In 2011, the American Academy of Dermatology (AAD) contracted an independent research firm to execute a series of interviews with senior leadership (both physician and non-physician) and staff (elected leaders) for 13 non-dermatology physician organizations. While the qualitative results of these inquiries are admittedly limited by their small sample size and lack of quantitative data, they reveal important insights into how our physician colleagues perceive dermatologists and the specialty of dermatology.

How are dermatologists and the field of dermatology perceived?

First the positive. Dermatologists are perceived by those interviewed as valuable colleagues and assets to the medical community. Furthermore, dermatologists are viewed as making contributions in advancing skin cancer treatment, skin cancer prevention, and controlling chronic skin disease.

But it was not all good news. The small group of leaders in organized medicine expressed several unfavorable opinions of dermatologists as well. Many of the interviewees commented on the inaccessibility of dermatologists and the difficulty of getting prompt consultations and appointments for patients in a timely fashion. This lack of access was attributed by interview participants to be due to the limited number of dermatologists and a shift from “classical” dermatology (i.e., medical dermatology) to more lucrative cosmetic dermatology or dermatologic surgery.

Dermatologists were also perceived as being unwilling to work as many hours as other types of physicians. Interviewees further felt that dermatology attracts physicians who want an easier lifestyle, i.e., not wanting to work nights or weekends. Some respondents felt that some dermatologic surgeons were unqualified to perform certain procedures and were operating under less stringent control than other types of surgeons, raising concerns for patient safety. Dermatologists based in academic/research centers were perceived more favorably than community-based dermatologists.

An impression of dermatology’s isolation from other fields of medicine also emerged. Interview respondents expressed that they felt dermatologists were isolated and not involved in the wider physician community as evidenced by lack of participation on hospital committees and in local and state medical societies. Dermatologists were further perceived as being unwilling to teach their physician colleagues (i.e., primary care providers) about dermatology.

Why perceptions matter

It is not known whether the opinions of the interviewees reflect the opinions of their organizations’ member physicians. But negative perceptions of dermatologists and dermatology, whether validated by factual data or not, pose significant harm to our success as individuals and a specialty. Perceptions of lack of access and lack of willingness on the part of dermatologists to perform inpatient hospital consultations and to attend to outpatient medical dermatology patients belies our training and could adversely impact patient care. If we are seen as being unavailable, will our medical colleagues stop asking for our help? Without our help and educational efforts, will dermatology care be usurped by primary care and other subspecialty fields? Will dermatologists be marginalized within medicine even further? Will our colleagues be unwilling to join us in our advocacy efforts with legislators, third-party payers, and other crucial stakeholders? Are the negative perceptions of this small group of physician organization leaders representative of their physician members? Will the negative perceptions of other physicians trickle down to their patients? The negative perception of dermatology may also threaten the future of dermatology in the form of future resident trainees. A survey of dermatology residency applicants to the University of North Carolina in 2011-12 revealed that 58 percent reported having experienced some form of mistreatment by other medical students (26 percent), residents (30 percent) or faculty (28 percent) after sharing their decision to pursue dermatology as a career, which resulted in feelings of...
Merz proudly supports the American Academy of Dermatology and the Young Physician Focus newsletter.
marginalization, belittlement, and humiliation. (Ziemer CM et al. Specialty bashing during medical training: experiences of students applying to a dermatology residency program. J Am Acad Dermatol 2012; 67: 1085-6.) Will continued negative perceptions of our specialty negatively impact our ability to recruit the best and brightest students into dermatology?

What can we do?

The Academy has taken action by instituting the Perceptions of Dermatology Task Force, chaired by Lisa Garner, MD, with the aim of devising innovative solutions to enhance dermatology’s perception within the house of medicine. Significant discussion is also ongoing within the AAD Board of Directors, and members can be assured that the Academy is fully engaged in developing strategies to cultivate a positive impression of dermatology.

But we all need to be aware of our role as individuals in the perception of the specialty. Within this changing health care environment there is much at stake for each of us, and we each have an obligation to represent the best face of dermatology by exhibiting a commitment to our profession as a service vocation, forging collaborative relationships with our medical colleagues, and actively engaging in our local communities and organizations. As individuals, we need to “take a seat at the table” of our hospitals and medical societies and give our colleagues a specific name and face on which to base their impressions of dermatology. Increasing communication and building positive individual relationships will be crucial to the broader organizational efforts to rectify the misperceptions of dermatology. As one interviewee noted, “For a lot of professionals who didn’t train in dermatology, it can be a black hole. Educating your medical colleagues and building more viable connections would help.”

“Many of the interviewees commented on the inaccessibility of dermatologists and the difficulty of getting prompt consultations and appointments for patients in a timely fashion.”

About the interviews

“The interviews were crafted to gain knowledge about the general perceptions and impressions of dermatologists, the specialty of dermatology as well as the elected leadership of the AAD. Specific interview items focused on whether dermatologists are viewed as: treating serious diseases and conditions, performing surgical procedures, supporting quality patient care, and being valued colleagues in providing medical care. Additional queries explored whether dermatologists are viewed as collaborative, free of industry conflicts, receiving fair compensation/reimbursement, making valuable contributions to medical research, promoting education and training, giving back to society, and caring about the well-being of patients.” — Dr. Schlosser.

Strategies to improve access to the dermatologist’s office

The AAD’s ad hoc task force addressing the perceptions of dermatology has suggested steps toward alleviating the problem of limited access. Suggestions include:

• Keep some slots open, preferably at the beginning or end of the morning and afternoon session.
• Set aside a few slots in addition to those normally reserved if you know a staff shortage will be occurring.
• Arrange to see established patients concerned about one “spot,” early in the morning, before other patients.
• Reserve emergency appointments for patients who share a condition (such as sore mouth or dermatitis).
• Reserve “hold” appointments for the use of the front desk receptionists who are scheduling patients as they leave.
• Set aside 45- to 60-minute slots for surgical procedures.

Read in more detail about access and other issues related to the perception of dermatology in the October 2013 issue of Dermatology World.

Bethanee J. Schlosser, MD, PhD, is chair of the AAD’s Young Physicians Committee.

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Zig Ziglar once said, “People often say that motivation doesn’t last. Well, neither does bathing — that’s why we recommend it daily.” Keeping your staff motivated to give their best performances is essential to a well-functioning office. Providing high-quality patient care is a goal that can only be reached by developing an efficient, accurate, and enthusiastic team within your practice. Ultimately, your success as a physician, both professionally and financially, depends on the motivation of those working around you.

So what are the most effective ways to motivate your employees? Usually the first thought that comes to mind is something monetary. True, most people are motivated to some degree by money and this article will take a look at that. For a young physician in a new practice, however, more money is not always the easiest incentive to provide.

A Public Agenda Foundation study examined what people find most rewarding in their jobs. The top 10 results are somewhat surprising:

1. To work with people who treat them with respect
2. Interesting work
3. Recognition for doing a good job
4. A chance to develop skills
5. To work for people who listen to ideas about how to improve things
6. Chances to think for themselves
7. Seeing results of their work
8. Working for efficient managers
9. A job that is challenging
10. Being well-informed about the goings on of the office

The most powerful motivators are all free! If you want your employees to feel invested in the success of your practice then you need simply to start with respect. Respect their hard work and their opinions. Let them know you value them as a vital part of the team.

Praise your staff members in public. Recognize them for jobs well done in front of other staff, and if appropriate, in front of patients. Tell them when they are complimented by patients. Let your employees know their work is appreciated.

Inconsistent employee discipline. Just remember always to do this in private. No one appreciates being criticized in front of others.

Consider trying the “sandwich plan” when you discuss a performance concern with a staff member. Sandwich the problem between two compliments: “Amy, you are a very efficient medical assistant and keep our office running on time. However, accuracy in what we do is just as important as speed. It’s essential that we correctly label all specimens before we leave the exam room. I need you to be more precise in your work. I feel sure you can combine these attributes and we will function even better when we are both efficient and accurate. I appreciate your attention to this and all your hard work.” This addresses what the employee needs to improve while reminding her that you still recognize her strengths.

Remember that all employee discipline must be consistent. Your staff must know what is expected of them and what will happen if they do not perform. This allows them to make their own decisions within given parameters; it gives your employees a feeling of security and ownership of their positions.

STAFF MOTIVATION: SO MUCH MORE THAN MONEY!

By Elizabeth S. Martin, MD

The flip-side of this coin is to reprimand privately. When an employee fails to perform as expected, a fair and consistent discipline plan is needed. Nothing will hurt the morale of an office more than unaddressed problems or inconsistent employee discipline. Just remember always to do this in private. No one appreciates being criticized in front of others.

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In an article entitled “The Power of Small Wins” (Harvard Business Review, May 2011), Amabile and Kramer discuss 15 years of research conducted on employee motivation. The research included an analysis of work diary entries kept by 238 team members employed at seven different companies. They found that what motivated these workers most of all was a sense of making progress in their work. When workers reported even small progress in their work on a given day, this correlated with these workers reporting positive emotions (good moods), feeling positive motivation about the work itself, and perceiving teammates and supervisors as being supportive of the work at hand. Conversely, when workers reported setbacks in their work, this led to these employees reporting negative moods and attitudes toward their work, feeling less motivated by the work itself (and less motivated by extrinsic rewards as well), and negative perceptions of their teammates and supervisors.

It is important to make sure your staff has the tools to make progress in their work every day. Set clear goals, train them appropriately, make sure they have the resources they’ll need, and then give them sufficient autonomy to complete their tasks. Be sure that you, your office manager, or other staff members in supervisory roles offer assistance, encouragement, and support when needed.

If one were to imagine the reception area of a successful dermatology practice, adjectives used to describe it might include welcoming, pleasant, warm, friendly, and comfortable. This is the environment you want to create not only for your patients, but for your staff. Make sure that your staff has a comfortable work space and the tools they need to function effectively. Morale in the office is just as important. The physician sets the tone in the office, often the minute you walk in the door. You can either be
It’s predicted that more than half of dermatologists will have non-physician clinicians in their office by 2015. Non-physician clinicians are not just a reality now, but will continue to represent a significant work force in dermatology in the future. When Jennifer Baron, MD, opened a solo practice in 2010, she discovered the process of hiring a non-physician clinician can be challenging. For this article, she offered her personal experiences and provided pearls for those considering hiring non-physician clinicians.

Last month marked the third anniversary of the opening of my very small solo practice. I mention this only to point out my fairly short life experience as a “boss,” chief-of-staff, marketing director, human resources specialist, and otherwise all-around decision-maker in the ever-changing and often challenging world of private medical practice. Throughout these three years, I have hired, fired, and trained more staff, including two mid-level providers, or non-physician clinicians, than I ever expected to. I now have a solid — albeit small — core of front- and back-office support staff who earn their weight in gold on a daily basis. I’ve actually read entire Yelp reviews of my practice in which I am not even personally mentioned — only paragraphs of praise for my amazing staff. It’s wonderful to have such a strong team, and I hope they will want to work in my office for many years to come. But I want to share a few surprises about my experiences bringing on a physician assistant, and later, a nurse practitioner to the practice.

As it does, I expect, for any solo physician facing the torrent of decreasing health insurance reimbursements, who must find the stamina to see higher numbers of patients in a given day, the ideal solution seemed obvious: hire a compatible provider of medical dermatologic care to take on some of my increasingly heavy patient load. This would theoretically help my practice grow while allowing me a realistic workday. I was willing to provide fair compensation, benefits, training — basically, whatever it took to make this happen.

My first mid-level hire was a very nice and bright physician assistant. She was even motivated to hit the pavement and introduce herself to the local primary care physicians while I tried to fill up her patient schedule. She had previous dermatology experience in the area and I trusted her as much as I could to make the right calls.

However, strange things started to happen. Patients started to insist that they see me, even when on her schedule, and important (and borderline dangerous) errors in judgment were made in regard to treatment plans. I found myself feeling vulnerable as a physician and business owner and had to terminate the relationship. It took three months to find and correct various mistakes following her exit from the practice. The worst parts for me were the times when I discussed these various issues with her — her attitude was aggressive and, frankly, intimidating.

I was willing to chalk it all up to the possibility that my way of practicing medicine and her way of seeing patients were not compatible. And the overwhelming rule was and is always good patient care. After all, it will always be my neck on the line when a melanoma is missed, high-dose prednisone is given to an elderly patient, medication interactions are not crosschecked, or notes are not adequately documented, right?

Several months with heavy patient loads later, I decided I’d give it a second try. A nurse practitioner, with no dermatology background was very interested in learning from me and requested to work on a probationary basis until she and I both felt confident that we had the same protocols nailed down for the most common patient complaints. I was very careful this time to set out detailed boundaries and limitations in order to create a win-win situation for both of us. She saw only return patients with relatively straightforward problems whose treatment plans I carefully outlined in my initial consultation notes. In three months, her patient schedule did not grow. She did not put any effort into meeting and winning the trust of the local medical community (in spite of my direct requests). I announced her presence on my website, posted her credentials on the wall, instructed my staff to praise her as my trusted colleague and capable provider to all patients, covered her on my malpractice plan, and many other small but important votes of confidence in her as an important part of the team. Eventually, when I gently confronted her with the very

Jennifer Baron, MD, is a board-certified dermatologist with specialized fellowship training in both Mohs micrographic surgery and pathology. She opened a solo practice in San Jose in 2010.

See Non-Physician on page 6
uncomfortable truth that I could not afford to pay her if she could not at least increase our total patient numbers even 10 more per day (over what I’d had before her hire), she decided to leave.

Although my recent experiences have led me to think that a non-physician clinician might not be the right approach for my particular practice, the non-physician clinician relationship can work in the right situations. The following tips can help in laying the foundation to a mutually beneficial relationship.

What should I be aware of before hiring a non-physician clinician?

Your practice should first develop a guidebook containing appropriate policies and procedures for a physician extender in your practice, which should be consistent with the Academy’s Position Statement on the Practice of Dermatology. 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 non-physician clinician. 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. The manual can be purchased online at the AAD store, www.aad.org/store, in the practice management section.

How do I recruit a non-physician clinician 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/.

What real-life advice might work best for a small dermatology practice hoping to succeed with a non-physician clinician?

Don’t settle for less. The person you invite into your office must be as invested in your professionalism and success as you are. Be as selective as possible, check all references thoroughly, hold more than one in-person interview with each candidate, and participate in educating non-physician clinicians in your community. Keep in mind that your mid-level provider will be a top-level provider in the eyes of your patients. With the right person, and some preparation, you may find a way to benefit your patients for years to come.

Dr. Baron: “The value of building a practice through patient referrals is important to recognize and foster.”

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To learn more, visit www.aad.org/awards.
Motivation from page 4

happy, excited, and upbeat about the challenges of the day ahead or you can be grumpy, tired, and frustrated about having to be at work. The attitude you display leads the attitude of your staff. Set a positive tone and your staff will follow right along!

One maxim to remember is “it is important to be friendly without being friends.” Show your employee you care about her as a person. Ask about her family and her interests outside work. Remember, however, that you must retain your supervisory role. You cannot manage effectively and consistently when you are best friends with your employees. Leading can be a challenge for the young physician when your employees are often your age or older and many have worked in the medical field longer than you have. Be friendly, but remember this is business.

Ok, so enough of the cheerleading. What are some tangible rewards to motivate staff? The first step in setting up staff incentives is to determine performance goals. These can be practice-wide such as number of patients seen each week or total charges for the week. The incentives could be more position-specific such as the amount of cosmeceuticals sold by your aesthetcian, how many Botox appointments booked by your assistant or billing errors/insurance refusals incurred by your clerical staff. Either way, to be effective, goals should be clear, consistent, and reachable with some extra effort.

When goals are reached, what rewards will you provide? This also needs to be made clear at the beginning of the plan, and the rewards need to be provided in a timely fashion. Salary bonuses are a standard method of reward. Consider quarterly or more frequent bonuses rather than annual bonuses. Compensation throughout the year provides recognition and incentive for continued good performance. Other obvious incentives include pay raises, profit sharing, and extra vacation time. For physicians employed by a hospital system or academic institution, changing these items is not always an option. In this case, consider rewarding employees with gift cards to their favorite store or with cash. Just remember to comply with all tax regulations.

Employees want to improve their skills and education. More skillful, educated employees benefit your practice and your patients. Providing educational opportunities as incentives is an excellent way for everyone to win. Consider covering the costs of an educational meeting and allowing employees to attend during office hours. You also could consider sponsoring an employee’s trip to the AAD or other large meeting. Some offices provide an educational stipend for each employee to use at his or her discretion. This amount could be increased as goals are reached. The options for structuring educational benefits are endless.

Consider scheduling lunches or dinners away from the office either as rewards or as standard staff feedback times. Not only are these events nice morale-boosters, they foster camaraderie and place everyone on a more even playing field. Employees may be more willing to voice concerns or creative ideas in these environments.

Similarly, days at the spa, the golf course, or sporting or cultural events are nice incentives for staff. Not only are they fun, but they can help develop a team spirit that is invaluable in the day-to-day function of your practice.

Simple gestures like remembering birthdays or other appropriate holidays such as Administrative Professionals Day, Nurses Day, or Veterans’ Day with small tokens or gifts will go a long way in developing employee loyalty. Other benefits, such as providing standard uniforms for your nursing staff or fresh flowers for your receptionist’s desk, provide your employees with a perk while improving your office’s image.

There are many ways to motivate your staff. President Dwight D. Eisenhower said that “Motivation is the art of getting people to do what you want them to do because they want to do it.” Ask your staff what would inspire them and then listen to their answers. Consider involving your staff in setting performance goals. Let your employees know each day that you value them and the jobs they do. Show your staff the essential role each plays in reaching the common goal of excellent patient care and practice growth. Then let them see how well everything flows when you work as a team. This will increase their personal investment in your practice. If your staff is striving for their individual personal bests, then collectively your practice should function at its best!
Autumn is a time of change — the cooling temperatures, the changing color of leaves, and the migration of birds. But I often feel a mental shift too — vacations, relaxed agendas, and a sense of levity give way to the start of the new school year, daily schedules full of activities and commitments, and a more resolute approach to daily life.

Dermatology and the medical climate continue to change dramatically this fall as well. As AAD President Dirk Elston, MD, wrote recently, “Dermatology is under siege” (see www.aad.org/members/aada-advocacy/dermatology-is-under-siege). Threats to reimbursement and scope of practice continue to pose obstacles to our practice of dermatology. Members — including young physicians — are making a difference and answering Dr. Elston’s call to action.

A significant number of young physicians have recently joined the AADA as grassroots advocacy state leaders, and more than 20 young physicians joined colleagues on the hill at the Legislative Conference in Washington, D.C., in early September. The heart of these efforts focuses on building relationships with legislators and other key stakeholders so that they can better understand our priorities and needs for our patients, our practices, and our specialty.

With the implementation of the Physician Payment Sunshine Act and the Open Payments reporting system by the Center for Medicare and Medicaid Services, it is essential that dermatologists understand and actively monitor their interactions with industry representatives. Young physicians may be disproportionately affected by these types of regulations given the duration of our careers under the new systems. To better understand what you need to do to comply, check out the AAD practice management resources available at www.aad.org/members/practice-management-resources/sunshine-act). Seemal Desai, MD, a young dermatologist in private practice in Plano, Texas, has been appointed to the AAD Ad Hoc Task Force on Physician/Industry Relationships, an important first step to conveying the specific concerns and needs of young dermatologists to our industry counterparts.

Yes, we are dermatologists, but first, we are physicians. As such, our relationships with our medical colleagues in primary care and other specialties need to be given priority. The perception of dermatology within the house of medicine appears not to be all sunshine and roses. The AAD is spearheading organizational efforts and crafting interventions to overcome negative perceptions of dermatology (see related article p. 1). I see no better way to overcome misconceptions of our specialty than by reaching out to our fellow physicians, one on one, within our own communities — to build individual rapport and increase understanding with regard to the nature of our specialty, our modes of practice, and obstacles to access to dermatologic care in our hometowns. Rectifying the misperceptions of dermatology within the house of medicine may be the most important grassroots campaign of our professional lives.