procedure (modifier 25).

The mere decision to perform any type of surgery does not justify a separate E/M service. According to Medicare, “both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.” When performing major surgery, the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery can justify the need to report an E/M service. The initial evaluation is always included in the allowance for a minor surgical procedure.

Example 1:
You see an established Medicare patient for a new lesion on the nasal tip. You perform an appropriate history and physical examination and upon discussion with the patient explaining the procedure, the decision is made to perform Mohs micrographic surgery with closure by means of an adjacent tissue transfer.

Mohs has a zero-day global period, but the flap closure has a 90-day global period. The E/M services provided, including the decision to perform surgery, would be reported with modifier 57. When an E/M service resulting in the initial decision to perform major surgery is furnished during the post-operative period of another, unrelated procedure, the E/M service must be billed with both the 24 and 57 modifiers.
Example 2:
You see a new Medicare patient with a lesion on the trunk. You perform an appropriate history and physical examination, including examination for other lesions, and make the decision to perform biopsy and curettage of the lesion.

When a suspected basal cell carcinoma is biopsied and curetted, it is appropriate to hold the claim until the pathology report is received. If the lesion proves to be a basal cell carcinoma, the only reported procedure is the destruction (reported using the size of the final curettage defect). If the lesion proves to be benign, the biopsy is the only procedure reported.

The decision to perform a procedure with a 10-day global period would not, by itself, justify a separate E/M service, but this is a new patient, and it is quite likely that the medically necessary cognitive services could justify a separate E/M code. If reported, it would be reported with a 25 modifier.

Note that when Medicare auditors review claims with modifier 25, they first identify all documentation specific to the procedure. All customary pre- and post-operative counseling as well as the decision to perform the procedure is bundled into the procedure code (for a procedure with a 10-day global period). The medical record documentation would have to sufficiently identify the separate and distinct cognitive services to justify a separate E/M code.

The auditor would consider all documentation separate from the documentation related to the procedure to determine if there is a significant, separately identifiable E/M service. Those services should be “reasonable and necessary” as defined in the Social Security Act, Section 1862(a)(1)(A).

When an E/M service resulting in the initial decision to perform a minor surgery is furnished during the post-operative period of another, unrelated procedure, the E/M service must be billed with both the 24 and 25 modifiers. dw

I’m a Dermatologist.
Last year, my practice was struggling.
I had increased denials, decreased reimbursement, even a few RAC audits.
The only thing growing was the size of my A/R.
This year, things are better.
...the Choice for Dermatologists.

Medical Billing. Simplified.
1-888-550-4734
MyDermatologyBilling.com
news in brief

Darryl Bronson, MD, MPH, AAD vice president-elect, mourned

Darryl Bronson, MD, MPH, the Academy’s 2012 vice president-elect, died on Aug. 31. He was 61.

Dr. Bronson, who previously served on the Academy’s Board of Directors, was the co-chair of the Dermatopathology Rapid Response Committee and a member of the Council on Government Affairs, Health Policy, and Practice, the Strategy Committee, the Executive Committee, the Priorities Committee, and the SkinPAC Board of Advisors at the time of his death. According to Academy President Daniel M. Siegel, MD, “Darryl was a mentor, a dear friend, a true gentleman with a heart of gold and a wry sense of humor. He was highly respected and admired by his colleagues on the Board and the many committees and task forces he led, and by all the staff who had the privilege to work with him. His warmth, grace and intelligence, commitment to education, support to the specialty and the Academy, and devotion to his family was inspiring. He will be deeply missed by all of us who knew him.”

Dr. Bronson earned his medical degree from the University of Illinois in 1976, finished a dermatology residency at Chicago’s Cook County Hospital in 1980, and completed a dermatopathology fellowship at the University of Chicago and New York University in 1982. In addition to his service to the Academy on numerous committees and task forces, he had served as president of the Chicago Dermatological Society, the Illinois Dermatological Society, and the Noah Worcester Dermatological Society. He was a dermatologist and dermatopathologist in private practice in Highland Park, Ill.

When he ran for vice president-elect in 2011, Dr. Bronson wrote of the Academy, “Our founders laid the groundwork for an organization valued by its members, respected by fellow medical organizations, and looked to as a leader in American medicine. An organization boasting virtually 100 percent membership and full of second and third generation dermatologists must be doing something right. My vision for our Academy is that we continue to maintain and build upon that solid foundation.”

The Academy’s Board of Directors will appoint a replacement to serve Dr. Bronson’s term as vice president in 2013.

Memorials to Dr. Bronson may be sent to the University of Chicago Cancer Research Foundation. - RICHARD NELSON

Academy Board approves position statement on psoriasis maintenance therapy

AT ITS AUG. 18 MEETING, THE ACADEMY’S BOARD OF DIRECTORS approved a position statement on maintenance therapy for psoriasis patients. The statement outlines the basics of the disease and circumstances under which long-term therapy may be necessary. Developed by the Academy’s Psoriasis Expert Work Group based on the guidelines of the Academy and National Psoriasis Foundation, as well as clinical guidelines in use in Canada and in Europe, the statement supplements the Academy’s six guidelines on psoriasis. Together, they will be used to inform and facilitate appropriate reimbursement policy, particularly with regard to recent Medicare Recovery Audit Contractor attention to maintenance therapies like phototherapy.


The Board also approved a policy for clinical practice guideline derivatives — products being developed by the Academy to help dermatologists implement guidelines in their practices — that lays out how and when the Academy may accept corporate support to develop those derivatives. The policy requires derivative development to abide by the Academy’s Code for Interactions with Companies, its Principles of Corporate Relationships, and the Accreditation Council for Continuing Medical Education’s standards. It also specifies that, as it does with guidelines, the Academy will retain complete editorial control over the content of guideline derivatives. The policy was added to the administration regulation on evidence-based clinical practice guidelines. - RICHARD NELSON
Treat Acne at It’s Root: the HORMONES!

Anti-DHT Acne Treatment

HOW IS CLEAROGEN DIFFERENT?

Clearogen fights the root cause of acne using a synergistic combination of FDA approved acne medications and natural anti-DHT ingredients to normalize oil production and prevent acne.

RESULTS

Before

After

- 95% Effective in Clinical Trials
- Time Released Medications
- Natural Anti-DHT Ingredients
- 60 Day Money Back Guarantee

INTRODUCTORY OFFERS AVAILABLE FOR WHOLESALE
CALL FOR DETAILS (877) 512-4247

Scan the QR Code to request more information. Jennifer@clearogen.com

Visit www.Clearogen.com | Call 877-512-4247
Two widely read salary surveys show slight compensation growth

SURVEYS OF DERMATOLOGY COMPENSATION offer dermatologists data they can use to benchmark their practices — and often create the foundation for outside impressions of the specialty. According to two of the best-known and widely reported compensation surveys, dermatology compensation increased slightly in 2011.

The median compensation for dermatologists grew by 3.69 percent in 2011 according to the Medical Group Management Association's (MGMA's) 2012 Physician Compensation and Production Survey, based on 2011 data. The survey's top-line data showed median compensation for dermatologists rose from $430,874 in 2010 to $446,774 in 2011. Specialists in general saw a 7.73 percent increase in median compensation in 2011, according to MGMA. The figures for dermatology reported in the MGMA survey are based on responses from 453 dermatologists, including 57 who defined themselves as Mohs surgeons and 16 who defined themselves as dermatopathologists. Data without Mohs or dermatopathology, reported as the median for dermatology in some outlets, showed a compensation figure of $428,882.

The American Medical Group Association's (AMGA's) 2012 Medical Group Compensation and Financial Survey, based on 2011 data, showed a 2.93 percent increase in median compensation for dermatologists, from $386,068 in 2010 to $397,370. The AMGA figures for dermatology are based on responses from 553 dermatologists, all of whom reported working in one of 112 groups with more than 35 physicians. AMGA also reported data from 87 Mohs surgeons with a median compensation of $538,750.

MEDIAN COMPENSATION FOR DERMATOLOGISTS 2005-2011

<table>
<thead>
<tr>
<th>Source</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGMA</td>
<td>$334,277</td>
<td>$348,706</td>
<td>$365,524</td>
<td>$368,407</td>
<td>$413,657</td>
<td>$430,874</td>
<td>$446,774</td>
</tr>
<tr>
<td>AMGA</td>
<td>$306,935</td>
<td>$316,473</td>
<td>$344,847</td>
<td>$350,267</td>
<td>$375,176</td>
<td>$386,068</td>
<td>$397,370</td>
</tr>
</tbody>
</table>

Sources: 2012 MGMA Physician Compensation and Production Survey, AMGA 2012 Medical Group Compensation and Financial Survey

CMS advances health information exchange in meaningful use stage 2 final rule

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) released its final rule for the stage 2 requirements for its Electronic Health Record (EHR) Incentive Program on Aug 23. Under the rule, CMS advances health information exchange by requiring eligible professionals (EPs) to electronically submit summary of care records for transitions of care and referrals, exchange such data at least once with a health care provider using different EHR technology, and give patients online access to health information.

The final rule, which adopts many provisions from the proposed rule published last March, specifies the criteria that EPs and others must meet to qualify for incentive payments, and also specifies the payment adjustments that will be made starting in 2015 for failing to demonstrate meaningful use of certified EHR technology. In response to comments received on its proposed rule, including those from the AADA, which were critical of measuring an EP’s performance based on actions of patients/EHR vendors that are not within the EP's control, CMS lowered compliance thresholds for some measures, but did not back away from finalizing information exchange requirements.

Notably, the final rule provides for a one-year compliance delay, pushing back the onset of stage 2 criteria for participants to 2014. In addition, although few of the selected Clinical Quality Measures are relevant to dermatology, stage 2 provides greater flexibility in measure reporting. CMS believes that the timeline delay, lowered compliance thresholds, greater flexibility in reporting, and impending payment adjustments will increase participation in the EHR program.

More information about the stage 2 criteria is available on the CMS website at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html. To learn more about implementing EHR, visit the Academy's HIT Kit at www.aad.org/hitkit. - RICHARD MARTIN, JD

JAAD apps available for iPad and iPhone

TWO NEW APPS DESIGNED to let you access the *Journal of the American Academy of Dermatology* anywhere, anytime are now available. The apps provide full access to the journal in convenient tablet or smartphone versions.

To download the iPad app search “Journal of the American Academy of Dermatology” in the Apple App Store. *JAAD* is accessible for the iPhone and Android phones via publisher Elsevier’s HealthAdvance app. To download, search “HealthAdvance” within the Apple App Store or Google Play store. Once you have downloaded the app, select Browse at the bottom to locate *JAAD* among the variety of Elsevier journals included.

In order to access the full spectrum of *JAAD* content via the apps, members must register and claim access on the JAAD.org website. To claim access, visit www.jaad.org/content/mobileaccessinstructions. Be sure to follow the instructions numbered 1 through 5.

Details about the iPad and iPhone app features, and instructions for use, are also available at www.aad.org/member-tools-and-benefits/publications/jaad/jaad-apps. - RICHARD NELSON
Your patients deserve a stretch marks therapy that lives up to its promises.

Mederma® Stretch Marks Therapy is specifically formulated and clinically shown to reduce discoloration and improve the appearance of stretch marks.¹

- **76% of women who used Mederma® Stretch Marks Therapy for 12 weeks were satisfied with their results.**²

- **80% of women in a clinical study showed visible improvement in 12 weeks.**¹

More information at mederma.com. ©/®/™ 2012 Merz Pharmaceuticals, LLC.

¹SKINmed: Dermatology for the Clinician, April 2010. ²2011 Survey conducted by Merz Pharmaceuticals, LLC.
Do TCIs cause lentigines with prolonged use?

IN THIS MONTH’S ACTA ERUDITORUM COLUMN, Physician Editor Abby S. Van Voorhees, MD, talks with Leslie Castelo-Soccio, MD, PhD, about her recent Archives of Dermatology article, “Induced Lentiginosis With Use of Topical Calcineurin Inhibitors.”

Q&A

DR. VAN VOORHEES: Let’s start by your telling us what you noticed in your patients.

DR. CASTELO-SOCCIO: We noticed younger children who didn’t have any actinic damage or history of sunburns developing lentigines in areas we wouldn’t expect; areas of the hand, areas in the popliteal fossa, the antecubital fossa, where typically we don’t see lentigines in kids under 10.

DR. VAN VOORHEES: What were the diagnoses of the children using the calcineurin inhibitors? Where were these lesions? Did you see lentigines everywhere that the patients were using these topicals or was there only a single area that developed them? Were these noted in adults too?

DR. CASTELO-SOCCIO: We looked primarily at children; the average age was about 10 but our youngest was an infant and our oldest was an adult male with psoriasis. The majority of patients had chronic inflammatory conditions, with eczema or atopic dermatitis being number one, but also perioral dermatitis and psoriasis, both plaque and inverse, represented. We did see lentigines in many of the areas where tacrolimus or pimecrolimus was applied. It wasn’t in every area, but we did see that in patients who had perioral dermatitis they had it around their mouths; in patients who had psoriasis, particularly in the lower extremities, they had lentigines just in the areas where they had their plaque psoriasis and were applying tacrolimus as long-term maintenance. Duration of usage ranged from a few months to years.
DR. VAN VOORHEES: You mention in your article that biopsies were performed on several of these patients. What did the histology reveal? Was there evidence for chronic actinic damage on the biopsies?

DR. CASTELO-SOCCIO: Biopsies showed common lentigines without any actinic damage. We only did biopsies on two patients of our 12.

DR. VAN VOORHEES: Were the biopsied sites in areas of extensive sun exposure?

DR. CASTELO-SOCCIO: Potentially. Dorsal hand, for example, an area in which you might expect some actinic damage, although less in kids. That was a big issue for us; we went back and asked the parents about sun exposure or burning. None of the children who had lentigines had any significant sun exposure history and many of the patients were not Type I or II but Type III, IV, or V skin colors.

DR. VAN VOORHEES: Do you believe that the underlying diagnosis was a contributing factor in the development of these lesions?

DR. CASTELO-SOCCIO: Absolutely. We’ve seen some patients whose parents did not remember the use of tacrolimus or pimecrolimus, who had developed lentigines in areas where they have used chronic steroids or where they have chronic atopic dermatitis. So there’s probably something about having chronic inflammation that makes you more at risk for lentigines. But it does seem that the calcineurin inhibitors push you to have more of them, and more frequently.

DR. VAN VOORHEES: Have these lesions been noted in patients taking systemic calcineurin inhibitors?

DR. CASTELO-SOCCIO: No. There is an increased risk of melanocytic nevi in patients who take oral tacrolimus but there are no reports of increased lentigines in patients taking oral tacrolimus due to transplants or for other reasons.

DR. VAN VOORHEES: Did these lesions regress when treatment was discontinued?

DR. CASTELO-SOCCIO: Some of the lesions will regress a little bit, but the majority of them were still present six months or more later, even three years later, in follow-up. The majority are still present. They may be a little bit lighter.

DR. VAN VOORHEES: Is there an understanding of how calcineurin inhibitors might be contributing to the development of lentigines?

DR. CASTELO-SOCCIO: Calcineurin inhibitors appear to act directly on keratinocytes and not melanocytes and by doing so create a favorable environment for melanocyte growth and migration. This data comes from in vitro models using cultured melanocytes and melanoblasts in keratinocyte supernatant.

DR. VAN VOORHEES: That’s probably the basis for using it in things like vitiligo?

DR. CASTELO-SOCCIO: That’s probably why it works very well for the pigmentation of vitiligo, and probably why you see, in vitiligo, the recruitment of melanocytes around hair follicles. I think it’s a very similar process.

DR. VAN VOORHEES: Have you seen additional evidence to support your paper since it was published?

DR. CASTELO-SOCCIO: We had put 12 patients in our paper, but since then we’ve seen many more patients with atopic dermatitis who have a similar phenotype. We feel very confident this is related to the medication.

DR. VAN VOORHEES: Is this something dermatologists should be discussing with their patients when they prescribe topical calcineurin inhibitors?

DR. CASTELO-SOCCIO: We tell patients about long-term use and the potential for lentigines. The benefits of having anti-inflammatories without the side-effect profile of steroids still make me use these medicines quite a bit, but it’s something physicians should point out.

DR. CASTELO-SOCCIO is assistant professor of clinical pediatrics at the University of Pennsylvania’s Perelman School of Medicine and an attending physician in Pediatric Dermatology at the Children’s Hospital of Philadelphia. Her article was published in Archives of Dermatology, 2012;148(6):766-768. doi:10.1001/archdermatol.2012.377.
Dermatologists have options for storing and accessing photos in their records

BY MORRIS W. STEMp, CPA, MBA, CPHIMS

Dermatologists have the unique requirement amongst almost all medical specialties to capture and store standard photographic pictures of their patients. Many specialists rely on X-rays, MRIs, and other non-invasive diagnostic imaging techniques which generally require sophisticated equipment including DICOM storage and retrieval systems. Dermatologists rarely require such fancy and expensive imaging and storage techniques but can instead use a good old-fashioned photo camera. Whether snapping a picture of a rash or a pre- and post-operative Mohs lesion, a basic $100 digital camera, circa 2005, will do the job.

DICOM, (an acronym for Digital Imaging and Communications in Medicine), is the standard used by most non-invasive diagnostic imaging systems. The DICOM standard defines how these images are stored and transmitted along with their embedded patient and diagnostic data. Capturing images with an off-the-shelf camera, however, has no such standards. And thus, the simplicity of the standard photo camera to capture images presents some complications when seeking to store and retrieve these images and to associate patient information with the photos.

Dermatologists may rely on photos to compare pre-op and post-op regions to evaluate the success of a surgery and to document how a patient looked before surgery. Certain diagnoses require the analysis of specific pathologies over time. Photographs of lesions taken at physician-determined intervals and then compared to earlier images can be used to ascertain growth, shrinkage, or other changes. Photos may also be used for patient education.

Thus, images are part of the medical record and must be treated with the same care, privacy, and security as written medical records. HIPAA regulations require that health care providers control and track those who have access...
to identifiable digital medical information. Placing images in a folder on a file server with no security or access auditing could be considered a violation of the HIPAA privacy and security rules, especially if they are patient-identifiable images such as images of the face.

HIPAA privacy rules allow physicians to obtain any image for treatment purposes without specific authorization. Physicians who wish to photograph patients for purposes other than treatment, such as practice marketing, should first obtain written authorization.

FIRST THINGS FIRST: PHOTO CAPTURE

While the focus of this article is on photo storage, in many respects, how a photo is acquired directly impacts how it is processed and ultimately stored on the file system. Thus a review of storage options cannot be separated from a discussion of photo acquisition options.

Photos may be acquired in a number of ways using a variety of devices:

- Standard digital cameras
- Smartphones and tablets (Apple iPhone or iPad, Android phones)
- UV cameras
- 3D imaging systems
- S-video camera

Regardless of the photo capture device being used, the key to successful use of comparative, time-lapse, or before and after photography is to ensure consistency, meaning that each photo is taken under similar lighting, distance, and focus. A number of tools are available to help dermatologists to achieve reproducible, consistent photos. In an article in the Indian Journal of Dermatology, Venereology, and Leprology, “Basic Digital Photography in Dermatology,” Feroze Kaliyadan, et al, present a detailed overview of how to use digital cameras to achieve the most effective clinical results (doi: 10.4103/0378-6321.44334).

It is also important to note that a photo may be acquired by someone other than the physician doing the analysis and delivered on a USB thumb drive or sent via email directly to a specialist for review.

Once the photo is “snapped,” it must somehow now be copied from the acquisition device to be viewed, stored, and optionally printed.

All digital cameras capture their photos on either non-removable internal camera storage or some type of removable storage such as a secure digital (SD) card or memory stick. Images may be easily accessed, viewed, and transferred to permanent storage in four different ways. Transfer can be achieved by connecting the camera via USB to a computer or by removing the storage card and placing the card inside a USB-connected reader. Alternately, some cameras have WiFi built in which can wirelessly transmit photos through the WiFi in a physician’s office. (Any medical office using WiFi should have their WiFi security set to a minimum of WPA2 to ensure compliance with HIPAA encryption and security requirements.) For the majority of cameras, which don’t have WiFi, an innovative technology called Eye-fi is available on a specially designed removable storage card. This technology wirelessly transmits images to a designated storage location on some computer in a physician’s office and then clears those images off the storage card effectively making space to capture additional images.

Other cameras operate in a tethered manner in which the camera is operated while connected to a computer. In this scenario, the photos or video are captured and stored directly on the tethering computer. This saves the step of having to transfer the data from the camera.

Smartphones such as iPhones work in a similar manner to standard digital cameras but with the added feature that the smartphones are actually mini-computers. As computers, smartphones can run applications (apps) which can facilitate the transfer of images from the smartphone onto a storage device (generally via WiFi). Browse the iPhone or Android app store using the key words “file sync” to review the many available file transfer apps.

PHOTO STORAGE

The photo is taken and the image transferred to a secure, preferably encrypted storage device in compliance with HIPAA security guidelines. The most important consideration at this point is how can a physician search and retrieve a desired image or set of comparative images from within the thousands.

APPS FOR PHOTO CAPTURE

Two iPhone-only solutions for photo capture exist. One unique iPhone-only solution called the FotoFinder Handyscope (www.handyscope.net) incorporates photo capture of moles and lesions with photo transfer and storage in one solution. It uses a special illuminated camera which slides onto the iPhone case and includes an app designed to record patient and diagnostic info related to each photo. The photo and data can then be uploaded to a Web-based hosted storage system for analysis. Images and patient data captured by FotoFinder are encrypted on the iPhone for HIPAA compliance in case the phone is lost.

tkDerm Touch (www.tkderm.sourceforge.net) is another iPhone app that allows a physician to capture images on an iPhone or iPad and to associate patient metadata with the image. These images can then be sent to a desktop computer running a back-end database for retrieval.
of images in file storage? This is the role of an image management system (IMS).

Searching through images requires a physician to associate metadata to each image file which can then be queried by the IMS. Metadata could include patient name, image date, location on body from which the photo was taken, diagnosis, etc. Assigning metadata for each photo takes time but this task could be assigned to a medical assistant or other office staff. One of the evaluation criteria for selecting an IMS is the efficiency with which metadata can be assigned. For example, as you assign the patient name, date, and diagnosis to each image, some systems will remember the data used on the previous image and use that same data as the default for the current image. This can be helpful when multiple images are taken of the same patient, but requires caution to avoid mislabeling photos.

Many physicians probably started storing images years ago using what I call a poor man's image management system designed around a self-enforced intelligent Windows file and folder naming convention. For example, all images related to Mary Smith could be stored in a folder called “Smith, Mary.” The file name for Mary’s mole on the left arm taken on Jan. 15, 2012 might be “Left Arm Mole 2012-01-15.” This system has many limitations, such as having multiple patients named Mary Smith and taking multiple images of the Left Arm Mole on the same day. Of course, each limitation can be resolved by increasing the amount of metadata incorporated into the folder or file name but this can get very unwieldy.

Another limitation of this method is that it makes selecting images for comparison either within a single patient or across patients very difficult. For example, if a physician wanted to look at the evolution of the left arm mole over many years, or all moles (vs. other lesions), or a specific type of lesion across many patients, this poor man’s filing system would make retrieval of the desired images almost impossible.

Custom-designed databases can solve some of these problems. See the sidebar for information about a few solutions.

**CONCLUSION**

Imaging is a critical diagnostic tool in many medical professions. Dermatologists are fortunate in that they can use standard, low cost, and relatively low-tech imaging tools and software to capture, store, and retrieve their diagnostic images. All of the required technologies to implement an effective image management system are readily available. I recommend that readers consider which technologies would best fit their existing IT environment and would be most adaptable to their practice workflow and discuss it with their IT support organization, if they have one, before making any investment in new technology.

---

**IMAGE MANAGEMENT SYSTEMS**

Purchasing a custom-designed image management system (IMS) backed by a database designed to associate metadata with a unique or random photo ID number or with the photo time stamp from the photo file on the file system can help dermatologists more effectively handle their images. A review of a few options follows.

- The PC version of **tkDerm** ([www.tkderm.sourceforge.net](http://www.tkderm.sourceforge.net)) can create a database record for each photo file into which a physician can enter desired metadata. This system is open-source and thus free to download, but at the same time has very limited support or development resources. This may not be the best solution if you are uncomfortable with technology.

- **Canfield Scientific** ([www.canfieldsci.com](http://www.canfieldsci.com)) publishes a system called Mirror PhotoFile with unlimited user-defined data fields and many comparative image-viewing options.

- **Etiam** ([www.etiam.com](http://www.etiam.com)) publishes a system called DICOM-Izer which makes it possible to associate metadata with a digital image and then wraps the metadata with the image into a DICOM-compatible image which can then be stored and retrieved on any DICOM-compatible server. This method makes sense for any practice that already uses other DICOM-compatible diagnostic equipment along with an existing DICOM server. Otherwise, setting up a DICOM server is probably beyond the means (due to cost and advanced technology) of a small dermatology practice. Etiam also sells its own storage and distribution server for digital images called STaR.

- **Profect Medical** ([www.profectmedical.com](http://www.profectmedical.com)) offers two digital imaging software suites designed to organize, analyze, and present digital images.
How do you get to be a household name in Dermatology? The Personna DermaBlade® is the name for the highest quality product of its kind. Designed for shave biopsies, it has a unique look and feel that will make your job easier than ever. The Personna DermaBlade’s flexible design provides the sharpest blade available, while our MicroCoat® technology reduces tissue trauma. Special side grips allow for a three digit grip for extra control and make it a snap to pick up. Each DermaBlade is packaged to guarantee sterility and complete protection. And DermaBlade is disposable, for added safety. So use the product that Dermatologists swear by. DermaBlade by Personna.

To learn more, visit us at personnablades.com

Personna DermaBlade is the sharpest on the market. Our exclusive MicroCoat® coating process allows blades to glide with smooth, clean precision.
Considerations when adding a physician extender

Each state has its own laws governing a physician extender’s duties in a medical practice. For a thorough overview of each state’s laws and regulations, please consult the American Academy of Physician Assistants’ resource at www.aapa.org/the_pa_profession/federal_and_state_affairs/resources/item.aspx?id=755 or the American Academy of Nurse Practitioners’ website at www.aanp.org/. Additionally, the American Academy of Dermatology has developed a position statement related to the use of physician extenders. The position statement, titled “The Practice of Dermatology: Protecting and Preserving Patient Safety and Quality Care,” is available at www.aad.org/Forms/Policies/ps.aspx. This position statement particularly notes that “the optimum degree of dermatologic care is delivered when a dermatologist ... provides direct, on-site supervision to all non-dermatologist personnel.”
The System for Digital Dermoscopy and Total Body Photography.

Call 888-501-0805
or visit www.fotofinder-systems.com

Check out our mobile solution handyscope.

The better choice in medical imaging.
WHAT SHOULD I BE AWARE OF BEFORE HIRING A PHYSICIAN EXTENDER?

Your practice should first develop a guidebook containing appropriate policies and procedures for a physician extender in your practice. This guidebook should detail the supervising physician's role and responsibilities, delegation duties, prescriptive authority, and training requirements for the PA or NP. Additionally, this guidebook should detail all diagnostic and therapeutic procedures that can be performed by the PA or NP.

It is also important to have a standard non-physician provider agreement and supervisory/delegation of services/collaborative agreement in place prior to hiring a physician extender. These two agreements will serve as the employment contract for the PA or NP. Model agreements are available in the Academy's Dermatology Employment Manual; see www.aad.org/store/product/default.aspx?id=6366 for information.

HOW DO I RECRUIT A PHYSICIAN EXTENDER INTO MY PRACTICE?

Advertise an opening throughout the dermatology community by posting ads online or in trade publications. You can visit www.aadcareercompass.org to post an ad through the Academy. The Society of Dermatology Physician Assistants (SDPA) also has an online job board at www.dermpa.org/jobs and the Dermatology Nurses Association (DNA) has recruitment opportunities for nurse practitioners at www.dnanurse.org/.

HOW DO I BILL FOR A PHYSICIAN EXTENDER?

Once you have hired a PA or NP into your practice, you will have to determine how best to structure your billing arrangements. Medicare will reimburse a PA or NP at 100 percent of the fee schedule as long as the supervising physician follows “incident-to” guidelines. These guidelines require that the physician meet several criteria:

1. The services are rendered under the direct supervision of the physician. Direct supervision is defined as the physician being present in the office suite and immediately available to provide assistance.
2. The services are furnished as an integral, although incidental, part of the physician’s professional services in the course of the diagnosis or treatment of an injury or illness.
3. The physician must initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient’s case.
4. New patients or established patients with new problems can be seen by a physician extender; however this can only be reported under their NPI number and be billed at 85 percent of the fee schedule.
5. A signed employment arrangement must exist between the physician and the physician extender.
6. The physician extender must enroll with Medicare Part B to obtain his or her own NPI number.

7. The physician extender may not provide services outside of his or her own scope of practice based on state-specific law.
8. The physician cannot hire an extender and bill incident-to if the extender has professional qualifications equaling or exceeding those of the supervising provider. For example, a dermatologist cannot bill the services of a physician in the same practice as incident-to. If you determine that your physician extender can meet the incident-to guidelines, you may bill for services under the physician’s NPI. You will be reimbursed as if the physician performed the service. If the visit cannot be classified as incident-to, you will have to bill under the PA or NP’s NPI, and your reimbursement will be at 85 percent of the fee schedule. Please note: very few national insurers allow incident-to billing and your practice will need to check with each individual carrier to determine their rules regarding non-physician practitioner billing.

ADDITIONAL RESOURCES AVAILABLE

CODING INFORMATION

HIRING AND TRAINING
More information and resources to assist in hiring a PA or NP are available in the Academy’s Dermatology Employment Manual, available at www.aad.org/store.

The Academy’s Medical Student Core Curriculum is an excellent resource to help supervising dermatologists train a PA or NP in dermatology. The core curriculum is available at www.aad.org/mscc. PAs and NPs working in an AAD fellow’s office may also register to attend the AAD Annual Meeting, which includes several sessions directed specifically to PAs and NPs. Information on the meeting is available at www.aad.org/meetings-and-events/2013-annual-meeting.
Four Great Reasons to Read
Dermatology World Online

1. **Easily Searchable**
   Improved search capability helps you find articles you remember seeing months ago and want to reference again or research topics of interest to you.

2. **Online-only Bonus Content**
   Audio, image slideshows, and more in-depth coverage of practical topics related to articles from the print edition provide a broader view of the issues.

3. **Catch Up on Areas of Interest**
   Every edition of Cracking the Code, Legally Speaking, and Management in Practice — just a click away.

4. **Versatile Viewing Options**
   View the digital edition or download a PDF for future reference or printing.

Most important election ever?

Parties make different promises about health care’s future, but some changes have bipartisan backing.
The phrase is a cliché. Every two or four years, politicians seeking office (and raising money) and pundits seeking viewers declare that the results of this election, perhaps more than any other, will determine the course of the future. But for physicians wondering about the future of the American health care system, there is more truth to the phrase than usual this time around. With the future of the Affordable Care Act (ACA), 2010’s health system reform law and the most sweeping change in the health care landscape since the enactment of Medicare, very much in play, dermatologists and their advocates in Washington, D.C., agree that this election will determine whether and how that law is implemented and have major impact on dermatology’s key legislative priorities. But they also caution that some of the ideas the law contains, including care coordination, shared cost savings, and electronic record keeping, are likely here to stay regardless of who wins.

**FATE OF IPAB**

When the American Academy of Dermatology Association made a list of its key legislative priorities this summer, eliminating the Independent Payment Advisory Board (IPAB), a panel of 15 appointed officials created by the ACA to rein in Medicare spending, was one of the top three items. This status reflects IPAB’s role as a chief sticking point for the AADA during the legislative process. Dermatologists are not alone in viewing IPAB as a problem, according to Sabra Sullivan, MD, PhD, chair of the AADA’s Congressional Policy Committee. “We’re not the only specialty concerned about this,” she said, and suggested pushing for IPAB repeal may be an opportunity to work with other groups in medicine.>>
Shawn Friesen, the AADA’s director of legislative, political, and grassroots advocacy, agreed that there is broad-based concern about IPAB and noted that it crosses the aisle. “This could be a very interesting fight,” he said. “There are court challenges percolating that contend that IPAB would take a congressional function and move it to the executive branch. By surrendering that power, the question becomes, is that allowed under the constitution?” IPAB has faced bipartisan opposition, particularly in the House, he noted. “In addition, IPAB was a significant issue during consideration of the ACA. The concept, which originated in the Senate and was supported by the White House, faced considerable opposition by House Democrats.”

Even if IPAB repeal does not go forward because a Democratic Senate or a re-elected President Obama block it, there are scenarios under which the board could fail to gain traction. “IPAB appointments could fail to get cloture in the Senate [the 60-vote threshold for clearing a filibuster], which would be an interesting scenario,” Friesen said. “Will the White House appoint acting members? Will Congress defund it? It could be one of the more fascinating fights.” (For more details on how IPAB is supposed to work, visit Dermatology World online at www.aad.org/dermatology-world/monthly-archives/2012/reform/ipab.) Similarly, as long as Republicans retain control of the House, they are likely to fight approval of funding necessary for some aspects of ACA implementation, Friesen noted.

MEDICARE PHYSICIAN PAYMENT

Another top legislative priority for the AADA is Medicare physician payment, specifically finding a permanent replacement for the sustainable growth rate (SGR) formula, which dictates a 27 percent cut in payments to physicians in 2013. According to Sandra Read, MD, chair of the AADA’s political action committee, SkinPAC, partisan politics plays less of a role here than the difficult math of a fix.

“We need a permanent SGR fix to ensure access to care for Medicare patients. If we can’t afford to practice, we’re not there,” Dr. Read said. But, she added, “I don’t think the SGR is really going to be affected much by who’s in control after the election. This is a larger issue than Republicans and Democrats. There are questions about how to regulate; there may be changes in reimbursement for doctors, increased taxation to recipients; the beneficiaries’ benefits might be reduced.” But both parties, she said, have recognized that such a draconian cut in payments would devastate the Medicare program and its beneficiaries.

The methods used to close the budget gap created by the SGR, as well as a further gap created by the Budget Control

SKINPAC RAISES DERMATOLOGY’S PROFILE

What does $1 million buy? In the case of SkinPAC, the American Academy of Dermatology Association’s political action committee, which crossed the $1 million fundraising threshold for the first time in August, it buys significant visibility for the specialty, according to Sandra Read, MD, chair of SkinPAC for the 2012 election cycle.

“When I came in as chair, my goals were to increase participation and achieve the million-dollar mark,” she said. “Because when you hit that number, people take notice; it’s a barrier, an entry number. We hope the PAC will grow even bigger after the election. But it’s a significant PAC. People return your phone calls, and ask for your advice about issues that are important to dermatologists, things that only we can answer,” Dr. Read added. “I’ve seen other situations where medical associations are not involved when regulations are written — we don’t want that. Even though we’re a small specialty, we can be mighty and have a big impact.”

With her goal of raising $1 million achieved with an assist from AADA President Daniel M. Siegel, MD, who carried out his pledge to shave his head and beard at Summer Academy Meeting 2012 if the target was reached (see article and photo, p. 40), Dr. Read said that SkinPAC turned to determining a disbursement strategy that would maximize its opportunities to elevate dermatology’s profile and affect policy discussions.

“We had a lot of high-level conferences with the SkinPAC Board of Advisors,” she said, including meetings with outside counsel and the former physician chair of another large medical PAC. The best strategy for building visibility, Dr. Read said, seeks to build relationships in three tiers. The first includes leadership on both sides of the aisle, physician members of Congress who may bring particular insight to dermatology’s issues, and key advocates for the specialty’s priorities. The second includes members who may be part of committees of particular interest, such as members of the Senate Health, Education, Labor, and Pensions Committee, Appropriations Committee, and Finance Committee, as well as the House Ways and Means Committee, Energy and Commerce Committee, and Appropriations Committee, and members of relevant health subcommittees. The third includes newer members of Congress who may be open to learning more about dermatology’s concerns.
Act (part of the agreement that ended 2011’s debt ceiling battle), could also differ depending on which party is in control, according to Friesen.

“Those varying approaches will impact what happens for providers and patients — if you’re not collecting more money from patients, you’re more likely to have to decrease Medicare physician payments,” Friesen said. In addition, the potential expiration of the Bush tax cuts at the end of 2012 could put revenue on the table, he added, “but you still have a fight over being able to use those funds that would come into play. It may show up on the ledger sheet but there would still be policy fights.”

**INDOOR TANNING AND POSSIBLE REGULATORY SLOWDOWN**

If the Academy’s IPAB concerns would seem to lean Republican and Medicare payment is somewhat neutral, its goals for another top priority, indoor tanning and skin cancer prevention, are expected to fare better under a Democratic administration. While a Republican sweep might wipe out IPAB or even the entire ACA, it could take some tanning regulations with it.

“Romney’s election to the White House could really hold up the release of the indoor tanning regulations, if they are not released before the election,” according to Leslie Stein Lloyd, JD, the AADA’s director of regulatory and payment policy. “These regulations are likely to be controversial with the tanning industry and small businesses, and would be more likely to get through the Office of Management and Budget in the Obama administration than in Romney’s.” Additionally, she said, “If Romney is elected and/or the Republicans take control of Congress, we can expect to see a push to repeal [all or parts of] the Affordable Care Act, which would impact a tremendous number of regulations already in the works,” including those related to biosimilars and the 10 percent tax on indoor tanning that the AADA pushed to have included in the law.

However, she noted, some things would not change. “I think the Romney White House and/or a Republican Congress would likely continue the push toward integrated care models, episodes of care, and bundled payments,” Lloyd said.

A change in the administration would probably grind business to a halt in D.C. in the short term, Lloyd said; this often happens when one party takes over from the other.

“While who is in the White House and on the Hill impacts the implementation of regulations, changes in the administration are significantly impactful on the regulatory process across the board, and across all issues and agencies. A change in the White House would likely prompt a turnover of political appointees at the agency and department level, which

“We’re trying to raise our visibility and position ourselves so that whoever is in office, we are engaging on both sides of the leadership, on major committees, and in both parties,” Dr. Read said. “You don’t want to put all of your eggs in one basket. We have to be interacting with all of these key decision-makers.”

While the election on Nov. 6 may strike some as the endpoint, in fact it is just a new beginning, Dr. Read said, and she was optimistic that SkinPAC’s fundraising success would continue when the new election cycle begins. Shawn Friesen, the AADA’s director of legislative, political, and grassroots advocacy, agreed that raising funds early in the cycle plays an important role in raising the PAC’s visibility.

“By having a good presence through SkinPAC after the election, we’re better able to raise dermatology’s visibility and better positioned to forge relationships early with folks who may be new members or may be moving up in leadership or into new positions on committees of interest to our members and their patients,” he said. “Having an effective PAC after an election gets us recognized as a leader, and it raises awareness of dermatology among members of Congress. People will want to build their support early and when you have a large PAC organization you’re in a position to raise your organization’s visibility early on so that you are able to build relationships and hopefully maximize the opportunities to influence policy over the next two years. Members of Congress remember who gives early.”

AADA members who want to learn more about SkinPAC or find out how contributions are distributed to candidates can visit www.SkinPAC.org. Members looking for tips on how to get involved with the election should visit www.aad.org/member-tools-and-benefits/aada-advocacy/how-you-can-get-involved-in-the-2012-elections.

SkinPAC’s political purpose is to solicit and receive contributions to be used to make political campaign expenditures to those candidates for federal elective office, and other federal political committees, who demonstrate understanding and interest in the views and goals of the American Academy of Dermatology Association.
takess a toll on the efficiency of agencies,” she said. Also, “A new administration would likely freeze the release of all regulations. This kind of turmoil would impact the rate of making regulatory changes for at least six months.”

**BIPARTISAN ADVOCACY STRATEGY**

Given that it has support for some of its issues on both sides of the aisle, dermatology must maintain a bipartisan advocacy stance, according to Marta VanBeek, MD, MPH, chair of the Academy’s Council on Government Affairs, Health Policy, and Practice. “We always advocate in a bipartisan manner,” she said. “We choose the issues that matter to our patients and our specialty and work with members of Congress who share our position on them.” (SkinPAC takes a similarly bipartisan stance; see sidebar, p. 22.)

In the run-up to the election, key Academy committees and staff are considering what to do depending on the election results, Dr. Sullivan said.

“We’re exploring how to move forward with our priorities and how we need to prepare Academy members for what may come,” she said. “The priorities are the same; the question is how to achieve them. Even if Republicans win everything, repealing is easier said than done. What will we do if the individual mandate goes into effect? We’re looking at every contingency.”

Dr. Sullivan noted that while the ACA is law after being upheld by the Supreme Court, much of the regulation that will give it life has yet to be written. “In talking with different people in my state, there’s a sense that although there’s a law even the people at the very top who are making the decisions are finding that there’s much that has not yet been interpreted. We know the different scenarios but we don’t yet know the whole picture of what they will be.” Until the election, she added, “we won’t know who we’re going to be dealing with in the next stage of the process.” But she promised dermatologists that “as things unfold, you’re going to see a lot more action; no one is twiddling their fingers. There’s lot of discussion, and action plans are being developed depending on what happens. We’re evaluating where opportunities for dermatology will lie depending on the scenario. You can bet that all of us who are working on this haven’t given up on trying to achieve what we need for our specialty.”

**SOME CHANGE IS HERE TO STAY**

While continued advocacy will affect the law’s implementation, dermatologists would do well to be realistic about the degree to which changes that may be referred to under the broad umbrella of “reform” are unrelated to the fate of the ACA, according to Jack S. Resneck Jr., MD, associate professor and vice-chair of dermatology at the University of California San Francisco School of Medicine.

“Many of the changes in health care delivery that will ultimately affect our practices are being driven by both private insurers and public payers, and would continue to move ahead whether the ACA had been upheld or struck down,” he said.

“There is momentum to increasingly base payments on quality measures, drive full adoption of electronic health records, and incentivize integration of practices. Our specialty will have to actively seek ways to demonstrate the quality we offer and fit into the evolving system in order to preserve and enhance our ability to care for our patients.”

Dermatologists will have to make their voices heard to ensure that their important role is recognized as changes are implemented, Dr. Sullivan said. “I don’t think you’ll find any dermatologist who isn’t trying to help cost-save or be a diligent steward of our medical resources,” she said. “Dermatology is a unique specialty, one that is very fiscally efficient in that you can receive complete medical care for your skin in an economical model. We as dermatologists really help bend that cost curve the right way.” Advocates for the specialty will continue to make that argument, she said, regardless of who wins the election in November. “The bottom line is that we’re going to be fighting tooth and nail to maintain access for patients, to be able to maintain our practices and protect all aspects of our practice, so that people can continue to deliver the best care possible for their patients.” *dw*

---

**RESOURCES FOR COPING WITH REFORM AVAILABLE**

While the Affordable Care Act is an issue in the November election, in the meantime implementation of the law continues. Dermatologists looking for information about how the law will affect them, their practices, and their patients can turn to the Academy’s website and *Dermatology World*. The Health System Reform Resource Center, at www.aad.org/hsr-resource, includes a timeline for implementation and information about key provisions of the law. A special online supplement to *Dermatology World*, available at www.aad.org/dermatology-world/monthly-archives/2012/reform, packages all of the magazine’s articles about reform implementation and its impact on the specialty, including discussion of accountable care organizations (ACOs), the Independent Payment Advisory Board (IPAB), the Physician Compare website, and insurance exchanges. Summer Academy Meeting 2012 also featured discussion of reform, with guest speaker Kevin Fickenscher, MD, talking about the future of health care and Jack S. Resneck Jr., MD, MPH, discussing the forces driving reform. Read more about their lectures at www.aadmeetingnews.org/highlight.aspx?id=4979&p=390 and www.aadmeetingnews.org/highlight.aspx?id=4980&p=390.
Reach Your Patients on the Internet
Anywhere, Anytime, Any Device

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

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

877-367-0260
www.AADDermsOnline.org
FIVE-STAR PRACTICE,

ONE-STAR REPUTATION?

Fair or not, online reviews may be the first thing a potential patient sees about a dermatologist
The Internet allows for aggregation and dissemination of information on an incredible level. As a tool for communication, it’s unparalleled. And just as diners offer up their ratings for their favorite and least-favorite restaurants, with a few clicks, one can also find the best and worst things patients have to say about their doctors. Just as the opinion of a practice management consultant can improve one’s efficiency, operation, or patient care, harnessing online opinions can allow practice owners to keep tabs on their business and strive for continuous improvement. >>
GROWING ONLINE INFLUENCE

The Internet runs on opinion and social interaction, according to DePaul University assistant professor of public relations Matt Ragas, PhD. Throughout a host of platforms, whether Twitter, Facebook, or Yelp, people are broadcasting opinions about businesses 24 hours a day. How that feeds into the public perception of one’s practice, Dr. Ragas said, is a marketing concern for small business owners.

“What I tell my students and small businesspeople is that when you search using Google and Bing, what comes up in the first page or two of results — that’s your brand, that’s your reputation. Whether you like it or not,” Dr. Ragas said. “When you dive deeper into rating sites, if someone doesn’t have any other point of reference when it comes to your practice, those ratings have an impact and influence.”

A survey released in early 2011 by the Pew Research Center confirmed the growing influence of the Internet in American health care. A nationwide survey of all Internet users found that while only 4 percent of users posted a review of a physician online, 80 percent of users (which translates to 59 percent of all U.S. adults) seek health information online, whether it’s reading the experiences of others, watching medical-related videos, or finding others with similar medical concerns.

THE EFFECT OF ANONYMITY

The biggest concern related to online opinions available for all to see is the permanence of the negative ones, according to Niagara Falls, Ontario, dermatologist Kevin C. Smith, MD, who gave a presentation on the topic at the American Academy of Dermatology’s 69th Annual Meeting in New Orleans.

“It’s kind of out of your control. In North America, at least, the laws are such that anybody who wants to can say whatever they want with a high probability of getting away with it, unless you want to spend a great deal of time and money,” Dr. Smith said. “Just like you will eventually be involved with a lawsuit during your career, you will eventually be slammed on the Internet. My advice is to get used to it.”

While the most attention-getting comments are the negative ones, dermatologist Steve Feldman, MD, PhD, who founded DrScore.com, said that the vast majority of physicians are exceptionally rated by their patients.

“I think that the opportunity of online rating is to make it easy to collect and publish opinions that represent a real opportunity to set the record straight. The vast majority of patients love their doctors. If you ever look at representative ratings, you’ll see that if your patient satisfaction score is only nine out of 10, you are well in the bottom half — maybe

ONLINE COMMENTS

The anonymity of online review sites creates a far different dialogue and tone than most practitioners would expect before the advent of the Internet. This is a sample of some of both the positive and the negative things that online reviewers have had to say about dermatologists on rating websites. All comments have had the physician’s name removed. The negative reviews have been paraphrased to reflect their sentiments. Spelling and grammar have not been altered.

“Dr. [redacted] is the best doctor I’ve ever seen. He is unbelievably friendly, and after talking to him for just a few minutes, you really feel like you’ve made a good friend/ally in your battle against whatever it is you are seeing him for. He is great at forming a treatment plan and making his patients feel as though they are in it together, rather than just outlining a list of things the patient should do. My only regret is that I didn’t come to see him sooner.”

— Yelp.com, 2011

“Shocked at the indifference and unfriendliness Dr. [redacted] showed on my first visit ... She came off as unconcerned about me and anxious for me to leave... The look on her face made it clear she thought she was indulging me by responding to questions. I wasn’t expecting a fun chat or a new friend, but I have been to a lot of doctors and I’ve never been made to feel this unwelcome.”

— RateMDs.com, 2008

“Doctor [redacted] was excellent! He is very patient, and I felt very comfortable with him. I could tell he is very experienced in his field. After listening to my concerns and examining me, he gave me an exact diagnosis and proper treatment. My problem went away within 5 days. The office is clean and welcoming and the staff is friendly while answering questions and scheduling appointments.”

— Google.com, 2012
the bottom quarter — of American physicians,” Dr. Feldman said. “You’ve got all these doctors, all getting scores around 95/100. Say you took a representative group of 100 doctors. If all 100 got one rating, then 95 of those doctors would have gotten 10s and five would have gotten zeroes. It doesn’t mean that five of those are different than the other 95, it’s just the randomness of events. I think patients are the same way. If we get a zero from a patient and say that they’re a chronic complainer, my guess is that those patients are giving 10s 95 percent of the time, just like everyone else. You got the unlucky straw and happened to catch them while unhappy with one event.”

In combating statistical anomalies that can lead to unfairly low aggregate ratings, Dr. Feldman said, a number of physicians will ask each of their patients to rate them following the visit. While it doesn’t eliminate the possibility of negative or even unfair reviews, he said, it directs more loyal and happy patients to the ratings site or sites of one’s choice.

The high regard that most patients have for their dermatologists, Dr. Feldman said, is borne out by a national survey done by the National Psoriasis Foundation while he worked with the group. After daily calls by patients saying that they were finding it impossible to find a good dermatologist, the group did a quick survey asking its members about their dermatologists.

“The survey came back saying that the members loved their dermatologists. So the foundation thought that they must have done the survey wrong, and brought in a national survey research firm to carry out a representative survey in collaboration with dermatologists and epidemiologists,” Dr. Feldman said. “They carried out the survey, and found that patients loved their dermatologists. They realized that they weren’t getting calls from all the people who were very happy with their doctors, and that what they were seeing was an unrepresentative sample. You can get that same impression if you only read the negative online reviews of your practice.”

Acceptance and adjustment, according to Dr. Smith, seem to be the best course of action in most cases. Under HIPAA, a doctor’s recourse to negative online comments is severely constrained compared to other business owners. Doctors, of course, cannot discuss a patient, only how their practice is generally run without any patient specifics. The last legal recourse — suing for defamation — is also the most attention-grabbing, which can backfire, according to Dr. Ragas.

“The media spotlight has a way of being attracted to threats and lawsuits. The person you’ve filed suit against, regardless of the facts of the case, can try to turn things around on you, the doctor suing the regular person for saying something online,” Dr. Ragas said. “Legal recourse is always an option, but it has to be considered in the larger context.

During my short visit with him, he received a phone call. I listened to him discuss his new couch for about 12 minutes. It would have been nice if he’d been interested enough in me to spend 12 minutes!

— Yelp.com, 2011

“My experience at Dr. [redacted] office had to have been one of the best I have ever had. The office staff was professional, courteous and efficient and Dr. [redacted] was caring, considerate and extremely thorough. She allayed my fears about my problem and explained everything in clear, understandable language. She not only diagnosed and treated me appropriately, but she also went to great lengths to coordinate my care with a plastic surgeon and my general dermatologist. She also called me personally the night of my surgery which is unheard of in today’s world. I have never seen such a conscientious, intelligent, and thorough physician. I would highly recommend Dr. [redacted].”

— Vitals.com, 2009

“Dr. [redacted], as well, has been an excellent doctor.... has a great bedside manner, he knows each one of his patients. Every time I see him he is able to ask about my school, studies and my family. I even remember being privy to his and his wife’s decision regarding indoor paint colors. I have had warts removed, fungus treated, acne medicated and many other embarrassing conditions examined by Dr. [redacted] without ever feeling awkward or uncomfortable. He treats everything as very important, and will continue to recommend different treatments until you are satisfied!

— Yelp.com, 2010

“The location is great — right off the highway, easily accessible with it’s own lot. The office is warm and welcoming.... The receptionists, most of whom I know by name and who also return the favor, are very sweet.... I couldn’t ask for a team of professionals who work harder or care more about their patients.”

— Yelp.com, 2011

“... has a great bedside manner, he knows each one of his patients. Every time I see him he is able to ask about my school, studies and my family. I even remember being privy to his and his wife’s decision regarding indoor paint colors. I have had warts removed, fungus treated, acne medicated and many other embarrassing conditions examined by Dr. [redacted] without ever feeling awkward or uncomfortable. He treats everything as very important, and will continue to recommend different treatments until you are satisfied!”

— Yelp.com, 2010
scheme of things. Perception doesn’t always line up the way you intend, so you have to be careful.”

The key to achieving acceptance, Dr. Feldman said, is to gain something from the negative experience that helps improve one’s practice.

“I know when I get a negative rating, my first thought is that patient must have me mistaken for someone else, or that they’re just acting like a jerk — but I don’t think that for very long. How patients feel at the end of a visit is usually under my control, and my patients need to be happy with the service I provide,” Dr. Feldman said. “Good businesses take these comments and use the negative ones as the customer telling them how to improve on something we do. It’s not a level playing field, but a lot of people wouldn’t feel comfortable telling their doctor what they could do better without the benefit of anonymity. We have to look at even the negative ratings as a gift.”

Assessing the risks of online reputation management is crucial to effectively coping with the potential damage and stresses of negative ratings, according to Ron Culp, who previously directed the public relations efforts of Sara Lee and Sears, is a former partner for global public relations agency Ketchum, and currently serves as the professional director of DePaul University’s public relations and advertising graduate program.

“Too often marketers focus 99.9 percent of their energy on the bells and whistles and not enough time on what might go wrong. Someone in the organization should be the devil’s advocate so that you’re ready for the unexpected,” Culp said. “Physicians and others need to address business model issues that are causing negative online comment — poor scheduling that causes late appointments or frontline staff that needs more training — and they also have to do something that makes them very uncomfortable. They have to engage in social media themselves. Too often, they take criticism personally and write off the complaint as being from a hard-to-please patient. That approach worked before, but not today.”

Physicians who see a comment that they seemed impersonal or rushed, for example, may write off the complaint as a hard-to-please patient. But, he said, it’s an opportunity to consider whether one is making adequate time to provide patient care and address concerns.

**ADDRESSING COMPLAINTS ETHICALLY**

Putting one’s credentials online in an informative and positive light often serves as an effective tool against inaccurate reviews, according to dermatologist Stephen Webster, MD, a member of the AAD Ethics Committee. At the very least, he said, it makes for a more trustworthy public face than a marketing-heavy promotional page.

“I encourage doctors to have a website that lists their training, their certification, what procedures they do, and things like that which profile one’s qualifications and practice patterns in a very positive way,” Dr. Webster said. “We very much discourage websites that discuss ‘I do something better than anyone else does, I have better secret compound that I can give you, I can do things with lasers that other doctors can’t do.’”

Where some physicians might adopt a defensive attitude over negative online ratings, Jeff Segal, MD, JD, the founder and CEO of physician reputation management group Medical Justice, said that the best course of action may be to actively solicit more of one’s patient population for ratings and specific feedback.

“On the vast majority of review sites, there are between zero and three reviews for the average physician. So when you get the inevitable negative review, you would certainly like it to be balanced by a more representative sample of your practice. Take advantage of your patient base to do that,” Dr. Segal said. He explained that his company provides practices with an iPad that patients in exam or waiting rooms can use to complete a point-of-service survey. With the patient’s permission, information from the survey can also be posted online, helping to create a more representative sample of reviews.

Dr. Webster agreed with Dr. Segal that encouraging positive feedback engages the physician-patient relationship far more effectively than attempting to prohibit negative online feedback, an approach Dr. Segal used to recommend but no longer considers appropriate that required patients to agree not to make negative statements about practices.

“Restrictive online behavior agreements are something that patients are looking at and losing interest in a practice. That, we feel, is a little unethical, in that it strains the doctor-patient relationship,” Dr. Webster said. “Try to be positive with the patient, emphasize answering their questions above anything else.”
AVOIDING HIPAA CONCERNS WHEN RESPONDING

Dr. Segal now advises a three-step approach for handling a practice’s online reputation that breaks down to monitoring what’s said online, engaging patients directly to respond to complaints where possible, and promoting patient feedback. Learning how to craft a HIPAA-compliant response, he said, can help a physician provide better care to patients in cases of miscommunication.

“We work with a fertility group, and in the survey, there was a comment that we brought to the doctor’s attention that a patient had said it would be good if there was a counselor on site for patients whose treatments had failed. What’s interesting is that there was, in fact, a counselor on site. But the patient didn’t know that, and the doctor didn’t know that the patient didn’t have access,” Dr. Segal said. “So they responded by saying ‘we’re sorry to hear about your experience. We do have a counselor on site, and we’ve changed the processes to make sure that all patients receiving news of this type do have an opportunity to meet and work with a counselor.’”

The response was perfectly crafted, Dr. Segal said, under the circumstances of the visit and the solicited online feedback, which lacked any identifying patient information. The key, he said, is to tailor one’s response expertly to the unique demands of patient privacy.

“The reason that they were able to produce this public response [without triggering HIPAA concerns] is because the patient’s note was public and anonymous, and there was no personal health information to tie it back to that patient,” Dr. Segal said. “HIPAA is a strange beast. You have to know what you’re doing. If a patient posts with their real name online, you can’t respond publicly to that because it identifies that you’re the doctor for this patient. It’s walking the line, but you do need to be aware that when a patient has posted online, they haven’t waived their expectation of privacy under HIPAA.”

In addition, anonymous patient complaints that cannot be engaged directly may fall outside a rating website’s terms of service agreement with the patient-user if the information is false or potentially libelous. Many of the more popular rating websites, Dr. Segal said, have shown an increasing willingness to work with physicians recently.

“Right now there are probably 80 sites out there, and no one has become the go-to site, the TripAdvisor, if you will, of medical ratings. And because of that, some of the more high-profile ones have been more open to taking into account the concerns of the doctors,” Dr. Segal said. “If a person doesn’t have first-hand information, they will remove posts that say something like ‘my wife visited Dr. Smith, and said he was very rude,’ if you bring it to their attention. In addition, if a patient’s calling the doctor, for example, an alcoholic without any terms to substantiate, they’ll remove those posts. A lot of these places are putting together some moderation in the effort to become a go-to site. We have a long way to go until it’s doctor-friendly, but it’s improved a lot recently. We’ll know when we’ve gotten to the correct place when doctors and nurses are using these sites to choose their own doctors.”

increase patient flow and overall practice efficiency. 
Increase profits.
Varitronics can show you how!

See more patients in the same amount of time without increasing staff.

Varitronics, the leader in Non-Verbal Interoffice Communications for over four decades, offers the most feature-rich systems on the market today.

Our custom designed Call Systems will streamline the way you work so that you can decrease your patient’s waiting time while increasing your staff’s efficiency.

Call, email, or visit our web site today to see how easy it is to benefit from the efficiency of Varitronics’ Call System.

Varitronics
Leading the way in Interoffice Communications

800.345.1244 • email@varitronics.com
www.varitronics.com
Military dermatologists treat troops, provide humanitarian missions abroad
What do a Marine deployed in Afghanistan, a soldier stationed at an Air Force base in Texas, and a Peruvian fisherman have in common? They all have likely been treated by a military dermatologist.

Even with operations winding down in Iraq and Afghanistan, dermatologists in the military continue to treat active duty personnel stationed in the U.S. and abroad as well as treat people in medically underserved countries as part of the military’s humanitarian missions around the world.

TREATING MILITARY PERSONNEL AT HOME

With the demand for dermatology services on the rise coupled with a shortage of military dermatologists, which is due either to their deployment or exiting the military to enter private practice or retire, the U.S. military is increasingly relying on the use of teledermatology.

The Southern Regional Medical Command Teledermatology program, which began in 2001, serves Air Force, Army, and Navy facilities across the United States. Patients include active duty personnel, family members, and retirees, explained retired Lt. Col. Chuck Lappan, the program’s project manager. Most dermatologic conditions can be adequately managed through teledermatology, he noted. To date, nearly 40,000 teleconsultations have been submitted. Thirty-five dermatologists answer skin-related teleconsultations. >>
This program improves patient access because patients can receive a clinical evaluation through a teledermatology consultation. Lappan, the program’s medical director, explained that dermatology is not a high-dollar-item for the military, and teledermatology appears to be a break-even proposition rather than a cost-saver. It is likely to remain a way to extend care to underserved areas rather than taking over as the preferred method for routine dermatologic care for non-deployed personnel.

TREATING MILITARY PERSONNEL IN COMBAT

Another teleconsultation program, the Army Knowledge Online (AKO) initiative, supports deployed health care professionals who can send a teledermatology consultation and expect to receive a reply within 24 hours. In fact, the average reply time is approximately five hours. Most of the individuals treated are active duty personnel. However, military personnel from other countries, U.S. or foreign national contractors, host nation nationals, detainees, and civilians are also among the patients.

The AKO grew out of a 2003 conference of military dermatologists who noted that many soldiers were being evacuated from Iraq for dermatologic issues that could have been managed there if the deployed physicians had a formal way to consult colleagues akin to the Southern Regional program, Lappan said. The AKO began formal operations in 2004. Since then, 18 other specialties have joined the program. Unlike the Southern Regional program, the AKO teleconsultations do not transmit any patient identifying information.

Since its inception, nearly 10,500 teleconsultations have been made from more than 50 foreign locations and the U.S. Navy at sea. Health care providers in Iraq and Afghanistan have been the biggest users of the program, Lappan noted. Initially, 41 percent of the teleconsultations were for dermatology, but that has tapered off to between 22 percent and 30 percent in the past few years largely due to the wind down, he noted. Another reason is that PCPs are becoming more knowledgeable about dermatologic conditions; thus, their usage of the program has decreased.

Still, dermatology remains the most-often-requested teleconsultation. Because dermatology is such a visual specialty it lends itself well to teleconsultation, Dr. Cragun said. “Images often speak a thousand words and are easily sent via teleconsultation systems.”

Various rashes top the list of common dermatologic complaints, Lappan said. Also common are cutaneous leishmaniasis, scabies, blister beetles, and spider bites, not to mention infections that are fungal, bacterial, and viral in nature. Then there are the occasional patients with chronic conditions, such as psoriasis, that worsen during deployment. One patient had a strange looking mole on the nape of his neck that changed in appearance, Lappan recalled. The provider, a flight surgeon, requested a teleconsultation asking if he should remove the mole for cosmetic purposes. The consulting dermatologist said it looked like a malignant melanoma. The patient was evacuated and had surgery five days...
later. A pathology report determined that the lesion was malignant melanoma.

**TREATING CIVILIANS AROUND THE WORLD**

Pounding the pavement on another continent, military dermatologists are busy treating civilians as part of New Horizons, a U.S. Southern Command-sponsored program that combines the provision of medical services and the building of critical community structures that takes place annually in Latin American and Caribbean countries.

Requests for these missions are submitted to the U.S. State Department by the governments of the various countries, explained Lt. Col. Stephanie Schaefer, MD, USAF, who is currently on assignment in Guam, but had previously helped plan these missions for Lackland Air Force Base in Texas. Each year, a list of humanitarian missions is assigned to the larger military medical centers, such as Lackland.

“Since these are peacetime activities aimed at improving the health and well-being of citizens in the areas visited, they portray a totally different impression of our uniformed personnel and not the war-fighting image that most see in the media,” she said. Because these missions are often carried out in conjunction with health care providers and security personnel from the host nation’s military, they allow an opportunity to teach each other different ways of practicing medicine and also help the host nation’s military gain trust and credibility among its people. This is important in areas where the host nation military is not a well trusted or respected entity, usually because of previous civil war or past issues with corruption. It also lends credibility to the local medical community when they are seen working as a team with a U.S. medical team that is known for its high level of education and clinical skills, Dr. Schaefer said.

**TREATING MILITARY PERSONNEL ON THE FRONT LINES**

Approximately 25 percent of all patients he saw during his tour of duty in Iraq had dermatologic complaints, noted Douglas J. Pugliese, MD, MPH, now an assistant professor of clinical dermatology at the University of Pennsylvania’s Perelman School of Medicine. He treated a lot of fungal and bacterial skin infections. They were almost always methicillin-resistant Staphylococcus aureus (MRSA) infections, he said. This limited the type of antibiotics that could be given as the more effective ones can cause phototoxicity — not a good side effect for individuals deployed in the sunny desert. Heat rashes occurred especially during the summer months when the temperature soared to 115 degrees. The 70 pounds of protective gear worn by the Marines and soldiers didn’t help the situation, but it did save lives, he noted. Dr. Pugliese also had to consider cutaneous leishmaniasis whenever a wound or ulcer did not heal, as the disease is endemic to Iraq because it is transmitted by sand flies. “Especially earlier in the war, soldiers and Marines were sleeping in blown-out buildings where they would get bitten,” he said. Wounds from penetrating injuries often resulted in acinetobacter infections because the soil and water were contaminated with the gram negative bacteria. In parts of northern Iraq and Afghanistan, malaria was a big concern.

Dr. Pugliese was not yet a dermatologist when he was deployed in Fallujah. Consequently, he used teledermatology to consult with the dermatologist at the combat support hospital in Baghdad. Emailing pictures for a teleconsultation was much safer than sending a soldier or Marine in a helicopter to Baghdad. Using a vehicle to transport them was even more dangerous because of explosive devices. It also keeps them from having to come out of the field. Dr. Pugliese was able to manage most dermatologic cases with guidance from the dermatologist. Patients requiring a biopsy, however, had to go to the Army hospital in Germany because he lacked pathology capabilities. (Soldiers in Afghanistan today can be biopsied in-country and have their specimens sent to Germany to be read.)

After the buildup in Iraq and Afghanistan, most soldiers and Marines had the ability to shower once a week, which significantly reduced the number and morbidity of skin infections, he said. Having facilities in which to sleep reduced the incidence of cutaneous leishmaniasis, as well. In addition, the use of clothing made of dry weave material kept Marines and soldiers dry in a moist environment. Boots designed to perform better in the desert reduced blistering and other skin problems on the feet.

To learn more about how better armor protects soldiers, see the online-only slideshow in the Web version of this article by visiting www.aad.org/dw.
The military humanitarian missions are akin to civilian medical missions; the main difference is that the medical teams are comprised of military personnel. Once the communities are decided upon, local government agencies and health ministries advertise the dates and location of the missions. “Invariably a long line of people await the arrival of the medical team each morning,” Dr. Schaefer said.

In 2012, medical services were provided in 11 locations in Peru during a six-week period. But before that, military engineers worked with their Peruvian counterparts to construct a new town community center in Tambo de Mora, which was devastated by an earthquake and tsunami in 2007. The town center includes a library, clinic, auditorium, playground, and a central park area. They also added an emergency room facility to the clinic in Independencia. Then they set up a mobile field hospital in a remote area of Huancavelica where the medical services were provided.

Col. Steven E. Ritter, USAF, MC, FS, was among the 15 health care providers on the recent Peru mission. “We saw more than 7,000 people in 10 days,” he said. Dr. Ritter treated several cases of lupus, severe eczema, and deep fungal infections. “I saw the worst case of head lice in my life this past trip,” he added.

A man came hobbling in with a debilitating ingrown toenail that he had for three months. Dr. Ritter, who serves as the director of dermatologic surgery at Wilford Hall Medical Center at Lackland Air Force Base when he’s not on a mission, fixed the nail and prescribed antibiotics. “It wasn’t a big deal, but nobody there could fix it for him,” Dr. Ritter said, adding, “It’s not always looking for the zebra or rare things. We love those cases because we’re dermatologists. We like to take pictures so we can go back and teach about them. But the majority of my time is spent educating patients about common, simple conditions.” For example, people in many of these countries think all white patches are leprosy. They don’t understand that white patches may just be dry skin or eczema. Additionally, pigment problems have a social stigma attached to them. One patient with vitiligo burst out bawling after Dr. Ritter explained that it was not caused by parasites and it was not contagious as she had been told previously. Patients are often given erroneous information such as suggestions that their skin condition will cause their hair to fall out or infertility.

On a mission in Bolivia, patients complained about getting tingly after taking a shower or getting wet; they were concerned something was wrong. Dr. Ritter, who finally realized that they were describing goosebumps, was able to explain that goosebumps are a normal reaction and nothing to worry about. It is gratifying to educate patients and let them know that certain conditions are treatable and are not harmful, he said.

Treating a skin disease that has plagued an individual for years with a simple, long-lasting therapy or removing a small benign growth that no longer interferes with the person’s activities of daily living are the most gratifying experiences of these missions, Dr. Schaefer said. On the other hand, providing follow-up advice to a patient who is awaiting biopsy results can be difficult, she said. But that’s where the local medical providers can sometimes help if they are able to follow up with the patient. Another challenge is diagnosing a dermatologic condition that requires long-term treatment with medications not readily available in these locations.

Dr. Ritter concurred. “It’s difficult to see patients with severe skin disease who are not receiving any type of treatment. Back home, these patients would get an extensive work-up and be prescribed biologics,” he said. Even if these medications were available there, they would be too costly. “An average worker makes less than $20 a day and a tube of medicine costs $80,” he said. In many cases, Dr. Ritter will discuss alternative treatments that may be more readily available and stress the importance of hygiene.

Imparting medical knowledge is a secondary goal of medical missions. Most of the education occurs when seeing patients with the local physicians and medical extenders, the latter of whom are often the only medical provider in these small rural communities, Dr. Schaefer said. “We try to teach medical extenders in each region how to evaluate patients, triage, and diagnose and treat simple, common ailments.” They use a set of laminated reference cards printed in numerous languages by the American Academy of Dermatology as a leave-behind tool. Sometimes, military providers present after-hour lectures. Dr. Ritter, who participates in at least one mission a year, often leaves behind a textbook or two.

Long-lasting relationships are often fostered during these missions, Dr. Schaefer noted. Sometimes, these result in future visits to each other’s medical centers or training in U.S. military medical institutions. Dr. Ritter still keeps in touch with people from his first mission in Bolivia as well as individuals in El Salvador. “I enjoy interacting with other members of the military and working with medical students,” he said. “I have made good friends through the years in the host nations.”
Upcoming CME Activities

Closure Course and Fundamentals of Mohs Surgery

DoubleTree Hotel San Diego, Mission Valley
San Diego, California

November 5 - 7, 2012 – Closures Course for Dermatologists
Course prerequisite is basic experience in cutting and sewing skin, with program designed to take dermatologists to the next level of dermatologic surgery practice. This is an intense learning 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 presenter’s 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

Annual Clinical Symposium – Dermatologic Surgery: Focus on Skin Cancer

Omni Amelia Island Plantation
Amelia Island, Florida

Memorial Day Weekend, May 23-26, 2013
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

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
There are many great things about being president of the American Academy of Dermatology. I get to meet and talk with many of you and hear your perspectives on our vibrant specialty. I see the inner workings of the organization and how hard members and our professional staff work to serve you. And I get to celebrate great successes, like when I had my head and beard shaved on Aug. 17 after SkinPAC topped the $1 million mark for the election cycle (about which, more on p. 40, and in this column next month).

But one of the most inspiring experiences of my presidency was my visit to Camp Discovery a few days before I met the shears. As you know, Camp lets children with skin conditions have the summer camp experience many of their peers take for granted as part of growing up. After seeing it first-hand, I have to tell you: It’s one of the best investments we make as an organization. We’re offering an amazing service to people who in many cases don’t get to go outside, or do things that most kids do. It’s a world where all of the kids, even those who are in wheelchairs, get to do everything other kids do.

When you see kids like this in the office, a patient with epidermolysis bullosa (EB) for instance, they’re generally in because something’s going awry. At Camp they’re doing a great job of just being kids. There’s an infirmary for all of the necessary dressing changes, and a volunteer medical staff on duty, but that isn’t the focus — the kids are swimming, boating, fishing, doing arts and crafts, and playing games. Of course, they’re all slathered in sunscreen and wearing hats.

It’s an idyllic setting for the kids and for the volunteers, who feel good just being there. Seeing it in-person reinforced a long-held belief of mine that one of the best, most durable presidential initiatives was when Mark Dahl, MD, set up Camp in 1993.

The particular iteration of Camp Discovery I visited, Camp Liberty in Hebron, Conn., is one of the newest additions to the family of camps we hold each summer. Other camps are held in Crosslake, Minn., Millville, Pa., Burton, Texas, and Carnation, Wash., giving kids from around the country and the world the opportunity to have this special experience.

Indeed, Camp is an international event; many of the facility-provided counselors when I visited were from England and Scotland and came to the U.S. for work for the summer as counselors; their majors include physical education and child development, among others. They were paid to serve as counselors for eight weeks at this multi-use facility built by Easter Seals; many of them so wanted to work at Camp that they chose to stay a ninth week on their own just to be with the kids they got to know last year.

It was interesting meeting them, and hearing about differences between our respective health systems in terms of kids with severe skin conditions like EB. In the U.S., the Dystrophic Epidermolysis Bullosa Research Association (DebRA) of America not only funds research, but also helps families to afford the dressings and supplies needed to care for children with the disease. DebRA in the U.K., on the other hand, is able to focus more of its efforts on funding research, because the health system provides the needed dressings and supplies to families. As we await the outcome of the election and its impact on health system reform (see p. 20), it’s worth remembering that whatever happens, we need a system that takes good care of our sickest and most vulnerable patients.

Speaking of good care, you can ensure that the kids at Camp receive it by volunteering at one of the weeks of Camp, or by making a donation to the Sustaining Fund. Your generosity will join that of many others, both individuals and companies; for instance, this spring Coolibar donated a hat for every camper and shirts and goggles to one camp in Minnesota. Staffers from Leo Pharma spent time at camp in Pennsylvania this summer, helping with activities and participating in the talent show, and current and former Coria Laboratories staff volunteered as counselors at camp in Minnesota. And for next year’s camp, Project Linus has committed to donating quilts for the campers in Connecticut. These are just a few examples of the kind of generosity Camp inspires. Visit www.campdiscovery.org to learn more, and be sure to flip to the back page of this issue of Dermatology World to see some highlights from this year’s Camps! dw
Experience… Learn… Evolve… with AAD Regional Courses

**DERM EXAM PREP COURSE**
JW Marriott Desert Ridge • Phoenix, Arizona • November 16-18, 2012
Maximize your study efforts and refresh your knowledge as you approach examination day with the Derm Exam Prep Course.
Register by October 24 and receive the advanced rate of $750!

**PRACTICE MANAGEMENT AND CODING COURSE**
JW Marriott Desert Ridge • Phoenix, Arizona • November 16-18, 2012
Innovative solutions for how to manage a dermatology practice start here!
Designed for the entire dermatology care team!
Register by October 24 and receive the advanced rate of $595!

**ADVANCES IN TROPICAL MEDICINE**
Moshi, United Republic of Tanzania • January 13-15, 2013
Take advantage of an educational experience of a lifetime as you explore cases not seen in everyday practice.
Registration now open!

Don’t wait… Register today!
www.aad.org/meetings
AADA president shaves head for SkinPAC

Following through on a pledge made in January, American Academy of Dermatology Association President Daniel M. Siegel, MD, had his head shaved on stage following the Aug. 17 plenary session of the Summer Academy Meeting 2012. The shearing took place after the PAC reached the $1 million mark in fundraising for the 2011-2012 election cycle. Above, SkinPAC Chair Sandra Read, MD, takes one of the first passes with the clippers; donors who had maxed out their allowed $5,000 contribution were offered a chance to participate in the million-dollar haircut.

To see video of the haircut, visit www.SkinPAC.org. To learn more about SkinPAC and what it plans to do with the money, see p. 22. - RICHARD NELSON

2013 Annual Meeting registration and housing available online

REGISTER TO ATTEND THE ACADEMY’s 71ST ANNUAL MEETING in Miami Beach, Fla., being held March 1-5, 2013, and ensure you can attend the sessions you want by registering online at www.aad.org/meetings-and-events/2013-annual-meeting. Online registration and housing opens Nov. 14 for physician members, including life, honorary members, and applicants for membership. It opens Nov. 20 for residents, medical fellows, AAD graduate members, and medical students, and Nov. 28 for all others.

Guest rooms are being held at several major hotels in Miami Beach and Miami at AAD discounted meeting rates available only to those who book through the AAD. For a current listing of official AAD hotels, visit www.aad.org/meetings-and-events/2013-annual-meeting beginning in early November. Hotel reservations must be made online in conjunction with registration for the meeting. More information is available on the Academy website and in the 2013 Annual Meeting Advance Program Book, which is being mailed to members this month.

Consider adding a donation as you register for the Annual Meeting. You can be a part of the Academy’s efforts to Spot Skin Cancer by contributing to the AAD Spot the Difference program, or help support a unique summer camp opportunity for young patients by giving to the AAD Camp Discovery Endowment. Make a difference today! - SUSAN TREECE

Nominees sought for humanism award

THE ACADEMY’S VOLUNTEERISM COMMITTEE seeks nominations for the Arnold P. Gold Foundation Humanism in Medicine Award. The award recognizes physicians who are mindful of the life context of health and illness, and have become skillful in the habit of humanism, or how to communicate effectively and empathically to help patients heal.

To be eligible for the Humanism in Medicine Award, nominees must meet at least five of the following criteria:

- Demonstrate compassion and empathy in the delivery of patient care
- Show respect for patients, families, and coworkers.
- Demonstrate cultural sensitivity when working with patients and family members of diverse backgrounds.
- Display effective, empathetic communication and listening skills.
- Understand a patient’s need for interpretation of complex medical diagnoses and treatments and make an effort to ensure patient comprehension.
- Comprehend and show respect for the patient’s viewpoint.
- Be sensitive to the patient’s psychological wellbeing and identify the emotional concerns of patients and family members.
- Engender trust and confidence.
- Display competence in scientific endeavors.

The recipient will receive a monetary award of $1,000 and will be honored at the Academy’s recognition luncheon during the 2013 Annual Meeting in Miami Beach, Fla. In addition, expenses for the winner to attend the Annual Meeting, including airfare and accommodations, will be reimbursed up to $2,000. The winner also will be recognized in Dermatology World, on the Academy’s website, and in other media where award winners are covered.

Requests for nominations must be submitted online at www.aad.org/HumanismIn-Medicine by Nov. 2, 2012. For more information, contact Nikki Haton at nhaton@aad.org or (847) 240-1350. - NIKKI HATON
We couldn’t do it without you!

Your generosity is making a world of difference. Every year more kids with skin disorders can attend AAD Camp Discovery, shade structures shield thousands more people from the sun, our sun safety message reaches millions of people, and member dermatologists learn valuable leadership skills, nurtured through hands-on training and mentoring. Your gifts are changing lives!

Thank you!

EUGENE J. VAN SCOTT AWARD FOR INNOVATIVE THERAPY OF THE SKIN AND PHILLIP FROST LEADERSHIP LECTURE

$100,000 - $250,000
Phillip Frost, MD, FAAD

1938 LEGACY SOCIETY^ (PLANNED GIFTS)

Anonymous
Rex and Johnnie Amonette
John U. Buchman, MD, FAAD
Dr. Gene and Ann Burrish
Family Endowment
C. Ralph Daniel, MD, FAAD
Hobart C. Parkhurst, MD*
Stephen and Lisa Stone
Hiram M. Sturm, MD, FAAD and
Richard L. Sturm, MD, FAAD
George A. Waldriff, MD*

*deceased

2012 PRESIDENT’S CIRCLE ($5,000 – $9,999)

Individuals
Murad Alam, MD, FAAD
Rex and Johnnie Amonette
Humberto C. Antunes
Darryl M. Bronson, MD, MPH, FAAD

Brett M. Coldiron, MD, FAAD
John H. Epstein, MD, FAAD
C. William Hanke, MD, FAAD
Terence J. Harrist, MD
Hiroshi Ikeno, MD
Suzanne Olbricht, MD, FAAD
David M. Pariser, MD, FAAD
Daniel M. Siegel, MD, FAAD
A. David Soleymani, MD, FAAD
Stephen and Lisa Stone
Dr. John S. and Mrs. Susan T. Strauss

Associations, Corporations, Societies
Hunt Family Foundation
The Irma Giddey Charitable Fund
National Rehab Equipment, Inc.

2012 LEADERSHIP CIRCLE ($2,500 – $4,999)

Individuals
Thomas C. Chin, MD
Lisa A. Garner, MD, FAAD
Eileen M. Murray, MBA, CFRE, CAE
Ryan S. Owsley, MD, FAAD
Phoebe Rich, MD, FAAD

Associations, Corporations, Societies
The Clarence S. Livingood Lectureship and Education Fund
Kids for Kids, Dancing for Life, Inc.
Noah Worcester Dermatological Society

^If you have included the Academy in your estate plan please contact us at Development@aad.org.
“As our needs have grown and changed, the Academy has adapted with us to meet those needs. Your gifts ensure that the Academy will continue to provide essential programs and services that serve us and help us serve our communities.”

– C. William Hanke, MD, FAAD
2012 PATRON (CONT.)
($250 – $999)
Boní E. Elewski, MD, FAAD
Vilma C. Fabre, MD, FAAD
Dennis L. Feinberg, MD, FAAD
Tammie C. Ferringer, MD, FAAD
David P. Fivenson, MD, FAAD
Van Fletcher, MD, FAAD
Alexander A. Fondak, MD, FAAD
Ellen H. Frankel, MD
Kathryn E. Frew, MD, FAAD
Bert C. Frichot, III, MD, FAAD
Cole M. Fulwider, MD, FAAD
Lynne K. Furlong, MD, FAAD
William W. Galloway, MD, FAAD
Charles E. Gambla, MD, FAAD
Sharon F. Gardepe, MD, FAAD
Lawrence J. Green, MD, FAAD
Robert G. Greenberg, MD, FAAD
Bernard Gregoire-Krikorian, MD
Ronald E. Grimwood, MD, FAAD
Mrs. Helen Gruber
Elizabeth K. Hale, MD, FAAD
Katherine R. Hamlet, MD, FAAD
Marta T. Hampton, MD, FAAD
Julie C. Harper, MD, FAAD
Curtis W. Hawkins, MD, FAAD
Richard R. Henderson, MD, FAAD
Ross C. Hensley, MD, FAAD
Terri H. Henson, MD, FAAD
James J. Herrmann, MD, FAAD
Robert J. Herten, MD, FAAD
Janet G. Hickman, MD, FAAD
Anita Highton, MD, FAAD
Howard Hines, MD, FAAD
Jeanine K. Hoang, MD, FAAD
Julie A. Hodge, MD, MPH, FAAD
Steven E. Hodgkin, MD, FAAD
Jean M. Holland, MD, FAAD
J. William Holtze, MD, FAAD
Beth A. Honi, MD, FAAD
Terrence T. Hopkin, MD, FAAD
Maria K. Hordinsky, MD, FAAD
Martin S. Horn, MD, FAAD
Bruce G. Howard, MD, FAAD
Jon D. Igelman, MD, FAAD
Farouk Iqbal, MD
Aleksandr M. Itkin, MD, FAAD
David B. Jackson, MD, FAAD
J. Mark Jackson, MD, FAAD
Robert L. Jackson, MD, FAAD
Victor Jaimes-Hernandez, MD
Amy Y. Jan, MD, PhD, FAAD
Brian T. Johnson, MD, FAAD
Lawrence L. Johnson, MD
Richard A. Johnson, MD, FAAD
Robert H. Johnsr, MD, FAAD
Aaron K. Joseph, MD, FAAD
Deana L. Kadyk, MD, FAAD
Teri A. Kahn, MD, FAAD
Donald Kay, MD, FAAD
Lloyd E. King, Jr., MD, PhD, FAAD
Louis S. Kish, MD, FAAD
Jay C. Klemme, MD, FAAD
Donna J. Ko, MD, FAAD
Liborka Kos, MD, FAAD
Carrie L. Kovarik, MD, FAAD
Geraldine Kurz, MD, FAAD
Mark A. Lake, MD, FAAD
Nikolajs A. Lapins, MD, FAAD
Anne E. Laumann, MBChB, FAAD
Andrew P. Lazar, MD, FAAD
Susan M. Leal-Khoury, MD, FAAD
Stanton S. Lebouitz, MD, FAAD
Francis C. Lee, MD, FAAD
Phillip H. A. Lee, MD, FAAD
Larry L. Legum, MD, FAAD
John C. Lepage, MD, FAAD
Michael R. Lerner, MD, PhD, FAAD
Jack L. Lesher, Jr., MD, FAAD
Stuart R. Lessin, MD, FAAD
Brian W. Lester, MD, FAAD
Thomas G. Lewis, MD, FAAD
James J. Leyden, MD, FAAD
Ruey-Yi Lin, MD
Charles E. Linden, MD, FAAD
Merrill G. Liteplo, MD, FAAD
John C. Long, Jr., MD, FAAD
Eve J. Lowenstein, MD, PhD, FAAD
Lee R. Lumpkin, III, MD, FAAD
Susan J. Mahler, MD, FAAD
Michael J. Majors, MD, FAAD
Bruce D. Mallatt, MD, FAAD
Stephen H. Mandy, MD, FAAD
Linda Susan Marcus, MD, FAAD
Victor J. Marks, MD, FAAD
Jeffrey L. Marx, MD, FAAD
C.G. Toby Mathias, MD, FAAD
Marie F. Maurice, MD, FAAD
Elizabeth L. McBurry, MD, FAAD
David H. McDaniel, MD, FAAD
Charles J. McDonald, MD, FAAD
Daniel K. McKenzie, MD, FAAD
Thomas O. McMeekin, MD, FAAD
Alexandria Meccia, MD, FAAD
John W. Melski, MD, FAAD
Jeffrey L. Messenger, MD, FAAD
Russell D. Metz, MD, FAAD
Charles C. Meuregh, MD
Suzanne Micciantuono, DO
Alexander Miller, MD, FAAD
Elaine K. Miller, DO
Richard L. Miller, MD, FAAD
Larry E. Miltikan, MD, FAAD
Harold J. Milstein, MD, FAAD
Matthew A. Mittelbronn, MD
Juan A. Mujica, MD, FAAD
George J. Murakawa, MD, FAAD
Susan T. Nedorost, MD, FAAD
Dennis E. Newton, III, MD, FAAD
Chau M. Nguyen, MD, FAAD
Masayuki Nishimura, MD
James J. Nordlund, MD, FAAD
Antoinette P. Notaro, MD, FAAD
Fred M. Novic, MD, FAAD
William B. O’Grady, MD, FAAD
Dr. Jason Olin
Thomas G. Olsen, MD, FAAD
Emily F. Omura, MD, FAAD
Robert L. Orme, MD, FAAD
Laila M. Osman, MD
Anastasios A. Pappas, MD, FAAD
Herbert M. Parnes, MD, FAAD
Sylvia L. Parra, MD, FAAD
Robert M. Paull, MD
Lindall and Jane Ann Perry
Susan B. Perry, MD, FAAD
Angela R. Peterman, MD, FAAD
Clay M. Pickard, MD, FAAD
Dr. and Mrs. Jeffrey D. Pittis
Peter R. Pless, MD, FAAD
Gerd Plewig, MD
Andrew K. Pollack, MD, FAAD
Mark D. Popkin, MD, FAAD
Robert M. Portman and Annette F. Simon
Adam S. Pritzker, MD, FAAD
Rachel M. Qualley, MD, FAAD
Scott C. Rackett, MD, FAAD
Eric O. Rasmussen, MD, FAAD
Steven E. Rasmussen, MD, FAAD
Sandra I. Read, MD, FAAD
Ronald E. Reece, MD, FAAD
Christopher G. Rehme, MD, FAAD
Gregory C. Richterich, MD, FAAD
Jennifer M. Ridge, MD, FAAD
Johannes Ring, MD
Elisa M. Roberts, MD, FAAD
Bernard N. Robinowitz, MD, FAAD
Cynthia J. Rogers, MD, FAAD
Roy S. Rogers, III, MD, FAAD
Thomas E. Rohrer, MD, FAAD
Gerald A. Rosenblum, MD, FAAD
Ruth G. Rothman, MD, FAAD
Adam Rubin, MD, FAAD
Ronald E. Reece, MD, FAAD
Donald Rudikoff, MD, FAAD
Earl J. Rudner, MD, FAAD
Beata L. Rydzik, MD, FAAD
Jorge L. Sanchez, MD, FAAD
Bryan D. Sands, DO
Kathleen Y. Sawada, MD, FAAD
William S. Sawchuk, MD, FAAD
Lilly H. Schaffer, MD, FAAD
Rhonda R. Schneider, MD, FAAD
Arnold L. Schroeter, MD, FAAD
Jeffrey Schuldenfrei, MD, FAAD
Joseph J. Schwartz, MD, FAAD
Kathryn Schwarzenberger, MD, FAAD
Deborah A. Scott, MD, FAAD
Patricia L. Seab, MD, FAAD
Alan C. Semion, MD, FAAD
Robin B. Septon, MD, FAAD
Alan R. Shalita, MD, FAAD
Amie B. Shannon, MD, FAAD
Karen A. Sherwood, MD, FAAD
Linda J. Sheu, MD
James G. Simpson, MD, FAAD
Kristin W. Smallwood, MD, FAAD
Cindy F. Smith, MD, FAAD
Scarlett D. Smith, MD, FAAD
Wallace B. Smith, MD, FAAD
Robert M. Soderstrom, MD, FAAD
George B. Sonnier, MD, FAAD
David A. South, MD, FAAD
James M. Spencer, MD, FAAD
Brian R. Sperber, MD, PhD, FAAD
Alan L. Spinowitz, MD, FAAD
Sarah Stein, MD, FAAD
Robyn M. Stengel, MD, FAAD
Dr. Patricia A. Storck
Richard M. Storm, MD, FAAD
Richard B. Swint, MD
Amy F. Taub, MD, FAAD
Robert E. Taylor, Jr., MD, FAAD
Tadashi Tezuka, MD
Oscar W. Thompson, III, MD, FAAD
John M. Tieman, MD, FAAD
Kenneth J. Tomecki, MD, FAAD
Charles B. Toner, MD, FAAD
Mary B. Toporcher, MD, FAAD
Sheila M. Torres, MD, FAAD
Thomas A. Van Meter, MD, FAAD
Kent D. Walker, MD, FAAD
Patrick Walsh, MD, FAAD
Hao Wang, MD, PhD, FAAD
Michael R. Warner, MD, FAAD
Thelma G. Warshaw, MD, FAAD
Kalman L. Watsky, MD, FAAD
Stephen B. Webster, MD, FAAD
Pamela K. Weinfield, MD, FAAD
Mark B. Weinstein, MD, FAAD
Jonathan S. Weiss, MD, FAAD
Margaret A. Weiss, MD, FAAD
Robert A. Weiss, MD, FAAD
Christine Welsh and Douglas S. Mitchell
Sheila Welsh
Ronald G. Wheeland, MD, FAAD
Michael J. White, MD, FAAD
Richard E. White, MD, FAAD
Lori Ann R. Wilcox, MD, FAAD
Scott M. Wilhelmus, MD, FAAD
Dorota M. Wilson, MD, FAAD
Mr. and Mrs. L. Mark Wine
Peter L. Winters, MD, FAAD
Gregory P. Wittenberg, MD, FAAD
David J. Wolf, MD, FAAD
Dr. Barbara A. Wolf
Burrell H. Wolk, MD, FAAD
Patricia P. Wynnin, MD, FAAD
Kim B. Yancey, MD, FAAD
Masaru Yasuda, MD, PhD
Ruth A. Yates, MD, FAAD
James A. Yeckley, MD, FAAD
Inia I. Yevich-Tunstall, MD, FAAD
James W. Young, DO
Lori and Bill Youngdahl
Janice W. Yusk, MD, FAAD
Mark J. Zalla, MD, FAAD
Bella Zubkov, MD, FAAD
Warren S. Zwecker, MD, FAAD

**Associations, Corporations, Societies**
American Academy of Dermatology
The Barn Sale, Inc.
The Crutchfield Dermatology Foundation
DNA-Hudson Valley Chapter
GetWellNetwork
KAO USA Inc.
Michelson Diagnostics Ltd.
Tilly & Salvy’s Bacon Street Farm, LLC
Women’s Dermatologic Society

Includes contributions through August 1, 2012. The Academy apologizes for any errors or omissions.
Statements sought on proposed bylaws amendments
Due Dec. 1
THE AMERICAN ACADEMY OF DERMATOLOGY is seeking statements to the proposed bylaws amendments beginning Oct. 17. The proposed amendments will be presented to the membership for a vote on the spring 2013 election ballot. The ballot will be accompanied by statements from members who express support for or opposition to the proposed amendment. Any member who wishes to submit such a statement to the secretary-treasurer for consideration can do so using one of the following methods:

Website: www.aad.org/statements
Email: statements@aad.org
Mail: American Academy of Dermatology
Attn: Secretary-Treasurer
Bylaws Statements
930 E. Woodfield Road
Schaumburg, IL 60173-4729

Statements may not exceed the length of two typewritten, double-spaced pages. A statement may be submitted by one or more members, but no more than three members can be designated as principal authors and identified with the statement. The deadline for receipt of statements is Dec. 1, 2012. - JOAN TENUT

Proposed Amendment to the Bylaws of the American Academy of Dermatology
Recommendation of the Board of Directors: Not approve

ARTICLE I
Name and Purposes

Section 1. Name
The name of this corporation is AMERICAN ACADEMY OF DERMATOLOGY AND DERMATOLOGIC SURGERY, INC. (hereinafter referred to as the “Academy”).

Proposed Amendment to the Bylaws of the American Academy of Dermatology Association
Recommendation of the Board of Directors: Not approve

ARTICLE I
Name and Purposes

Section 1. Name
The name of this corporation is AMERICAN ACADEMY OF DERMATOLOGY AND DERMATOLOGIC SURGERY ASSOCIATION, INC. (hereinafter referred to as the “Association”).

Thanks for your thoughts!
OVER THE SUMMER, DERMATOLOGY WORLD MAILED A SURVEY about the magazine to 1,500 Academy members and offered those who completed it the chance to win one of five $50 Amazon.com gift cards. Congratulations to Laura Klein, MD, Colby Evans, MD, Joseph Luger, MD, James Roller, MD, and April Larson, MD, who were randomly selected as the winners. More information about the survey’s results will appear in a future issue.

Want to offer your own feedback about Dermatology World? Email dweditor@aad.org.
Nominations sought for 2013 AAD election
THE AMERICAN ACADEMY OF DERMATOLOGY Nominating Committee seeks nominees for the offices of president-elect, vice president-elect, Board of Directors, and Nominating Committee member representatives in the Eastern Region. The current Administrative Regulation on Nomination and Election Procedure requires that nominees submit all the required materials to the Nominating Committee no later than Nov. 1, 2012 for the election that will take place in spring 2013.

Successful candidates will take office in March 2014, at the close of the 72nd Annual Meeting in Denver. Nominees for the offices of president-elect and vice president-elect must have served on the Academy Board of Directors for at least one year prior to assuming office. President-elect nominees incur a four-year commitment — a one-year commitment prior to president-elect, one as president-elect, one as president, and one as immediate past president. Vice president-elect nominees assume a three-year commitment — a one-year commitment prior to vice president-elect, one as vice president-elect, and one as vice president.

The Nominating Committee screens and evaluates all nominees and selects a definitive slate of candidates based on professional, scholarly, and administrative skills, and geographic representation. Remember, make your nomination(s) early to ensure that nominees have the necessary time to complete and submit all the required materials no later than Nov. 1.

The 2013 Nominating Committee members are Diane R. Baker, MD, chair, James O. Ertle, MD, John C. Maize Sr., MD, Susan C. Taylor, MD, Lawrence F. Eichenfield, MD, C. William Hanke, MD, MPH, and Raymond L. Cornelison Jr., MD.

Submit nominations to www.aad.org/election/nominate or by mail at:
American Academy of Dermatology
Attn: Call for Nominations
930 E. Woodfield Road
Schaumburg, IL 60173-4729

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

Unauthorized Member Activities
No member of the American Academy of Dermatology shall directly contact any member of the Nominating Committee regarding nominees under consideration. All letters of support and/or nominations should be addressed to the Nominating Committee chair at the Academy’s Schaumburg headquarters. Any lobbying of committee members may eliminate the nominee from consideration by the Nominating Committee.

Direct Financial Relationship
With the Academy’s adoption of the Council of Medical Specialty Societies (CMSS) policy (see www.aad.org/cmss_policy), the successfully elected president-elect candidate will be required to divest him- or herself of any direct financial relationships with companies during his or her entire term (utilizing the time from the close of the election to officially taking office for divestiture). For purposes of Key Leader disclosures, the definition of direct financial relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099, or equivalent income report. Key Leaders may provide uncompensated service to for-profit companies and accept reasonable travel reimbursement in connection with those services. Key Leaders may accept research support as long as grant money is paid to the institution or practice where the research is conducted, not the individual. Compensation (e.g., royalties) from intellectual property rights does not need to be divested. - Joan Tenut

Nominations sought for Master Dermatologist Award
THE ACADEMY’S HISTORY COMMITTEE seeks nominations for the AAD Master Dermatologist Award. The Award recognizes an Academy member who throughout the span of his or her career has made significant contributions to the specialty of dermatology as well as to the leadership and/or educational programs of the American Academy of Dermatology. The selected individual will be presented with the Master Dermatologist Award at the 72nd Annual Meeting in Denver, March 21-25, 2014.

Recipients should possess a national or international presence and a well-recognized expertise. The recipient should be a long-standing member of the American Academy of Dermatology.

Requests for nominations are solicited annually from the Academy membership at large, via Dermatology World, as well as from the members of the Board of Directors and the Academy’s History Committee. The recipient will be selected by the History Committee and presented to the Board of Directors for approval.

Requests for nominations must be submitted online at www.aad.org/MasterDermatologist. For more information, please contact Marlene Banihe at mbanike@aad.org or (847) 240-1289. - Nikki Haton
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
Botswana dermatologist awarded developing country honor

D}iditle Motsepe, MD, head of dermatology at Princess Marina Hospital in Gaborone, Botswana, has received recognition from the Society of Pediatric Dermatology (SPD). Dr. Motsepe, who has become an integral part of the American Academy of Dermatology’s Resident International Grant program, was awarded the SPD’s Dermatologist from Developing Country Award.

Dr. Motsepe, who completed her residency in South Africa, returned to her home country in 2010 as the only residency-trained dermatologist in Botswana. Since, she has partnered with the AAD to oversee recipients of the Academy’s Resident International Grants, which bring American dermatology residents to Botswana to train with her. She also assists medical students from Canada on pediatric and general medical rotations.

“The AAD program is quite wonderful in many ways. I am the only dermatologist in a population of just above two million. I see patients from all over the country. You can imagine if I had to do it alone, I would be overwhelmed,” Dr. Motsepe said. “I really like the program, and enjoy working with residents. I think they enjoy it as well, because they get exposed to so many pathologies they never thought they would see with their own eyes.”

Gaining recognition from her colleagues in dermatology, she said, should help raise the profile of the need for skin specialists in Botswana. As part of her efforts to expose more young physicians in training to the specialty, Dr. Motsepe mentors students and residents from the University of Botswana.

“I had always wanted to be a pediatrician. But I decided that there was need for dermatology, and that I would train in it, only to find out that I love it. I love what I’m doing,” Dr. Motsepe said. “I want to open a full-fledged clinic with all the equipment and medication that I need. The thing that makes me most excited is that more people will know of the need for dermatologists in our country. We need to raise the profile of dermatology with doctors in Botswana.” – JOHN CARRUTHERS

Media Highlight

Academy members continue to share their valuable expertise with the media, and their audiences, to educate the public about skin, hair, and nails. The dermatology topics that topped the charts with the most media coverage this summer were skin cancer/sun protection at 54 percent followed by acne at 35 percent.

In an article in the New York Times (circulation 1,586,757), “Follow the Rules for a Beautiful Summer,” Joshua Zeichner, MD, and Doris Day, MD, discussed how the public can protect themselves from the health risks of hair and nail salon services. To read other dermatology stories in the news and access key messages about skin conditions and breaking news topics, visit the Academy’s Media Relations Toolkit at www.aad.org/member-relations-toolkit. – ROSE HOLCOMB

To download the complete Media Relations Toolkit, visit www.aad.org/dw

Members Making A Difference: Dayna Diven, MD

DERMATOLOGIST ENGAGES THROUGH LEGISLATIVE PROCESS

Dayna Diven, MD, spent time and effort participating in the legislative process in her home state, serving as a dermatologic society representative to the Texas legislature. She balances that effort with doing medical missions focusing on both general medicine and dermatology. Throughout, she’s managed to volunteer at homeless outreach programs in her community, host exchange students from the Czech Republic and Germany, and serve as treasurer for the local Girl Scout troop.

“The bottom line is that if we aren’t involved in the process of legislation, decisions are going to be made for you.”

• Dr. Diven’s experience in public policy started when she began to be called to provide expert testimony during legislative sessions for bills that related to the practice of dermatology. Soon, instead of merely commenting on bills just prior to passage, she and her colleagues at the Texas Dermatologic Society got involved earlier in the process, examining the language and evolution of various bills related to the specialty.

• “Getting involved in the process can be exciting, frustrating, slow … but it’s always interesting.”

• In 2009, a tanning bill came through the Texas legislature that would set an age limit on tanning bed use. Dr. Diven said that she learned a great deal about the legislative process through the tanning industry’s attempt to invoke parents’ rights on the issue. The bill, supported by the Texas Dermatologic Society, eventually set the minimum age for tanning at 16 years, six months, a number chosen for its relationship to unrestricted driving privileges in the state.

• “I’ve always liked the ‘white hat’ issues, where it’s not a turf war, it doesn’t have anything to do with money. It’s when you have nothing to gain and work only for the public good. If anything, tanning booths help my business. With that issue, you’re clearly serving the public interest.”

To nominate a physician, visit www.aad.org/membersmakingadifference.

– JOHN CARRUTHERS
classifieds

PRACTICES FOR SALE

OREGON
Mohs 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 pgoodkin1@aol.com. www.GoodSkinMD.com.

DALLAS
Forty-year, established, general and cosmetic dermatology practice available for purchase. In mid-city, it serves a surrounding area of over 4 million people. The first practice in the area to offer cosmetic dermatology and surgery. Will train if interested. Office designed for 2 physicians, or P.A. or N.P. All furnishings and equipment included. Contact dra@alkek.com.

N.P. All furnishings and equipment designed for 2 physicians, or P.A. or surgery. Will train if interested. Office to offer cosmetic dermatology and people. The first practice in the area and surrounding area of over 4 million able for purchase. In mid-city, it serves cosmetic dermatology practice available. In practice since 2003. Send CV to judyflanagan52@yahoo.com.

SPACE FOR LEASE

LAKE GENEVA, WISCONSIN
Great Lease Opportunity: We are a large Dental Practice located in downtown Lake Geneva, Wisconsin looking to create cosmetic synergy by leasing a recently built out 2200 SF space within our building to a Cosmetic Dermatology Practice. Visit our website at www.chicagolanddentists.com, where you can take a virtual tour of our aesthetic office space. Cosmetic dentistry together with a dermatology group in one building would be a match made in heaven! Please contact Colleen Vaccino at (630)640-3967.

PROFESSIONAL OPPORTUNITIES

SOUTHEASTERN CONNECTICUT
Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

RURAL COLORADO
Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

FT. LAUDERDALE, FLORIDA
Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

ATHENS, GEORGIA
Highly qualified MOHS candidates who are committed in patient care and possess strong clinical skills for very busy, high end practice for 2-3 days a month. Five MOHS Surgery Suites and a fully equipped histopathology CLIA approved laboratory. In practice since 2003. Send CV to judyflanagan52@yahoo.com.

Baltimore, MARYLAND
Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

MARYLAND
Outstanding opportunity offering an immediate patient base for a BC/BE dermatologist to work with preeminent physicians in a large primary care based multi-specialty practice in Montgomery County, MD and surrounding areas. For confidential consideration, please email a CV to eliotrgoldstein@yahoo.com.

NEW HAMPSHIRE
Fellowed Mohs surgeon 2 days/month. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

UPCOMING DEADLINES:

December.................October 25
January...................November 21
February..................December 21
March.....................January 25

NORTHERN NEW JERSEY
Well established thriving dermatology practice in Parsippany, NJ seeking BC/BE dermatologist interested in providing medical and surgical care to a diverse patient population. Full-time position. Partnership opportunity. For more information contact Dr. Laila Almeida at (973) 335-2560 or lalmeida1@optonline.net. www.dermatologysassociatesofmorris.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 or CV to susanne@accentderma.com.

MILBURN, NEW JERSEY
Dermatologist needed to join busy practice. Beautiful state-of-the-art facility, EMR, lasers, great work environment, Medical, surgical and cosmetic derm. Competitive compensation. Send CV to me@somalaser.com.

DERMATOLOGIST OPPORTUNITY IN FLORIDA
(Between Tampa and Orlando)
Financially stable multi-specialty group seeks a BE/BC Dermatologist to join our existing collegial group of 6 Dermatologists, 2 Dermatopathologists and Mohs surgeon. Option to read your own slides.

- Extensive services in-house (lab, radiology including MRI and CT, phototherapy with UVB & PUVA)
- Medical Spa
- 200+ physician-owned and run practice; 40 specialties
- Very competitive 1st yr salary guarantee + bonus; Partnership after 2 yrs
- Extensive benefits with professional liability insurance & relocation assistance
- Exceptional suburban setting with excellent reimbursement
- Abundant recreation year round – 500+ lakes and numerous parks; within 45 minutes of Orlando & Tampa attractions
- NO STATE INCOME TAX!

WATSON CLINIC LLP
1600 Lakeland Hills Blvd. Lakeland, FL 33805
(800) 854-7786 • Fax (863) 580-7951
email: wgonzalez2@watsonclinic.com

Help Build a Gateway for Better Health
At Northwest Permanente, P.C., we want every patient we see to receive the medical care they need to live long and thrive. We also offer NWP physicians the opportunity to pursue their personal and professional goals with equal passion through cross-specialty collaboration and work-life balance. We invite you to consider these opportunities with our physician-owned and managed, multi-specialty group of 1,000 physicians who care for 479,000 members throughout Oregon and Southwest Washington.

DERMATOLOGIST - Pacific Northwest
We’re seeking a BC/BE Dermatologist to join our team of 16 Dermatologists. Our Dermatologists have an active practice with an unusual number of complex cases and opportunities, if desired, for cosmetic procedures. Ours is a collegial and stimulating practice in one of the most successful managed care programs in the country.

We offer a competitive salary and benefit package, including a comprehensive pension program, professional liability coverage, sabbatical leave and more.

To submit your CV and learn more about this opportunity, please visit our website at: http://physiciancareers.kp.org/nw/ and click on Physician Career Opportunities. Or call (800) 813-3763 for more information. We are an equal opportunity employer and value diversity within our organization.
Cambridge Health Alliance Dermatology

Cambridge Health Alliance (CHA) is a nationally recognized, award winning public health system and we are currently recruiting dermatologists to establish a Dermatology Division within the Department of Medicine. CHA is a teaching affiliate of both Harvard Medical School and Tufts University Medical School.

Our well respected health system is comprised of three campuses and an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston’s Metro North Region. As we transition to becoming an Accountable Care Organization, dermatology services will be essential to the success of our Patient Centered Medical Home Model.

These positions are primarily clinical and will practice general dermatology in an ambulatory setting as well as inpatient and emergency department consultations. For the right candidate, leadership opportunities exist and we will consider either PT or FT. Ideal candidates will be BC, possess two years of post residency experience and substantial interest in building a Dermatology Division, developing quality improvement projects, Tele-dermatology services, as well as curriculum development for both medical student and resident education. Candidates must possess excellent clinical/communications skills, commitment towards our multicultural, underserved patient population and a strong interest in teaching. Ability to collaborate and work in a multidisciplinary team environment is required.

At CHA we offer a supportive and collegial environment with a strong infrastructure— including an EMR system, as well as the opportunity to work with dedicated colleagues committed to providing high quality health care to a diverse patient population. Excellent opportunities exist for teaching medical students/residents, and we strongly encourage both women and minorities to apply. Please forward CV’s to Laura Schofield, Director of Physician Recruitment, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge MA 02139. Telephone (617) 665-3555, Fax (617) 665-3553 or via e-mail: Lschofield@challiance.org. EOE. www.challiance.org

NEW YORK Wall Street and Park Avenue offices of established plastic surgeon is seeking a BC general dermatologist to join practice. Please contact Gigi at (212) 744-9400 or info@donaldrolandmd.com.

COLUMBUS, OHIO Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

NORTHEAST PENNSYLVANIA Busy derm practice seeks BE/BC dermatologist for 32 yr old, 3 physician, 4 physician assistant practice. General derm and subspecialty interest welcomed. Excellent compensation, benefits and partnership opportunity. Please contact Kathryn Colombo, Practice Manager at Lackaderm@aol.com or by fax (570) 207-5579.

PHILADELPHIA, PENNSYLVANIA Partnership available – no cash required. Established practice. Contact Jeff Queen, (866) 488-4100 or hr@mydermgroup.com.

MaineGeneral Medical Center in Augusta/Waterville, Maine is seeking one or two well-trained BC/BE Dermatologists to join a general Dermatology practice or we will assist you in setting up a private practice. You will establish a thriving practice quickly as there is no availability currently in our service area and patients are driving one hour to see a provider. We offer an outstanding financial package with an incentive component. Loan forgiveness program, relocation assistance, CME time and dollars, and excellent benefits, including three pension plans are also available. We are located in scenic central Maine, just a short drive away from ski resorts, lakes and rivers, award-winning golf courses, abundant hiking trails, and the beautiful Maine coast. We are just an hour north of Portland, Maine’s largest city and three hours from Boston. Send your CV to Lisa Nutter, Physician Recruiter at lisa.nutter@mainegeneral.org or call 1-800-344-6662. Please visit www.mainegeneral.org for more information and plans for our brand new, state-of-the-art regional hospital to open late in 2013.

Carolinas HealthCare System (CHS) is actively seeking BC/BE Dermatologists to join two thriving internal medicine multi-specialty practices in the Charlotte Metro area. Candidates should have experience in general dermatology, cosmetic dermatology, and lasers. CHS has been committed to providing excellent and innovative patient care. Competitive compensation, Signing bonus. One year salary guarantee, Outpatient surgery. High quality physician peers. Well managed and well established practices. Established supportive environment to guide physicians through healthcare reform. EMR, Full time and part-time opportunities. Moving allowance and salary advance. Comprehensive benefit packages including health/dental plans, 401k matched savings and defined pension plan, disability/life insurance, malpractice insurance, attractive paid time off and a CME allowance. For more information or to submit a CV, please contact: Tracey Black, CHS Physician Recruiter, tracey.black@carolinashealthcare.org, 704-355-0159 Office / 800-847-5084 Toll Free / 704-355-5033 Fax.
Dermatology World

Statement of Ownership, Management, and Circulation


   a. Total No. Copies (Net Press Run) 18,060 17,914
   b. Paid and/or Requested Circulation
      1. Sales Through Dealers and Carriers, Street Vendors and Counter Sales 0 0
      2. Paid and/or Requested Mail Subscriptions 16,849 17,200
   c. Total Paid and/or Requested Circulation (sum of 15b1 and 15b2) 16,849 17,200
   d. Free Distribution by Mail, Carrier or Other Means; Samples, Complimentary and Other Free Copies 734 552
   e. Free Distribution Outside the Mail (Carriers or Other Means) 181 0
   f. Total Free Distribution (Sum of 15d and 15e) 915 552
   g. Total Distribution (Sum of 15c and 15f) 17,764 17,752
   h. Copies Not Distributed
      1. Office Use, Leftovers, Spoiled 296 162
      2. Return from News Agents 0 0
   i. Total (Sum of 15g, 15h1 and 15h2) 18,060 17,914
   Percent Paid and/or Requested Circulation (15c/15G x 100) 94.85% 96.90%

ad index

We gratefully acknowledge the following advertisers in this issue:

Company | Product/Service
---|---
Advanced Skin and Hair | Clearogen.................................................. 7
American Safety Razor | Personna.................................................. 15
American Society for Mohs Surgery | CME....................................................... 37
Care Credit | Credit Services......................................... 43
FotoFinder | Dermoscope STUDIO.................................. 17
Galderma Laboratories | Clorex .................................................... 1,
Henry Schein | AAD Advantage......................................... IBC
Merz | Mederma................................................ 9
NexTech | EHRS Software ......................................... BC
Officite | AADDERMsonline.org .......................... 25
Quantum Medical Billing, Inc | Corporate................................................ 5
Varitrions | Call System ........................................... 31

Recruitment Advertising

- Cambridge Health Alliance Dermatology........................................ 46
- CoxeHealth .................................................................................... 46
- Northwest Permanente, PC......................................................... 45

Classified ads are welcomed from dermatologist members of the American Academy of Dermatology, from dermatology residents of approved training programs and institutions with which they are affiliated, as well as from recruitment agencies or organizations that acquire and sell dermatology practices and equipment. Although the AAD assumes the statements being made in classified advertisements are accurate, the Academy does not investigate the statements and assumes no liability concerning them. Acceptance of classified advertising is restricted to professional opportunities available, professional opportunities wanted, practices for sale, office space available, and equipment available. The AAD assumes no liability concerning them. Acceptance of classified advertising is restricted to professional opportunities available, professional opportunities wanted, practices for sale, office space available, and equipment available. The AAD reserves the right to decline, withdraw, or edit advertisements at its discretion. The publisher is not liable for omissions, spelling, clerical or printer’s errors. For more information about classified advertising, visit www.aad.org/recruitment-opportunities, email DWclassifieds@aad.org, phone 908-420-2523, or fax 847-240-8618.
The Academy’s Camp Discovery program, a summer camp for children with skin conditions, hosted its 19th annual program this summer. Campers and volunteer counselors and medical staff gathered for six different camps at five locations: Hebron, Conn., Crosslake, Minn., Millville, Pa., Burton, Texas, and Carnation, Wash. The resulting experience, documented below, is one that the children who camped and the adults who watched over them will cherish. To learn more or make a donation to support Camp Discovery, visit www.campdiscovery.org or www.AADdevelopment.org/SustainingFund.html. - RICHARD NELSON

CAMP DISCOVERY MAKES MEMORIES

- Six exciting weeks
- Five different locations
- 335 campers
- 251 volunteers
- 39 AAD members
Why Rely on Henry Schein...
We are the authorized distributor for the AAD’s Member Buying Program. This program brings you supply chain savings and solutions for your practice. For weekly promotions and insights, visit www.henryschein.com/80ways

Your reliable network of trusted advisors provide exclusive solutions via the AAD’s Member Buying Program

Rely on Us
www.henryschein.com/dermatology | www.henryschein.com/aad
Government Data: **NexTech** is the Leader for Meaningful Use in Dermatology

Don’t miss out on receiving your Stimulus Dollars. Of these four Ambulatory Dermatology focused companies, NexTech has the **MOST Dermatologists** who have attested for Meaningful Use.

**NexTech is the One-Stop Shop**

- Electronic Medical Records (Medical & Cosmetic)
- Practice Management (Cosmetic & Electronic Billing, Scheduling, and POS/Inventory)
- Marketing, Medical Spa & Surgery Center
- Native iPad App

**Several Software Configuration Options Available:**

- Subscription License
- Perpetual License
- Windows version
- Cloud-Hosted Solution
- Client/Server Installation
- Native iPad

**Percentage of Dermatologists Attested**

- NexTech® Practice 2012™: 59%
- NextGen® Ambulatory EHR: 21%
- Encite® EHR: 20%
- Modernizing Medicine® EMA™: 0%

**NexTech® EMR & PM**

Software Designed for Dermatology

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


All registered marks and trademarks belong to their respective companies