DERMATOLOGY WORLD

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Health system reform bills signed into law

AADA will push for changes, SGR fix

By Richard Nelson, managing editor

HEALTH SYSTEM REFORM (HSR) legislation became law when President Barack Obama signed the Patient Protection and Affordable Care Act, the Senate's version of reform, on March 23. One week later he signed a series of changes made through the reconciliation process. The two bills combined comprise a law that the Congressional Budget Office estimates will spend $940 billion over the next 10 years, cut the budget deficit by $143 billion over that time period, and expand the number of Americans covered by health insurance by 32 million people.

President Barack Obama signs the Patient Protection and Affordable Care Act into law on March 23. The law, estimated to spend $940 billion over 10 years, reduce the deficit by $143 billion over that period, and expand the number of Americans covered by health insurance by 32 million, is the culmination of more than a year of debate on health system reform.

The legislation was ultimately opposed by the American Academy of Dermatology Association because several provisions did not conform to the AADA's long-standing HSR principles, though Academy President William D. James, M.D., noted that the organization "had worked throughout the process in an effort to achieve reform that would help us further promote our principles of quality care, improved and affordable patient access, and a patient-centered approach to health care delivery." He noted that the new law "provides coverage for more Americans who were previously uninsured, eliminates pre-existing conditions, and strengthens wellness efforts."

But some flaws in the new law need to be addressed, Dr. James said. Jack S. Resneck Jr., M.D., chair of the Academy's Council on Government Affairs, Health Policy and Practice, said the Academy's work is not over.

"We need to work on a few critical issues that were not addressed by the bill, including a permanent fix to the SGR physician payment formula and further efforts to reform the medical liability system," Dr. Resneck said. "In addition, we will continue to work constructively with Congress, where several members of both political parties share some of our ongoing concerns about specific provisions in the bill, including the Independent Payment Advisory Board (IPAB) and the mandates surrounding the use of flawed quality measures in public reporting and payment determinations. We will be active participants at the table as the regulatory framework to implement the new law is established, ensuring that we preserve and improve upon our ability to provide high-quality care for dermatology patients."

Medicare payment problem

One major weakness of the enacted HSR legislation, according to the AADA, was its failure to address the flawed Sustainable Growth Rate (SGR) formula,

See **REFORM** on p. 5

Tax on Tanning Bed Use Included in New Law

While the AADA opposed passage of the final HSR legislation, it does include a bright spot for dermatologists. When President Obama signed the Patient Protection and Affordable Care Act on March 23, a tax on tanning bed use became law. The AADA suggested this tax to replace a tax on cosmetic surgery that was included in previous versions of the legislation.

Annual Meeting breaks records

The Academy's 68th Annual Meeting, held March 5-9, broke all former attendance records for the second year in a row, making it the largest dermatologic meeting ever held in the world.

At the close of the meeting, the total number of attendees at the meeting was estimated to be 19,392 — more than 500 attendees higher than the previous attendance record, set in San Francisco in 2009. This year, almost 11,000 medical personnel, augmented by close to 700 non-medical personnel, 1,265 spouse/guest attendees, more than 100 press representatives, and 6,287 exhibitor attendees visited the Miami Beach Convention Center for the premier dermatology education event of the year.

More information about the Annual Meeting appears throughout this issue of *Dermatology World* and on the *Annual Meeting News* Web site, www.aad-365.ascendeventmedia.com.

FDA talks about tanning beds

American Academy of Dermatology Association President William D. James, M.D., testifies at the Food and Drug Administration's March 25 hearing on the risks related to the use of tanning lamps. Dr. James told the FDA's General and Plastic Surgery Devices Panel of the Medical Devices Advisory Committee that dermatologists are alarmed that melanoma is increasing faster in young women than in young men because dermatologists know that a major difference in behavior between the two groups is indoor tanning. He also commended the FDA for tackling the issue and pointed out that the AADA opposes indoor tanning and supports a ban on the production and sale of indoor tanning equipment for non-medical purposes.

Dr. James was one of several dermatologists, researchers, and patients who testified at the day-long public hearing. Others included Darrell Rigel, M.D., Henry Lim, M.D., Allan Halpern, M.D., Len Lichtenfeld, M.D, Michael Zanolli, M.D., Sandra Read, M.D., Robin Hornung, M.D., M.P.H., Lawrence Green, M.D., Kelley Redbord, M.D., Mary Maloney, M.D., David Fisher, M.D., Robert Silverman, M.D., Sewong Kang, M.D., Brian O'Donnell, M.D., Barbara Gilchrest, M.D., and Suraj Venna, M.D.

A full report on the March 25 hearing will appear in the May issue of *Dermatology World*.

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His mother may not realize the impact of incidental sun.

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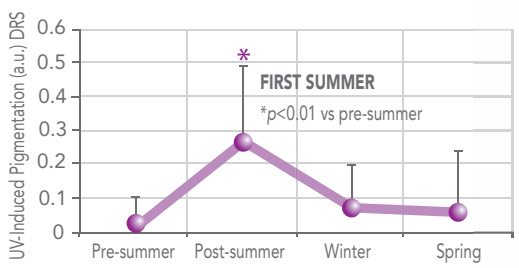
Help prevent incidental sun exposure from becoming accidental sun damage.

His parents don't think about incidental sun: like the sun he's exposed to under a shady tree.[1] On a cloudy day.[2] In the car.[3] The sun that causes 80% of his lifetime exposure to UV rays.[4] The effects are cumulative, causing wrinkling, toughening of skin, and freckling, and can be associated with skin cancer later in life.[5] UV effects can be seen, starting with his first summer.[6,7]

EFFECTS FROM UV EXPOSURE OCCUR IN THE FIRST YEAR OF LIFE [6,7]

Pigmentation increased significantly post summer.[6,7]

Indicates significant levels of exposure to UV rays and the associated risk of photodamage.[6-8]



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REFERENCES: 1. Safety Council of the Louisiana Capital Area. Sun Safety. http://www.safetylca.org/s/SafeFact.asp?loc=s&tag=s3&pg=SafeFact.asp&page=SafeFact_SunShine.htm. Accessed October 1, 2009. **2.** The Skin Cancer Foundation. UV Information. Ozone and UV: Where are we now? http://www.skincancer.org/ozone-and-uv-where-are-we-now.html. Accessed October 3, 2009. **3.** Tuchinda C, Srivannaboon S, Lim HW. Photoprotection by window glass, automobile glass, and sunglasses. *J Am Acad Dermatol.* 2006;54:845-854. **4.** Godar DE, Urbach F, Gasparro FP, van der Leun JC. UV doses of young adults. *Photochem Photobiol.* 2003;77:453-457. **5.** American Academy of Pediatrics. Shelov SP, ed. *Caring for Your Baby and Young Child: Birth to Age 5.* Revised ed. New York, NY: Bantam Books, a division of Random House, Inc; 1998. **6.** Mack M, Tierney NK, Ruvolo E, et al. Yearly exposure of infant skin to solar ultraviolet radiation incurs partially irreversible changes in skin pigmentation. *J Invest Dermatol.* 129:S143 (abstract). **7.** Mack C, Tierney N, Ruvolo E, et al. Infant skin displays persistent changes in pigmentation due to incident UVR exposure after the first summer of life. Poster presented at: 2009 Annual Meeting of the Society for Investigative Dermatology; May 6-9, 2009; Montréal, Quebec, Canada. **8.** Gilchrest BA, Eller MS. DNA photodamage stimulates melanogenesis and other photoprotective responses. *J Investig Dermatol Symp Proc.* 1999;4:35-40.

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Dermatology World® is edited to provide members of the American Academy of Dermatology with legislative, regulatory and socioeconomic news as it affects dermatologists and their practices, their patients, and their profession. It provides news and analysis/interpretation, reports on trends in dermatology, provides commentary and opinion, and reports on news and actions of the American Academy of Dermatology and the AAD Association.

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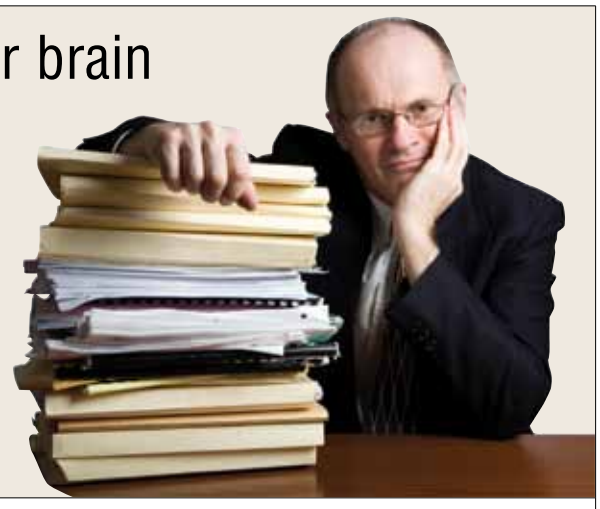

DERMATOLOGY DATEBOOK

Members, please note the following dates on your calendar.

April 12	Shade Structure Program applications due
April 30	Ad*dressing* Psoriasis contest entry deadline
May 3	Melanoma Monday
June 1	Identity theft rule takes effect
June 11	Deadline for Everett C. Fox, M.D., Lecture nominations (see p. 9)
June 30	Deadline for committee, task force applications (see p. 20)

PRESIDENT'S VIEWS

by AAD President William James, M.D., FAAD

New president feels renewed purpose as term begins

Editor's note: *This is an edited version of the President-elect's address delivered by Dr. James on March 7 in Miami Beach, Fla., during the Plenary Session of the Academy's 68th Annual Meeting.*

William D. James, M.D., FAAD
AAD President

I am pleased and excited to serve as your president for the next year, and I feel honored and humbled by this new role you have entrusted to me.

At the same time, I feel a sense of renewed purpose. During the next year, I intend to rededicate myself to serving you and our patients in fulfilling the Academy's vision, ensuring that we, as an organization, reflect the excellence in dermatology that all of you provide every day.

I'd like to share with you my plans for leading the Academy as we begin our journey into the second decade of the 21st century. I will discuss what you can expect from the Academy in terms of:

- advocating for our patients, you, our members, and for our specialty;
- enhancing the continuing medical education programs offered by the Academy; and
- developing the future leaders of our profession.

I will also review the tremendous impact that the Academy's philanthropic and volunteer efforts are having domestically and overseas, and I will share with you my vision for how we all can work — both individually and collectively — to extend the spirit of volunteerism and improve people's lives.

Reform and Medicare payments

We live in a time of unprecedented challenges for dermatology. Foremost on everyone's mind is the recurrent threat of a large cut in the Medicare physician payment rate. Concentrated daily efforts of a large team of physician volunteers and staff, your calls and visits to members of Congress, and pressure from the entire U.S. physician community, are attempting to avert this drastic action, which would certainly cripple the Medicare program, as most members of Congress have stated on the record. It would just as surely threaten all of our ability to provide access to high quality dermatologic care our seniors deserve.

We are continuing to work in every way possible to ensure a stable payment system for physicians, including a law that will permanently fix the flawed SGR formula. These short-term patches are not acceptable.

Other challenges are pressing as well. Increasing regulatory oversight and administrative requirements make it imperative that we speak with a united voice to protect our ability to deliver high-quality, cost-effective care. In an environment where legislation often is directed more toward large, inpatient-based entities, we will continue to serve as a visible and vocal advocate for our outpatient, mostly solo-to-small group practices. We will diligently educate policy-makers about our unique needs and challenges while advocating for legislation and public policies that are in the best interests of our patients and our practices. We will carefully monitor health system reform initiatives, emphasizing our unambiguous message that changes must be patient-centered, so dermatologists can continue to provide the best care possible. We will remain responsive to initiatives related to patient safety and quality measures, but we will urge decision-makers to institute such measures realistically, in terms of both their pace and scope.

Education

As most of you know, I have spent my career as an educator, and the Academy is an organization founded as an education provider. Increasing administrative requirements have complicated the business of education, just as they have complicated all aspects of medicine. But for all of us, the educational imperative remains simple: We must continue to improve ourselves through increasing knowledge, so that we can deliver the best of care to our patients.

You can count on your Academy to deal with the regulatory paperwork for you — and give you the tools you need to pursue your education goals. We will track trends, work to influence and minimize administrative burdens, and communicate changing education standards set by the many organizations whose missions include accreditation and oversight of our lifelong learning. We will continue to advance quality care through the development of evidence-based guidelines and world-class CME for dermatologists. We are offering more than 150 hours of CME annually for members who have enrolled in the American Board of Dermatology's Maintenance of Certification program. Although we didn't create maintenance of certification, your Academy will provide a number of tools to help you satisfy reporting, self-assessment, and quality-improvement requirements.

Leadership

We are always striving to mentor and train our young members to become great citizens of your Academy. These efforts have led us to expand our leadership programs by developing useful tools to help members of all practice types and ages become successfully engaged with your Academy, your local dermatologic or medical societies, your subspecialty societies, or anywhere you choose to become involved as a visible guiding force. This type of involvement strengthens the public perception of dermatologists and can lead to great personal satisfaction. Leadership development is one of the key priorities within the Academy's strategic framework, and providing the training and mentoring necessary to develop individual and collective leadership capabilities among our members and across our specialty is an important priority for strengthening the future of dermatology. During the next year, you can expect the Academy's Leadership Institute to become a more visible and active training initiative.

Volunteerism

Inextricably woven into some of the long-term concerns about health system reform and leadership in service organizations, is the call for volunteerism. There will always be people in dire need. Concern for those who have no jobs, no health insurance, and in many cases, no shelter, will continue to drive many of your fellow members to action. We have witnessed — and in some cases have highlighted in the "Members Making a Difference" section of *Dermatology World* — dramatic individual examples of love and compassionate aid to the nation's poor and homeless. One such example is a man I know well — and for whom I have the utmost respect — Marshall Guill III, M.D. Years ago, a patient of his who administered a local soup kitchen invited Marshall to visit the facility and offer treatment to homeless people with dermatologic conditions. He accepted the invitation, and soon, the service he provided outgrew the soup kitchen's capacity to house it. He moved the clinic to a new location, where colleagues and community members continue to treat the homeless today. Working with the homeless, Marshall says, has been one of the most meaningful parts of his career.

Marshall's words reflect a basic truth about why dermatologists do what we do. Fundamentally, we want to make people feel or look better. Your Academy offers many philanthropic opportunities, including our Camp Discovery summer camps, our skin cancer screening program, our mentorship activities, and our overseas training centers and clinics. Academy members participating in these efforts are having a profound impact. They are changing people's lives.

The passion our Academy volunteers display is inspirational. I have been privileged to serve on the resident selection committee for sponsored rotations to serve HIV-infected patients in Botswana. Since its beginning, applications have outnumbered available positions by a ratio of nearly three to one. The caring spirit and sense of responsibility evident in their words and feelings — along with the sheer number of applicants — should testify to the desire and commitment of young people entering our profession to make our world a better place. If their altruism and enthusiasm inspire you to share your expertise to help the less fortunate, I encourage you to contribute in some small way.

As Helen Keller once said, "I am only one; but still I am one. I cannot do everything, but still I can do something; I will not refuse to do something I can do." With many small efforts, we can make a big difference together. You can make a difference by simply donating money to support your Academy's charitable activities, or by donating materials, or by donating time to your Academy's outreach projects.

Telemedicine

I am hopeful that during the next year, the Academy can use telemedicine and other strategies to provide even more help to disadvantaged people in our own communities. We are actively exploring ideas with national free clinic organizations, with the long-term vision of helping the most-needy Americans address skin health concerns. As we develop new ways to help the needy, I hope you will answer the call to help with your time, your money, your ideas, and your thoughtful support.

In closing, I'd just like to touch on a few key points. First: Your Academy is strong and vibrant. We always are trying to anticipate and respond to threats to your practices and well-being, and we are dedicated to supporting all of you and your patients. In this time of challenges, where our patients and practices are threatened, we need to stay united with a strong message that echoes in the halls of Congress: Support our senior citizens and military families so they may obtain the health care they deserve! Second: You have a smart, insightful, and experienced Academy staff who are absolutely committed to our mission. You can count on them to help protect your interests as well. Third: I'd like to personally thank each of you for your daily work to improve the health of your patients. In spite of our current concerns, it is vitally important to extend our expertise to those in dire need in our great country. We must commit ourselves to improving the health of the poor and homeless men, women, and children in our own cities and towns. When we ask for your help in serving others, please consider its worth to you and others and how you might best be supportive.

I feel privileged to contribute in this role to which you have elected me. In partnership with your vice president-elect, Dr. Andrew Lazar, I pledge our time, our best efforts, and our abilities to your service over the upcoming year. Together, your Academy member volunteers and staff will be strong advocates for our patients, our profession, our Academy, and all of you. •

STATE PERSPECTIVES

Building strategic advocacy alliances: Your state society and the AADA

By Kathryn Chandra, assistant director, state policy

ADVANCING THE SPECIALTY OF dermatology, preserving access to care, protecting patient safety, and educating the public about the importance of skin cancer prevention are at the core of the American Academy of Dermatology Association's (AADA's) advocacy priorities. At the state level, the AADA relies on partnerships with state dermatology societies to address legislative and regulatory initiatives impacting dermatology. Over the last year, the AADA has developed multiple resources for members and state dermatology societies to engage in advocacy efforts.

Advocacy support from the AADA

The AADA is tracking more than 130 pieces of legislation impacting the specialty of dermatology in nearly 40 states. To aid state societies and members in accessing up-to-date legislative information about their state, the AADA lists all current state legislative activity on the Academy Web site. The information is updated in real-time, allowing members to access bill text, status reports, and notes from AADA staff.

See **STATE PERSPECTIVES** on p. 12

REFORM from p. 1

which would cut Medicare payments to physicians by 21 percent in 2010 and continue to make cuts in subsequent years. Dr. Resneck explained concerns about the SGR.

"It is clearly unacceptable for Congress to continue to pass short-term fixes to the SGR, leaving physicians without a stable payment system and unable to make needed investments to modernize and grow their practices," Dr. Resneck said. "The recent political blockage by Sen. Tom Coburn, M.D., (R-Okla.) of legislation to prevent impending cuts underscores the importance of a permanent solution. We managed to get a well-crafted permanent SGR repeal passed in the House, but the Senate continues to be challenging. We have several allies in Congress who want to work with us to achieve a long-term fix, and we remain hopeful that Congress will live up to its commitment to seniors in Medicare and military families in Tricare by permanently fixing the SGR in the months ahead."

As Dr. Resneck noted, the Senate failed to pass a temporary fix averting the 21 percent cut before adjourning for two weeks on March 26. Action was expected when Congress returns to session the week of April 12; Medicare planned to hold claims until April 14. The AADA, along with the American Medical Association (AMA) and other specialty societies, will continue to advocate for a permanent fix to the SGR problem.

IPAB

Another of the AADA's objections to the enacted legislation was the inclusion of the Independent Payment Advisory Board (IPAB), a 15-member appointed body that will have significant control over Medicare spending starting in 2014. Under the new law, in any year where Medicare growth exceeds a target, the IPAB will be called upon to recommend specific reductions to offset the additional spending. Congress would have limited capacity to overrule the IPAB by making its own reductions to bring spending within the target.

"Our concern is that IPAB, which is responsible for making recommendations to achieve specified cost reductions, will be comprised of only 15 members, a small minority of whom will be physicians, and this group's recommendations will be fast-tracked to implementation with limited Congressional oversight," Dr. Resneck said. "In addition, hospitals are protected from any cost reductions until 2019, leaving physicians to absorb an unfair share of any reductions. IPAB is fortunately prohibited from rationing care, so it is unlikely that they will get into the business of making specific coverage decisions, but dermatology services could be threatened, for example, if such a group reacted to the increase in utilization of skin cancer surgery and cut payment rates without taking note of the epidemic of skin cancer that is responsible for such a trend." The AADA will work with the AMA — which supported passage of HSR legislation but is urging revisions to the IPAB provisions — and other medical specialty societies to see that the IPAB as currently constituted does not take effect as scheduled.

Immediate impact

"The major physician-oriented changes in mandatory quality reporting, value-based payments, and IPAB-recommended payment changes do not take effect for three to five years, giving us time to work to improve those flawed provisions," Dr. Resneck said. But some changes will be felt sooner. "Beginning this year, dermatology practices with fewer than 25 full-time employees with average annual wages below $50,000 will be eligible for tax credits if they purchase health insurance for their employees. For those larger dermatology practices with more than 50 employees who will be required to contribute toward employees' premiums, the tax credits for providing insurance and the penalties for not doing so take effect in 2013," he said.

For patients and insurers, change will come more quickly. "The immediate reforms we will see are that our patients will fortunately no longer experience annual or lifetime caps on coverage, will be able to stay on parental plans until age 26, will no longer face rescissions when they fall ill, will have access to high-risk pools if they have pre-existing conditions, and will have assistance with drug costs in the doughnut hole if they have Medicare part D," Dr. Resneck said. "Beginning next year, insurers who fail to spend 80-85 cents of every premium dollar collected on the actual provision of care will have to refund enrollees the difference, limiting the amount of money that insurance companies can remove from the health care system to pay CEO salaries and skyrocketing administrative costs. The investment income and payroll tax provisions which will affect dermatologists as individual taxpayers do not take effect until 2013."

Amid all this change, dermatologists can look forward to some provisions directly related to the specialty, Dr. Resneck said. "The tax on indoor tanning, which the AADA was instrumental in proposing, begins this summer. Dermatologists will also see the emergence of follow-on biologic medications available at lower costs in the next few years." Academy President William D. James, M.D., hailed the tanning tax as a positive step. "This is good public health policy; it will discourage everyone, and particularly young people, from this dangerous practice," he said. "It has the potential to save our patients from a variety of adverse effects of chronic ultraviolet light damage, especially melanoma. It should reduce the future costs of treating skin cancers and reinforce other federal and state efforts to protect the public from the harmful effects of tanning beds."

A detailed breakdown of the provisions of the recently passed legislation is available on the Academy's Web site in the Health System Reform Resource Center; click on the legislation tab on www.aad.org/gov. •

Have May declared Melanoma/ Skin Cancer Detection and Prevention Month in your state

By Joanna Crooks, assistant director, grassroots affairs

DERMATOLOGY ADVOCACY Network (DAN) members will again be reaching out to state legislators to request resolutions declaring May 2010 as Melanoma/Skin Cancer Detection and Prevention Month. Last year, members of DAN partnered with state dermatology societies to ask their state legislatures to declare May 2009 Melanoma/ Skin Cancer Detection and Prevention Month. Dermatologists successfully worked with state legislators and governors across the country to obtain legislative resolutions or gubernatorial proclamations regarding melanoma prevention.

State dermatology societies that seek to have May declared Melanoma/Skin Cancer Detection and Prevention Month can take advantage of model resolution language available on the Academy's Web site as part of the Advocacy Tool Kit.

Reaching out to state legislators provides an opportunity for dermatologists to increase awareness about skin cancer and melanoma, and is a valuable way to build ongoing relationships with policymakers. Janet Hickman, M.D., worked to obtain a gubernatorial proclamation from then-Gov. Tim Kaine's office in Virginia. Dr. Hickman noted that "obtaining a melanoma proclamation is a news-worthy event that can prompt the media to give valuable coverage to our public education message."

State societies that held skin cancer screenings at the state capitol or worked on indoor tanning legislation were able to add the melanoma resolution request to their ongoing awareness and outreach efforts. The Pennsylvania Academy of Dermatology and Dermatological Surgery worked with a legislator who had sponsored indoor tanning legislation. Pennsylvania dermatologist Bruce Brod, M.D., said "it provides us with an opportunity to remind our legislators that dermatology is a serious medical specialty interested in the prevention, detection, and treatment of a serious medical illness. It enabled us to further our conversation with legislators on regulation of indoor tanning salons."

There are a number of state legislative and regulatory issues affecting dermatologists and their patients. Academy staff members are currently tracking more than 130 state bills specifically related to dermatology — so it is critical for Academy members to maintain relationships with state legislators. By maintaining these relationships over time, dermatologists can help educate state policymakers and their staff members about key issues such as indoor tanning, cosmetic taxes, and the practice of medicine by non physicians.

Representatives from states that are able to secure a resolution or proclamation will be invited to share their stories on the monthly DAN legislative and regulatory briefing call.

If you are interested in getting involved in grassroots outreach to state legislators, please contact Joanna Crooks. •

WEB INFO

www.aad.org/gov/toolkit/_doc/2009MelanomaSampleResolutionInformation.doc
Model resolution declaring May Melanoma/Skin Cancer Detection and Prevention Month

www.aad.org/gov/state/PendingStateLegislation.html
Track pending legislation related to dermatology

www.aad.org/dan
Dermatology Advocacy Network

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RAC your brain

Medicare fraud and abuse: As enforcement ramps up, experts advise physicians to be proactive

By John Carruthers, staff writer

THE EFFORTS EXPENDED by the government to detect, prevent, and punish Medicare and Medicaid fraud and abuse have increased rapidly over recent years. The Deficit Reduction Act of 2005 placed pressure on agencies to be more proactive in saving costs through a better system of detection and enforcement at the tail end of the second Bush administration. The early years of the Obama administration have continued that trend as the spotlight on health system reform highlights the importance of billions in potential cost savings that may soon go to fund new programs. The Office of the Inspector General has placed far more emphasis on data mining to more effectively and efficiently detect and address irregular billing patterns. Medicare and Medicaid have bolstered their own growing manpower through the use of Recovery Audit Contractors (RACs), outside consultants incentivized to recover reimbursement funds obtained through fraud and abuse.

According to James Sheehan, J.D., Medicaid Inspector General for the New York Department of Health, the emphasis on enforcement and recovery came swiftly and decisively from the top.

More funding, more people

"Here in New York, we had a series of stories in the *New York Times*, as well as a very negative review by CMS — one of the first reviews they did of a state program — that said we weren't doing the job," Sheehan said. "And that's how I got my job. I was brought in from the outside to do something about this. So we have doubled the size of the state workforce here doing investigations, workplace audits, and data mining. And we've also added a number of significant new tools to see what providers are doing and when it may be inappropriate. That's the background to where we are currently."

Sheehan oversees an office with a $100 million budget and a staff growing rapidly toward an ultimate goal of 675 people dedicated to investigating Medicaid fraud and abuse. He's a former assistant U.S. attorney who was brought into the agency due in part to his impressive background with whistleblower cases. While still at the U.S. Attorney's office, he capped a six-year investigation into a health care company that ended with a $155 million payment to the federal government.

Health care attorney Matthew Weber, J.D., says that under the Obama administration, the budget for program integrity will increase substantially over the next five years.

"There's been a steep increase in health care fraud and abuse enforcement in the last several years. The health care reform debate has fueled that increase by focusing attention on dollars that are wasted in the health care system. In addition, it's prompted policymakers to look to increased enforcement to fund various health care reform measures," Weber said. "So the health care reform debate has focused attention on fraud and abuse in both those ways. The Obama administration proposed a 50 percent increase in funding for program integrity, which comes to $1.7 billion over the next five years to fight health care fraud and abuse."

A new degree of scrutiny

Using New York state — with the nation's largest Medicaid agency — as a model, physicians should take note that they are entering an entirely new era in fraud and abuse detection and enforcement. In the previous 15 months, Sheehan said, his office has conducted over 1,400 audits. Along with doubling the size of the investigative workforce, Sheehan has placed an entirely new emphasis on data mining.

"The government's rolling out data mining projects which will be able to capture and analyze billing patterns for practices of all sizes and identify outliers," Weber said. "When outliers are identified, those practices will be candidates for further investigation."

This has largely been made possible through the development of data mining tools far more efficient than those seen in the past. The government has a checkered history when it comes to using data mining, but as a tool to combat fraud and abuse alongside increased focus and manpower, it appears to be poised to revolutionize the system.

"I think what you're seeing across the board — if you think of the current claims system for Medicare and Medicaid as the Subaru of computer systems — it's designed to keep on going, and to make sure that the checks go out. The focus in on simplicity and reliability, because you need to make sure the claims are processed," Sheehan said. "A lot of these newer systems are like fancy sports cars. You can take them out for a drive, and find out information from them, and put them back in the garage. So you can look at claims that are already paid and say 'which of these should we recover?' There are a host of vendors that have come out in recent years, spurred mostly by these initiatives from the federal government, but also because the software systems are getting so much better at analyzing large volumes of data. And that data is more accessible as well.

"In the old days, we could identify an outlier — a doctor's doing more in-office surgeries, maybe anesthesia that people weren't doing — but you had to be looking at codes. With a new tool we have that will go on line in June, you can drill down the data of a given physician and look at a whole series of different parameters based on what the investigator thinks they're going to find — who are the patients; what drugs were written for them; what other services were written for them; what kind of referral arrangements were there with other providers; what patients went to the hospital after or before; the frequency of services for that patient or the top 10. So what you're getting is a much better insight into what goes on in the practice based upon the billing patterns. I think it's great."

Increased recoveries

So far, according to Weber, the new tactics seem to be working for the agencies. "I can tell you in 2009, the OIG announced savings and expected recoveries exceeding $20 billion for the calendar year just completed. That gives you an indication of the magnitude of dollars we're talking about here."

Many of these changes haven't yet been felt by the majority of dermatology practices, as larger offices have been the first ones to react to this new focus on enforcement, according to Weber.

"I think most small practices have yet to see the effect of the increased focus on enforcement. It's mostly larger practices that are revamping their compliance programs to make sure they have systems in place to reduce the number of compliance issues they face, and effective reporting mechanisms in place to assure that any problems are handled quickly and effectively when they surface," he said. "As for smaller practices, if the office has the resources, it's helpful to employ a compliance officer who is trained in health care compliance. There are also resources available through organizations like the Health Care Compliance Association to help educate employees on the types of issues that may come up on a day to day basis."

Sheehan said that while enforcement is the key term for this push, the new tools available to his office, and Medicare and Medicaid offices across the country, should make enforcement both highly effective and far less intrusive than it has been in the past.

"What we hope to do, I can speak for New York state only, but I think the oversight agencies in general, is that we want to tailor our enforcement efforts based upon a wealth of information so they're much more focused, much more targeted," Sheehan said. "They're going at providers where we think it's much more likely that there's a problem, as opposed to auditing the five biggest, or ten with a particular code." •

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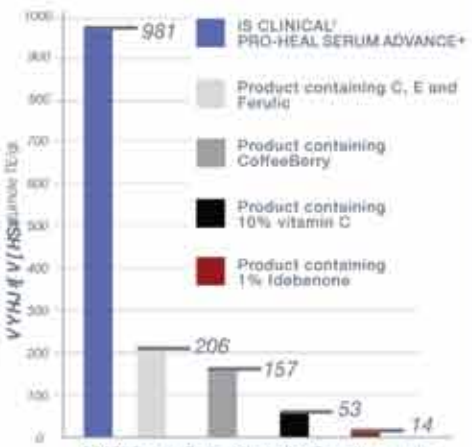
The ORAC assay is advantageous over many other methods. The mechanism of the ORAC is based upon sound chemical principles and the uniqueness of the ORAC lies in the quantitation technique. Indeed, many other methods have been developed for antioxidant activity, such as TEAC (Trolox Equivalent Antioxidant Capacity), TOSC (Total Oxyradical Scavenging Capacity), FRAP (Ferric Reducing Anti-oxidant Power), and DPPH method. However, the fatal drawback of these methods is either lack of oxygen radical or lack of complete quantitation technique. Therefore, only the ORAC provides anti-oxidant activity mechanistically and physiologically.



ORAC (Oxygen Radical Absorption Capacity) measures total lipophilic and hydrophilic antioxidant capacity. Testing independently performed by Brunswick Labs.

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SUPER SERUM ADVANCE+ measures more than 680 (µmole TE/g) total ORAC antioxidant capacity.

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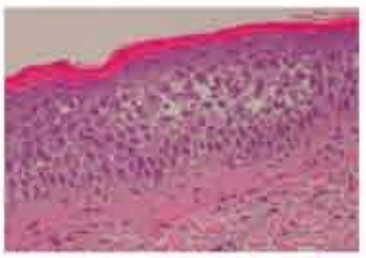
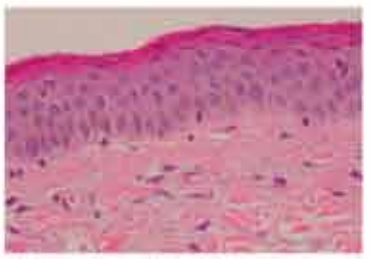
EFFECTS ON INFLAMMATION

STUDY DESIGN:
In this study, inflammation was induced by an applied agent. No product was applied to the control side. PRO-HEAL SERUM ADVANCE+ was applied to the treated side. Both treated and untreated sides were biopsied. The biopsies show the protective ability of PRO-HEAL SERUM ADVANCE+ against inflammation.



High power: Time: 48hrs - H & E stain control Control - no product applied

Note the marked inflammation with migration of lymphocytes and Langerhans cells into the area. Edema occurs and normal skin architecture is lost.



High power: Time: 48hrs - H & E stain with PRO-HEAL SERUM ADVANCE+

Note the absence of inflammatory cells and preservation of normal skin architecture.

Dermatopathology independently performed by PAML(InCyte

INFLAMMATION SCORE CHART

A cumulative inflammation score was given by an examiner and included the parameters of erythema, roughness, scaling, edema and fissure formation. The highest possible score of inflammation was +20. On the side treated with PRO-HEAL SERUM ADVANCE+, the cumulative inflammation score was +1 after 48 hours. On the untreated control side, the cumulative inflammation score after 48 hours was +11.

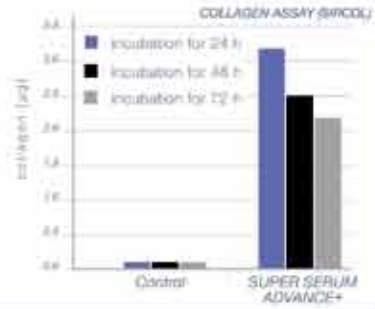
PERAMETER	CONTROL (no PRO-HEAL SERUM ADVANCE+)	TREATED (with PRO-HEAL SERUM ADVANCE+)
Erythema (0 - +4)	+3	+1
Roughness (0 - +4)	+2	0
Scaling (0 - +4)	+3	0
Edema (0 - +4)	+1	0
Fissure Formation (0 - +4)	+2	0
Cumulative Score (0 - +20)	+11	+1

RESULTS and CONCLUSIONS:
The side treated with PRO-HEAL SERUM ADVANCE+ exhibited minimal visual changes due to induced inflammation compared to the control. Histology demonstrated preservation of normal skin architecture on the treated side. The control side demonstrated marked cellular edema, influx of inflammatory cells and destruction of normal skin architecture.

IMPROVES COLLAGEN SYNTHESIS

STUDY DESIGN:
Human donor fibroblasts between the ages of 20 and 40 were cultured. The control samples were run without product treatment. The amount of collagen in both the treated and control samples was quantified using a collagen standard assay.

RESULTS and CONCLUSIONS:
SUPER SERUM ADVANCE+ markedly improved synthesis of collagen by human fibroblasts compared to the control. After 24 hours incubation, the amount of collagen in the treated sample was 3.2 mcg/100mcl and in the control sample was 1.0 mcg/100mcl.



IMPROVES SCAR TISSUE

STUDY DESIGN:
Part A: *Identical surgical wounds were made on the right and left mid-thigh region of subjects. A #15 surgical scalpel was used to make 1.5 cm full-thickness linear wounds extending into the adipose tissue. The wounds were sutured with 4 simple interrupted sutures of 5-nylon. The wounds were kept dry and plain Vaseline was applied to them 3 times daily for one week. Sutures were removed and product application began on the one side only, the other side serving as control. The wounds were not directly washed with soap. Product was applied twice daily for 3 months on one side and for another subsequent 3 months was applied once daily. Digital photos were taken at 3 months and 6 months.*

Part B: *Excisional surgical biopsies of both treated and control wounds in Part A occurred at 6 months. The biopsy specimens were sent to a dermatopathologist for microscopic examination. Photos of the histology were made.*

RESULTS and CONCLUSIONS:
Digital photos of the scars in Part A treated with SUPER SERUM ADVANCE+ show improved cosmetic appearance. Microscopic exams of PART B confirmed what was seen visually. Collagen bundles were more orderly on the treated side. The stratum corneum of the treated side exhibited no histologic indications of wounding. The stratum corneum of the control side was hyperkeratotic.

SCAR MATURATION: 3 MONTHS

3 months. Control

3 months with SUPER SERUM ADVANCE+ applied twice daily

SCAR MATURATION: 6 MONTHS

6 months. Control

6 months with SUPER SERUM ADVANCE+ applied twice daily for the first 3 months and once daily for the following 3 months

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Hiring squad

Physicians on both sides stress importance of comprehensive recruitment effort for associates

By John Carruthers, staff writer

DECIDING TO BRING AN associate into one's practice is one of the most important steps many dermatologists ever take. It requires careful consideration and skillful execution, and draws from a doctor's experience both as a medical professional and as a business owner. A successful recruiting effort means not only hiring a medical professional who is a good fit for the practice, but doing so in a cost-effective manner and in a time frame that doesn't keep the dermatologist away from patients for an extended period of time.

Deciding to hire

According to Neil Baum, M.D., author of *Hiring a New Associate: Tips for Finding Dr. Right*, the cue to hire an associate should come from a number of clear practice indicators.

"The best way to know it's time to hire someone on is to look at the workload. If you can't see a new patient for 6-8 weeks, that's indicative that there's more work to do than one can possibly handle," Dr. Baum said. "Your workload is growing, income is increasing, doctors are working harder, and you can't see a new patient in a reasonable period of time."

While workload and patient waiting times are excellent indicators, Dr. Baum advises going one step further and deciding if much of the existing workload is of the sort that could be executed by properly supervised non-physician medical professionals, such as physician assistants or nurse practitioners. (See sidebar, p.9.)

Where to look

Despite an abundance of more channels of communication than ever before available, dermatologists looking to hire can still be stymied by the frustration of not knowing exactly how to get their message out. The Internet is cheap and widely used among young physicians but unproven and frustratingly fragmented. National ads are prominent but expensive and hit or miss depending on the venue. Dr. Baum recommends that those who choose to advertise nationally in print do so in specialty journals or publications.

"Publishing in national publications is pretty low-yield unless it's for an academic appointment," Dr. Baum said. "Publishing in a specialty magazine is a better decision if you're going to go that route."

Many physicians available to be recruited are at the start of their careers, looking to establish themselves. And like so many other fields, careers in medicine are more often than not started by personal connections. Dermatologist Brian Sperber, M.D., Ph.D., who joined his Colorado single-specialty group practice five years ago, said that personal experience was the overriding factor in his job search during residency.

"I think I looked seriously at about four different practices. Mostly, it was some sort of personal connection that I had. The major thing was identifying the geographic region that I wanted to concentrate on," Dr. Sperber said. "In each geographic region I had some kind of connection that kind of prompted me to make that contact. I didn't contact many other practices within those regions, because I kind of knew in each city which practice I wanted to see. In retrospect, I don't know if that was the best idea, but it was the tack I took."

Dr. Baum advises those hiring an associate to contact training programs to get one's position promoted, but said that this particular tactic works far better when one has a connection with either the program director or the program itself.

> *"The best way to know it's time to hire someone on is to look at the workload."*
>
> – Neil Baum, M.D.

"Contact the training programs, particularly if you know one of the directors or it's where you trained," Dr. Baum said. "If they know you, they'll go to bat for you and reach out to graduating physicians, instead of just placing something on a bulletin board."

And while it may not seem a fruitful avenue of inquiry, Dr. Baum said that in many cases, just getting the word out among colleagues can yield unexpectedly successful results, saying "you'd be surprised how often someone two degrees of separation from you may know a graduating resident originally from your area who wants to come back home to practice. You have to speak up."

Headhunters are also available, but often at a steep cost. These services, most often retained by larger multi-specialty group practices and clinics, will not only locate and secure a candidate, but guarantee that candidate for six months employment in the practice before the full fee is expected. Otherwise, Dr. Baum said, physicians planning to execute a search largely on their own should budget the search at 10 percent of the associate's eventual salary.

Recruiting strategy

To effectively connect with a candidate — presumably, a younger physician — a practitioner must learn to understand the thoughts and motivations of that cohort. Different medical generations — each of them encompassing roughly a decade of physicians, according to Dr. Baum — are looking for different things from their medical careers. Understanding this will help showcase the practice in the most beneficial light.

"To showcase your practice, you have to emphasize the pluses. Young physicians today are looking for quality of life — two medical generations ago, people were looking for money and the ability to have a good case load, to work hard," Dr. Baum said. "Today, they want to be able to have regulated lifestyles, they want to have time off with their families, they want to have recreation nearby, cultural activities, opportunities for continuing education."

In Dr. Sperber's case, he was looking not only geographically through personal connections, but also for an institution that would match his desired practice style.

"I wanted to join a larger group of dermatologists, so I wanted to join a single-specialty group practice because I was hoping to subspecialize more than I would be able to if I practiced on my own," Dr. Sperber said. "I was also hoping to have instant volume, so to speak. I was hoping that I would have a niche where not only would I receive referrals from outside my clinic, but also internally from the clinic. That was important to me," he said.

"What turned out to be a big factor was structural or administrative setup. I was looking at a university practice in two locations and a multi-specialty practice in another. And those were two of my finalists, with me ending up landing in a single-specialty group practice," he said. "I wasn't attracted to the multi-specialty group practice because I felt that they didn't value dermatology as much as I'd hoped they would, and the same with the university for that matter. It came down to wanting to be in the place that was just dermatology."

Evaluating candidates

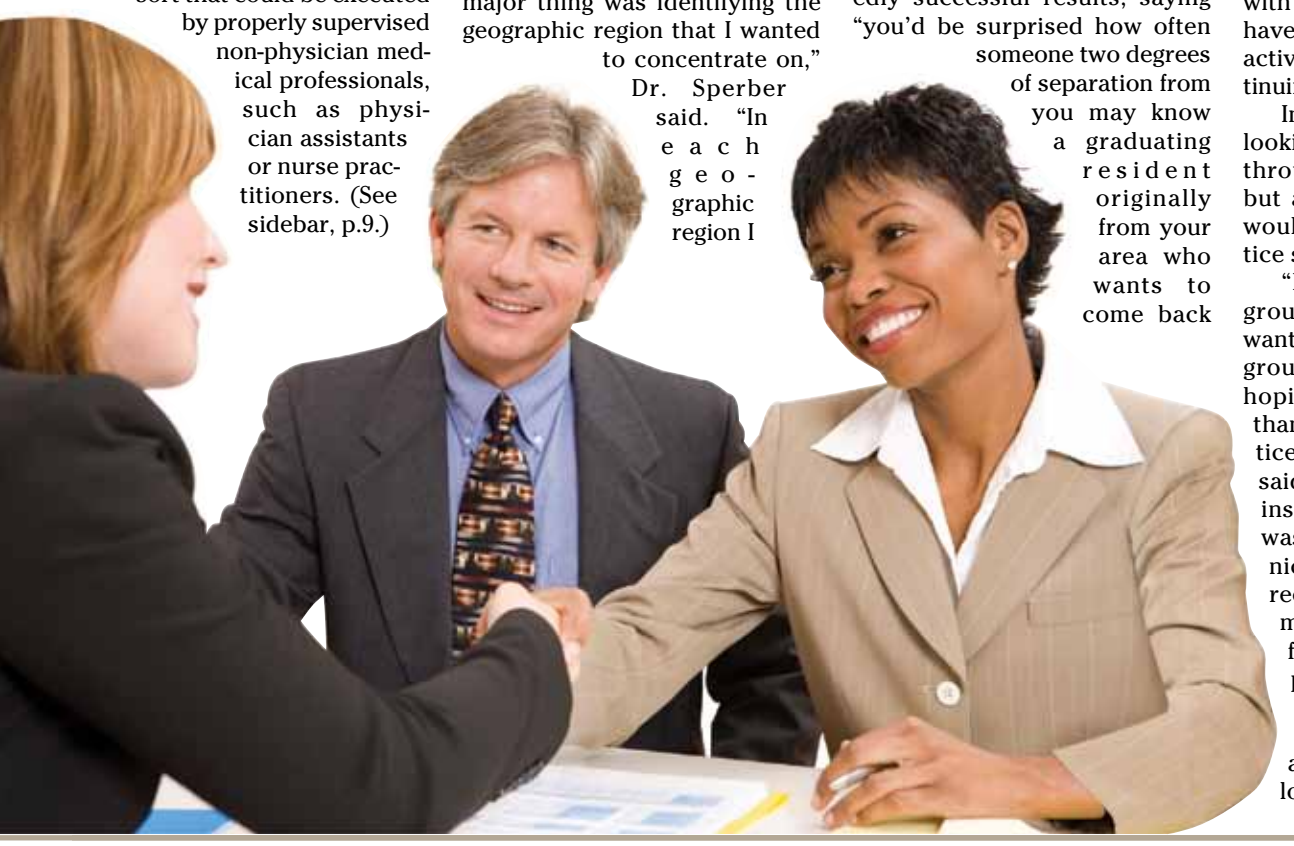
Once a practitioner makes contact with one or more interested parties, it's important to realize that despite the dermatology workforce shortage in many areas, scrutiny isn't a one-way street. The phone interview, and later, the site visit, allows the physician to fully evaluate the person who will become not just a colleague, but potentially a partner.

"The first step is always to ask for the CV/resume, but of course you can't just go by that. The phone interview is important. I would start with a phone conversation, usually with an office manager as well as the doctor," Dr. Baum said. "Before committing to the interview, you'll ask for the references — the director of the program, or if they're moving, ask for professional references. I would call those references and then ask if they know someone else who knows them. That way, you can go one layer deeper and do your due diligence. You should do all of this before you spend the money to bring them into your community — then you're talking about hotels, meals, time off of the practice, and so forth."

Both doctors said that while salary is important to all physicians — mountains of medical school debt considered — candidates who don't show interest in much other than money are to be avoided.

"I think if you're looking to hire somebody, you don't want to play too much to that crowd. There are some people out there looking for a job in dermatology who want to work three days a week from 9-2, and they want $400,000," Dr. Sperber said. "You don't want them — you'd be better off not having anybody. If someone comes in and the first thing out of their mouth isn't 'show me your practice,' or 'what is it like to work around

See **HIRING SQUAD** on p. 9



HIRING SQUAD from p. 8

here?' but 'I want these days off and this salary,' then they're not asking the right questions. You don't want them."

To entice the candidate without solely focusing on money, Dr. Sperber encourages practitioners to highlight the package value of joining the practice. This is extremely important, he said, for those in underserved or lower-population areas looking to attract candidates.

"I think a resident looking for their first job places an extremely high value on salary. For the individuals or groups looking to attract somebody, I would urge them to help that applicant understand the value of their practice from not only a financial standpoint, but from a non-financial one," Dr. Sperber said. "You have to help educate the applicant as to what your practice offers besides only financial considerations. And that their financial considerations go far beyond the salary — the buy-in, if there is one, what a partnership agreement could look like, how long your employee status is, how the practice is managed from a financial standpoint. You don't want to sign on to an antiquated practice administration that you may have to spend a lot of time and money updating in the future."

Sealing the deal

As part of the site visit, Dr. Baum suggests not only spotlighting the upsides of the practice, but of the surrounding community.

"An attractive community is higher on many candidates' wish lists than it was even two years ago. You have to recognize that and promote it. 'We have great schools in the city for your children, churches, places for camping,' etc. You have to find out what they're looking for in particular, but you have to realize that they're looking for a life that isn't 100 percent medicine." In addition, Dr. Baum said, many physicians have spouses who also have careers in medicine — whether as a doctor or another member of the medical industry. "If you're fairly confident so far, you can invite them with the spouse — especially if they're looking for a job as well. They'll both want to look at the community and see the opportunities available to them. You can also help the spouse set up interviews at the same time." •

Is an Associate the Answer?

Sometimes, Neil Baum, M.D., author of *Hiring a New Associate: Tips for Finding Dr. Right*, said, a practice's workload calls for an additional employee — but not necessarily a physician. He relates the story of a dermatologist acquaintance whose main workload issue was an abundance of acne patients. She came up with a rather ingenious solution to the issue that didn't involve the expense and time commitment of an associate search.

"What she did was start an emergency acne hotline — if someone has pimples and needs to go out and have them treated, they can call a hotline and the nurse practitioner can take care of them. And that hotline is busy all day long," Dr. Baum said. "A young patient with that problem wants to be taken care of immediately, not be told that they can come in in two weeks. She didn't need a new physician, but a technician to treat acne under supervision."

Low-risk specialty, stakes still high

By Ruth Carol, contributing writer

DERMATOLOGY REmains a low-risk specialty with regard to medical liability, but indemnity payments are on the rise, as is the cost of defending dermatologists against medical malpractice claims.

The above conclusions come from the Physician Insurers Association of America's (PIAA's) Risk Management Review for dermatology published in 2009. The report, which provides overall statistics regarding the number of claims reported and dollars paid for 28 different specialties, has data dating back to 1985.

"As far as trends go, there's good news and bad news," said Sandra I. Read, M.D., a dermatologist in private practice in Washington, D.C., who serves on the underwriting and claims committee for her insurance carrier, ProAssurance Corporation. "Clearly, we are a low-risk specialty when compared with our colleagues," she said. "But indemnity is going up and it is costing more to defend dermatologists."

Payment by specialty group

Dermatology ranks 19 out of 28 specialty groups in the number of claims reported. The percentage of paid claims to closed claims for dermatology is nearly 29 percent, less than 1 percentage point below the rate for all specialties.

The total indemnity paid on behalf of dermatologists was more than $106 million, ranking dermatology 22 out of 28 specialty groups in monies paid. The cumulative average indemnity for dermatology is 34 percent less than the overall average paid between 1985 and 2008 for all specialty groups (nearly $138,000 vs. approximately $209,000).

Top Five Most Prevalent Procedures Performed

The five most prevalent skin-related procedures performed that resulted in medical liability claims, based on claims reported between January 1985 and December 2008, are as follows:

- Operative procedures on the skin, excluding skin grafts
- Prescription of medication
- Diagnostic interview, evaluation, or consultation
- Diagnostic procedures of the skin
- Injections and vaccinations

Source: PIAA Risk Management Review of Dermatology, 2009 Edition

Claims down

Both closed claims and paid claims for dermatology were down in 2008. In 1998, there were 139 closed claims. In 2003, that number was 116, which fell to 72 in 2008.

A total of 17 paid dermatology claims were reported to the PIAA in 2008, representing a 50 percent drop from 2003, which saw a total of 34 paid claims. In 1998, that number was 28.

Consistent with the PIAA data, there has been a marked drop in the frequency of claims in dermatology during the last three years, a trend that mimics what the overall physician market has experienced, noted Frank B. O'Neil, senior vice president, investor relations and corporate communications, ProAssurance Corporation, Birmingham, Ala. These numbers leveled off in 2009.

He believes that this decrease is largely the result of plaintiffs narrowing the focus of their medical liability lawsuits prompted by the expenses associated with such lawsuits. "In the past, plaintiffs would sue every physician whose name appeared on the chart," he said. "Now they are narrowing it down to the physicians who had some liability." That translates into three claims instead of six, which on the surface appears to be a 50 percent reduction in lawsuits.

Indemnity payments up

The average indemnity paid on behalf of dermatologists was nearly $281,000 in 2008, according to the PIAA data. That figure was almost 19 percent less than the overall average indemnity paid for all specialties, which was approximately $345,000. The median indemnity for dermatology was $145,000 and the largest payment was $750,000.

In comparison, the average indemnity paid for dermatology was approximately $181,000 in 2003 and approximately $165,000 in 1998. Clearly, the PIAA data show that indemnity payments have gone up, Dr. Read said.

O'Neil concurred. The severity, which refers to either the verdict or settlement, continues to edge upward at a steady predictable pace, between 3 and 4 percent each year, he said.

In 2008, dermatology claims accounted for less than 1 percent of claims and indemnity dollars reported to the PIAA. These percentages have been consistent over the years, Dr. Read said. A decade ago, dermatology made up slightly more than 1 percent of claims and less than one percent of indemnity, according to the PIAA data.

Nearly 24 percent of dermatology claims closed in 2008 resulted in an indemnity payment to the plaintiff. This percentage is up from approximately 20 percent a decade ago, but is still less than the percentage for all specialty groups, which stands at 27 percent.

In 2008 it cost, on average, approximately $33,000 to defend all dermatology claims, which is lower than the average for all specialty groups. However, this figure is up from $19,000 in 1998. The average expenses paid to defend paid claims was approximately $76,000 in 2008, up from nearly $30,000 a decade earlier. In 2008, total indemnity paid for the 17 paid dermatology claims was more than $4 million. The cost to defend dermatology claims has steadily and significantly increased over the years, Dr. Read said.

The percentage of dermatologists with previous claims experience is lower than that for all specialties, 69 percent versus nearly 75 percent, according to the PIAA data. Previous claims experience is the most important piece of information for the insurance companies, Dr. Read suggested. They prefer that doctors are claims-free, she said, adding that it's important to keep in mind that a claim is just an allegation. It doesn't mean malpractice occurred. "The claim is simply a demand for payment," Dr. Read stressed. "It can be frivolous or meritorious."

Medical misadventures

In 2008, the top five most prevalent medical misadventures reported to the PIAA for dermatology were as follows:

- No medical misadventure
- Improper performance
- Errors in diagnosis
- Medication errors
- Failure to supervise or monitor case

The category "no medical misadventure" is a situation where there is an absence of an allegation of any inappropriate medical conduct on the part of the physician, explained Lizabeth F. Brott, J.D., regional vice president, risk management for ProAssurance Corporation. The top three claims by associated medical and legal issues (often involving no medical misadventure) for dermatology are informed consent, vicarious liability, and problems with the medical record.

"All three result in a high percentage of indemnity payment," she noted. On average, the PIAA data indicate between 24 percent and 29 percent of all dermatology claims result in payment, Brott said. However, 42 percent of claims involving the associated issue of informed consent result in payment and 40 percent of vicarious liability claims result in payment, not to be outdone by problems with medical records, for which half of all claims result in payment, she said.

Operative procedures account for 70 percent of the improper performance claims, according to the PIAA data. There's a very high paid to close ratio for improper performance at 41 percent, Dr. Read noted. If dermatologists are going to perform operative procedures, they should have the qualifications and skills to do those procedures, she added.

The most common diagnosis error is a missed melanoma and/or neoplasm, Dr. Read said.

Diagnostic errors with regard to malignant melanomas tend to be very expensive claims, Brott added, with an average indemnity of $437,000 per paid claim, according to the PIAA data.

Fourth on the list are medication errors. Dermatologists prescribe a lot of medications, Dr. Read noted. Each patient walks out with an average of three prescriptions. The two most common conditions involving medication errors were acne and psoriasis, Brott said.

Failure to supervise was the fifth most common medical misadventure reported to the PIAA. Dermatology practices may employ mid-level providers, such as nurse practitioners and physician assistants, as well as additional staff, such as medical assistants and estheticians, to whom certain procedures are delegated. "It's fine to delegate," Brott said, "as long as it's within the standard of care and the individual has the appropriate training, education, experience, and supervision."

Conditions

The five most prevalent patient conditions associated with medical liability claims, based on claims reported to the PIAA between January 1985 and December 2008, are as follows: malignant neoplasms of the skin, acne, dyschromia, psoriasis, and malignant melanoma.

"The five top conditions have been fairly consistent in their order on the list for the last twenty-three years," Dr. Read said. Often dermatologists are surprised at how far down the list melanoma is with regard to generating claims. But it is important that dermatologists understand it's not only their melanoma patients who are high risk, she warned, noting that the number of claims generated by patients treated for acne and psoriasis outrank those generated by melanoma patients.

A new condition that has been coming up slowly, but surely, in the PIAA data is "desire for plastic surgery," Dr. Read noted. "It hasn't even been in the top 10 before, and in 2008, desire for cosmetic surgery moved up to number 4 in the list." There were five closed claims in 2008 and $40,000 was paid out in indemnity. "We all know cosmetic procedures are generating claims," she said, adding, "I am deeply concerned about the cosmetic trend and where that will lead us as far as claims and payments."

As Dr. Read noted, dermatologists can benefit by translating these data into effective risk management strategies. To that end, risk management strategies targeting the PIAA data will be discussed in the next issue of Dermatology World. •

EDUCATION & MEETING NEWS

Genome mapping leads to new understanding of melanoma

By Richard Nelson, managing editor

MICHAEL R. STRATTON, M.D., Ph.D., told dermatologists they have a bright future of cancer-related discoveries to look forward to thanks to rapidly evolving DNA-sequencing technology. Dr. Stratton, who delivered the Lila Gruber Memorial Cancer Research Lecture at the American Academy of Dermatology's 68th Annual Meeting in Miami Beach, Fla., credited a 10,000-fold improvement in the technology since 2002 with making a variety of new discoveries possible.

Dr. Stratton's talk focused on the recent sequencing of the genome of a cancer cell line, COLO-829, derived from the metastatis of a malignant melanoma in a 43-year-old male. Researchers now have a complete map of all the mutations present in the cancer cells, Dr. Stratton said, which allows them to track the lineage of those cells to determine how their mutations were acquired. He pointed out that melanoma has many more mutations than cancers that are not associated with environmental causes.

Indeed, Dr. Stratton said, the genome showed that melanoma cells include many mutations due to ultraviolet light. UV creates pyrimidine dimers, Dr. Stratton said, and cells cannot repair all of them; their presence offers strong evidence that UV exposure contributed to the development of the cancer, confirming what most dermatologists have long believed: sun exposure can cause melanoma.

The sequencing of the melanoma genome is only the beginning, Dr. Stratton said. "We'll be able to do this kind of study on all manner of cancer," he said.

Already, the availability of fully sequenced cancer genomes has led to new discoveries, he noted. While studying the types of repair that had taken

Michael R. Stratton, M.D., Ph.D.

place on the transcribed and non-transcribed strands of the genome, he said, researchers realized there is another kind of cellular repair process at work, previously unknown. They also found at least three driver mutations, though he said there are certainly more — which will be found by sequencing more melanoma cancer lines. •

Consumer-driven care touted as alternative to comprehensive insurance

By John Carruthers, staff writer

MEDICARE SPENDING CURrently accounts for 20 percent of total government spending — and projections anticipate it will rise to an astronomical 50 percent by 2050. According to Clarence S. Livingood, M.D., Award and Lectureship winner James J. Leyden, M.D., the solution to this runaway spending involves not comprehensive medical insurance, but consumer-driven health savings programs and accounts, combined with increased competition between insurers.

Dr. Leyden's lecture during the American Academy of Dermatology's 68th Annual Meeting in Miami Beach, Fla., titled "An Inconvenient Truth: Comprehensive Medical Insurance is the Problem, Not the Solution," took aim at the versions of health system reform passed by both houses of Congress. Under these systems, he said, physicians who serve Medicaid patients would be, in essence, earning less for their professional time than a plumber.

"I'm personally committed to the fact that we, the richest country in the world, just have to find a way to assure that medical care is available to all citizens," he said. "As it is, we're spending too much on [the current system]. It's clear that this can't be continued."

The preferable way to do this, he argued, is through the elimination of antitrust protections that stymie competition among health care providers. This, he argued, will lead to more consumer-focused health insurance packages, which will combine with health savings accounts and catastrophic insurance to ensure that all citizens, while not comprehensively protected, will have access to proper care and the means to deal with unexpected medical expenses.

The overall picture, Dr. Leyden said, would look much like coverage plans in Massachusetts and Switzerland, both of which mandate citizens purchase health care privately. Those without the resources to do so are subsidized,

James J. Leyden, M.D.

and employers continue matching health care funds. The lack of government micromanagement, he said, works in favor of both insurance companies and consumers, who enter into a closer, more beneficial relationship.

"Consumers would pay the same, whether sick or well," Dr. Leyden said. "I believe that the AAD should become proactive for consumer-driven health care policies at the national level." •

Lecture considers light as 'magic bullet' for many conditions

By John Carruthers, staff writer

THE MAGIC BULLET — A NEW treatment that makes a huge leap to directly address a certain disease, condition, or ailment without harm to the surrounding organism — is a concept that has fed the dreams of fledgling scientists and researchers since the days of Hippocrates. The term itself was coined by German physician and syphilis researcher Paul Erlich, M.D., during the 1940s. Harvard dermatologist and researcher R. Rox Anderson, M.D., devoted the Phillip Frost Leadership Lecture to the concept of magic bullets and his fascination with developing new, groundbreaking treatments that will fuel the imaginations of the next generation of researchers. Dr. Anderson was presented with the Eugene J. Van Scott Award for Innovative Therapy of the Skin.

Among Dr. Anderson's areas of interest is the concept of selective photothermolysis and its potential application as a cancer-fighting therapy.

"All of our best treatments are magic bullets," Dr. Anderson said. "What interested me was the idea that wavelengths of light could be selectively absorbed by certain tissues."

The concept involves engineering gold nano-rods that respond to certain wavelengths of light. These rods are then injected into a cancerous growth and hit with their specific reactive wavelength. The heat produced by the reaction destroys the cancerous tissue without the collateral damage of more common cancer treatments. While still far from adoption as a human treatment, this method

R. Rox Anderson, M.D.

has proven itself effective in mouse models.

Other areas of research explored by Dr. Anderson include employing nano-scale engineering to produce a tiny array of laser beams. These beams, which scan across the skin and create tiny columns of thermal injury, allow for much quicker healing, which recasts the process as more of a remodeling than a gross replacement, according to Dr. Anderson.

"The epidermis heals very rapidly," he said. "You can get away with murder."

Another potential application of nanotechnology discussed by Dr. Anderson is the application of tiny holes through the skin, made to any depth, which would allow for a rapid and fast-healing way to deliver drugs to a patient. Dr. Anderson promised to use his award honorarium to treat underserved and underprivileged children in Vietnam. Whether it's treating patients abroad or researching the latest cutting-edge therapies, helping children, he said, is the ever-present goal of his life's work. •

ABD considering revised procedural certification

THE AMERICAN BOARD OF Dermatology (ABD) will hold a discussion of procedural dermatology certification on June 12. In a letter inviting the participation of a representative of the American Academy of Dermatology, ABD President Elaine C. Siegfried, M.D., noted that a six-member task force has been working on "major revisions to the previously proposed certification application." After a report on these revisions is presented, participants in the June 12 discussion would consider "the focus of the proposed certification, the name of the certification, and grandfathering options," Dr. Siegfried wrote.

The Academy will send a representative to this discussion. In 2009, the Academy's Board of Directors adopted an Advisory Board resolution opposing the ABD's previous procedural certification proposal. •

– Richard Nelson

Former HHS Secretary Shalala pitches reform

By Richard Nelson, managing editor

DONNA SHALALA, WHO SERVED as Secretary of Health and Human Services in the Clinton Administration, gave dermatologists her frank assessment of the latest efforts at health system reform during her lecture to close the plenary session of the American Academy of Dermatology's 68th Annual Meeting in Miami Beach, Fla.

Recalling her own experience, she said President Obama had learned from critics of the Clinton approach — a bill drafted in secret by a small group of experts, including Hillary Clinton — and had instead chosen to let Congress draft the bill in public. "He sent it to Congress, which is incapable of doing anything in secret," Shalala said. This resulted in a very messy process, which "proceeded to confuse people as we went from one bill to the other, from a bipartisan effort in the Senate to a very partisan effort in the House," she said. But this was to be expected if Obama made the process public, as many demanded. "You can't have it both ways. You can't say 'don't do it in secret' and then when you do it in public, expect it to be anything else but a very open, very messy process, which proceeds to confuse large numbers of people as they go through and listen to the debate."

Despite the mess, Shalala suggested that the resulting bill, while it has attracted a "negative coalition" of people who are united by their opposition to some part of it, does many of the right things to expand coverage. While recent months have seen a call to scrap the bill and start over with incremental steps, she said such steps would fail. The highly popular elimination of preexisting conditions and lifetime limits, she said, are unworkable unless everyone is required to be covered. "You can't have people who are well coming in and out of the system depending on when they need health care." Others push for cost containment within the present configuration, she said, failing to realize that efforts are already being made in that direction but not working well. Shalala suggested that expert, non-elected officials may have to weigh in to remove waste and fraud from the system.

Shalala also argued that the bill represents the next step in coverage expansion; having covered the elderly and the disabled, she said, it is time to cover the working poor, the group she said the bill would help the most. She also noted that while critics say reform would involve cost-shifting, the system already shifts costs in untenable ways, forcing companies to ensure their employees' uninsured spouses and hospitals to provide free care — costs that are eventually passed on to the insured.

While she acknowledged that physicians are concerned about proposed payment reforms in the bill and the lack of a comprehensive malpractice solution, Shalala offered calming words about both issues. The payment reform items in the bill, she said, are demonstration projects designed to help the Medicare program find ways to pay for services that create value; similar experiments in tort reform are intended to find ways to fix the broken malpractice system. The current system, she said, is awful, creating a burden for physicians without helping the people who are actually hurt by medical mistakes.

Donna Shalala

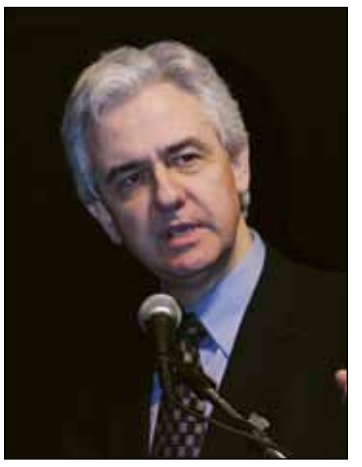
In conclusion, Shalala acknowledged that her audience was nervous about the proposed changes to the health system. "Should you be nervous? Absolutely. It's healthy to be nervous when you are making this many changes at the same time," she said. "But if you want to stop cost-shifting and get people to the health care system at the right time, you have to take steps to universal coverage." •

Hedgehog pathway shows promise as BCC therapy target

Inhibitors offer rapid tumor shrinkage, but further research needed

By Richard Nelson, managing editor

ANDRZEJ A. DLUGOSZ, M.D., told dermatologists that putting the brakes on an embryonic signaling pathway could be an effective way to shrink basal cell carcinomas — and could offer clues to other cancer treatments as well. Dr. Dlugosz delivered the Marion B. Sulzberger, M.D., Memorial Award and Lectureship at the American Academy of Dermatology's 68th Annual Meeting in Miami Beach, Fla.



Andrzej A. Dlugosz, M.D.

Dr. Dlugosz's research found that continuous activation of the Hedgehog pathway, which under normal circumstances signals embryonic hair follicle development and later turns on and off in the hair growth cycle, is associated with basal cell carcinoma growth. His team found that mice with BCC experienced rapid tumor shrinkage following the genetic inhibition of the Hedgehog pathway — and, in subsequent experimentation, found that when the Hedgehog pathway was reactivated, the tumors would return just as rapidly. Thus, Dr. Dlugosz warned, it is possible that treatment with Hedgehog antagonists may leave behind dormant tumor cells, which will reactivate when the antagonist is removed.

Further research by another group found that treatment of patients with advanced BCC with Hedgehog inhibitors showed response rates of 55 percent overall and 50 percent for metastatic BCCs. Additional studies, including trials on other cancers in which Hedgehog appears to play a role, are being conducted. Dr. Dlugosz said that up to 30 percent of human malignancies may involve altered Hedgehog signaling. •

STATE PERSPECTIVES from p. 5

In 2010 alone, the AADA has sent letters of support or opposition on specific legislation to a dozen states, and supported member testimony in nearly half of those states. As AADA staff identifies legislation of importance in a specific state, we gather intelligence from various sources, including state medical societies, national medical specialty organizations, members, and state dermatology societies. By working together, pooling resources, and coordinating efforts, we can build strategic alliances to support or defeat a particular bill. The AADA is poised to assist states in addressing a wide range of legislative and regulatory issues such as scope of practice, indoor tanning, taxes, and billing issues by drafting written and oral testimony, providing background information, conducting media outreach support, and mobilizing grassroots advocacy.

For example, in late 2009, the AADA worked with the Washington State Dermatology Association (WSDA) to introduce legislation in the 2010 session prohibiting the use of tanning devices by minors under 18. The WSDA was able to use the AADA's model legislation on this topic as a starting point for internal conversations about regulations that were needed in the state. The AADA provided support and guidance to the WSDA in developing an advocacy strategy, garnering legislative support, and moving the bill through the legislative process. Similarly, the AADA supported member outreach to legislators in Maryland to introduce tanning legislation.

It is critical for state dermatology societies to be aware of legislative and regulatory actions in their state, and to communicate with the AADA to develop a legislative strategy and action steps. Frequently, legislative language affecting the specialty of dermatology is hidden in other practice bills, such as dentistry, electrology, or cosmetology. In some instances, even optometric scope of practice legislation has ventured into dermatologic procedures. This reinforces the need for dermatology societies to stay attuned to legislative and regulatory issues at the state level, as at the surface legislation may appear benign, but can result in significant changes to the delivery of health care services, negatively impacting dermatology.

The AADA encourages state dermatology societies and Academy members to proactively approach legislative and regulatory changes to improve access to health care services, protect patient safety, and safeguard the practice of medicine and dermatology. However, as noted above, it is equally as important to be ready to react to legislative and regulatory advances on issues impacting dermatology. To further support state societies in advancing legislative and regulatory efforts, the AADA has developed an online advocacy toolkit (available online at www.aad.org/gov/toolkit/index.html) with background resources, talking points, model legislation, and templated communication materials. Current resources are available on indoor tanning, patient safety, truth in advertising/transparency in licensure, skin disease research, and disease awareness resolutions. AADA staff is willing and able to assist state dermatology societies and members in shaping legislative efforts that are appropriate to the politics and specific legislative environment in their states.

Working with your state medical society

In addition to communicating with the AADA, becoming involved with your state medical society is an excellent way to stay abreast of legislative and regulatory proposals impacting medicine. Developing relationships with colleagues in your state medical society can bring dermatology to the forefront of advocacy initiatives in the state, providing visibility for you and the specialty. Many state medical societies have legislative committees, and it can be extremely helpful to be engaged in these committees to share information across specialties, and engage with the medical community on advocacy efforts. AADA staff frequently works with state medical society staff and lobbyists to garner support for legislative and regulatory initiatives or discuss concerns with pending proposals.

The AADA encourages members and state dermatology societies to get involved with their state medical society by attending public meetings or becoming a representative to legislative committees. State medical societies also often arrange meetings for physicians at the state legislature, providing health care screenings or coordinating advocacy days. These opportunities allow physicians to create important relationships with elected officials and their staff.

For more information on state advocacy opportunities and activities, or to learn more about how to get involved, please contact Kathryn Chandra. •

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WEB INFO
www.aad.org/gov/state/PendingStateLegislation.html
AADA tracking of state legislation

Journalists attend Annual Meeting to learn about skin, hair, and nail health

By Jennifer Allyn, lead public relations specialist

(From left) Jenny Kim, M.D., Ph.D., Adnan Nasir, M.D., Ph.D., and Joseph F. Fowler Jr., M.D., discussed various aspects of skin health during one of the Academy's media briefings at the 68th Annual Meeting.

MORE THAN 115 JOURNALISTS from eight countries attended the American Academy of Dermatology's 68th Annual Meeting to learn about the latest advances in medical, surgical, and cosmetic dermatology. In addition to hosting a press office, the Academy provided a variety of communication services including presenting three media briefings and three roundtable discussions. These activities served to further increase the specialty's public visibility and prominence. The media will use the information in stories written and broadcast throughout the year to help educate the public about important dermatologic issues.

Each media briefing and roundtable discussion featured noted speakers selected by the chairs of the Council on Communications and Scientific Assembly Committee. A list of topics and speakers appears in the sidebar. An electronic press kit with all of this information was also distributed to 5,500 reporters nationwide.

The Academy also offered the Hometown Radio News Service, which provided more than 55 Academy members with the opportunity to record a 60-second radio interview on an important dermatologic subject of their choice. Interviews will be broadcast on radio stations in the member's local radio market as a way to educate the public about dermatology topics. •

Annual Meeting Media Briefings Educate Journalists

The three media briefing panels at this year's Annual Meeting were:

Your Skin's Health: Treating and Protecting Your Largest Organ

- *Contact Dermatitis Can Be Irritating, Especially When the Cause is a Mystery*
  Joseph F. Fowler Jr., M.D., University of Louisville, Louisville, Ky.
- *Sizing Up Nanotechnology*
  Adnan Nasir, M.D., Ph.D., University of North Carolina, Chapel Hill, N.C.
- *New Treatments and Good Skin Care Helping Patients Control Acne and Rosacea*
  Jenny Kim, M.D., Ph.D., University of California, Los Angeles

Skin Science: Medical Research and Treatments Offer Options for Patients

- *Melanoma Update: Recent Technological Advances are Helping Dermatologists Diagnose and Treat Early Stage Melanomas*
  Harold S. Rabinovitz, M.D., University of Miami, Miami
- *Dermatologists Can Help Women Win the Fight Against Common Forms of Hair Loss*
  Mary Gail Mercurio, M.D., University of Rochester, Rochester, N.Y.
- *Psoriasis is More Than Skin Deep*
  Alan Menter, M.D., Baylor Research Institute, Dallas

Derm A to Z: Dermatologists Have the Answers From Head to Toe

- *New Research Reveals How Popular Skin Filler Works at the Molecular Level to Stimulate Collagen Production in Sun-Damaged Skin*
  Dana L. Sachs, M.D., University of Michigan, Ann Arbor, Mich.
- *Skin of Color Population Faces Unique, But Treatable Dermatologic Conditions*
  Andrew F. Alexis, M.D., M.P.H., Columbia University College of Physicians and Surgeons, New York

The Academy also hosted roundtable discussions that provided journalists with an opportunity to learn about skin, hair, and nail topics in small-group sessions.

The three roundtable discussions were:

- *Fulfilling Great Expectations: Caring for New Mothers and Mothers-to-Be*
  Jenny E. Murase, M.D., University of California, San Francisco
- *Is There Really a Melanoma Epidemic?*
  Darrell S. Rigel, M.D., New York University Medical Center, New York
- *Bedbugs, Scabies and Head Lice – Oh My!*
  Albert Yan, M.D., Children's Hospital of Philadelphia and University of Pennsylvania, Philadelphia •

Academy to launch annual skin cancer awareness campaign in May

By Kara McFarland, public relations specialist

EVERY MAY, THE AMERICAN Academy of Dermatology launches its national skin cancer awareness campaign in recognition of Melanoma/Skin Cancer Detection and Prevention Month® and Melanoma Monday®, the first Monday in May. The public education campaign is designed to increase public awareness of the importance of early detection and prevention of skin cancer.

The Academy will conduct a national media relations campaign to educate the public. Media materials will promote the results of a 2010 nationwide consumer survey on sun-safety knowledge, attitudes, and behavior. A new feature, "31 Days, 31 Ways… To Prevent and Detect Melanoma," will be created for melanomamonday.org — the Academy's public Web site for Melanoma/Skin Cancer Detection and Prevention Month. The 25th Anniversary of the Academy's National Skin Cancer Screening program will also be highlighted. •

Celebrate 25 Years of Screenings

This year, the Academy celebrates the 25th anniversary of its national skin cancer screening program — the Academy's longest-running volunteerism effort.

Since the national skin cancer screening program's inception in 1985, Academy members have conducted more than 2 million screenings, detecting more than 197,000 suspicious lesions, including more than 22,500 suspected melanomas.

Please consider volunteering your time for this important public health program! To order your free skin cancer screening materials, visit the Academy's Web site at www.aad.org, e-mail Yvonne Urbikas at yurbikas@aad.org, or call (847) 240-1736. •

Albert M. Kligman, M.D., Ph.D., tretinoin pioneer, dies

ALBERT M. KLIGMAN, M.D., Ph.D., the dermatologist who patented tretinoin as an acne treatment in 1967 and later for wrinkle treatment in 1986, died on Feb. 9. He was 93.

Dr. Kligman, a life member of the American Academy of Dermatology, earned his medical degree from the University of Pennsylvania in 1947 and completed his dermatology residency there in 1951.

He was a major contributor to the science of dermatology. In addition to the discovery of tretinoin, a 2006 appreciation of Dr. Kligman in the *Journal of Investigative Dermatology* noted his work on a stain to visualize fungi in tissue, his description of the human hair cycle, his studies of acne, including the comedogenic properties of sebum, and the fact that he coined the terms photoaging and cosmeceuticals.

Dr. Kligman's work was both cutting edge and sometimes controversial. In 1951, the same year he joined Penn's department of dermatology upon completing his residency, he began experiments that would made him a target of criticism, testing a variety of treatments and agents on prisoners at Philadelphia's Holmesburg Prison. The testing later led to lawsuits, and Dr. Kligman frequently defended his work.

Despite the criticism, he was honored for his contributions to dermatology in many ways. He served as president of the Society for Investigative Dermatology (SID) in 1978, having received SID's highest honor, the Stephen Rothman Memorial Award, in 1976. In 1994, the Academy named him a Master of Dermatology.

Dr. Kligman is survived by his wife Lorraine, two sons, a daughter, two stepsons, a sister, and six grandchildren. •

– Richard Nelson

EXECUTIVE DIRECTOR'S REPORT

Cultivating a specialty of leaders

Ronald A. Henrichs, CAE
Executive Director and CEO

SEVERAL MONTHS AGO, I HAD the pleasure of attending the commissioning ceremony for my longtime friend, U.S. Surgeon General Regina Benjamin, M.D. As I spoke with others attending the ceremony, including several dermatologists, I couldn't help but be struck once more by the quality of people who are drawn to dermatology.

Also in attendance at the ceremony was Howard Koh, M.D., a member of the American Academy of Dermatology. Dr. Koh is currently serving as assistant secretary for health in the U.S. Department of Health and Human Services where he oversees the U.S. Public Health Service Commissioned Corps. I also greeted Boris Lushniak, M.D., M.P.H., another Academy member, who is an assistant commissioner at the Food and Drug Administration (FDA) and an assistant surgeon general and rear admiral in the Commissioned Corps of the Public Health Service.

These individuals are emblematic of one of the American Academy of Dermatology's key priorities within our strategic framework, specialty leadership. They are just two of many Academy members who are showing leadership through their service to the public. Indeed dermatologists are leaders across the continuum, in federal and state governments, with national and local medical organizations, in community groups, and within the Academy.

The AAD recognizes the value of having dermatologists ready, willing, and able to serve as leaders in many capacities. Our commitment to leadership assures that AAD members can step in and make a difference for patients whenever needed. For example, dermatologists acted on behalf of patient safety in drawing the attention of the Federal Trade Commission to false advertising claims made by the Indoor Tanning Association. I attended the original meeting with FTC attorneys on this matter in 2008, and I saw how well represented the public was by dermatologists, including then-Academy President C. William Hanke, M.D., and others. These physicians clearly and persuasively explained the public health risks at play, and in January their efforts bore fruit with a settlement that requires Indoor Tanning Association advertisements to include a notice of the dangers associated with indoor tanning.

Dermatologists again spoke for patients on this issue at public hearings held by the FDA's Center for Devices and Radiological Health on reclassification of indoor tanning devices on March 25 (see p. 1). Academy President William D. James, M.D., offered a compelling, clear, and well-supported argument for greater regulation of these devices, a case repeated by several of his colleagues. We believe this effort will positively influence the FDA toward greater regulation of these dangerous devices. Full coverage of the hearing will appear in the May issue of *Dermatology World.*

Advocacy is just one of the many ways our members act as leaders. Dermatologists who are educating our next generation of practitioners, who are volunteering their time to treat the underserved, who inform the public about skin disease, and more all exemplify how dermatology is a specialty of leaders.

In order to assure that dermatologists continue to be engaged and ready to lead the specialty on critical issues at the national and local levels, in 2009 the Academy created the Leadership Institute, spearheaded by one of our veteran leaders, Mary E. Maloney, M.D., to provide interested members with opportunities to develop their leadership potential. In January, I attended the Academy's 2010 Leadership Forum, a weekend of leadership and communication skills building and networking for aspiring dermatology leaders. Throughout the weekend I was struck by how bright, articulate, and engaged the participants were. I could clearly see that they took to heart the training offered and embraced it as an opportunity to be better leaders. The skills developed will serve them well in whatever aspirations they have.

The Leadership Forum is just one of the many aspects of the Academy's Leadership Institute. All the activities are based on a set of leadership competencies and aimed at the mission of developing leadership skills in dermatologists so that they will be prepared and motivated to serve effectively in organized medicine; policy-making, advocacy, and practice management; and their own careers. Our Annual and Summer Academy meetings now feature a Leadership Institute track with courses designed to meet our leadership competencies. Check the Summer Academy Meeting 2010 Program Book for recent offerings. More information on the Leadership Institute is available online at www.aad.org/leadership/.

The Academy's commitment to leadership has one ultimate aim — serving dermatology patients — and it has long been at the core of everything AAD members do. Including leadership in our strategic framework simply acknowledges how central it is to the dermatology profession. Observing this commitment first hand — evidence of character and caliber of the individuals who comprise the AAD — is truly one of the great rewards of my job as executive director and CEO. •

BOARD REPORT

Boards of Directors discuss scope of practice, other issues

By Katie Domanowski, senior manager, publishing

THE AMERICAN ACADEMY OF Dermatology and AAD Association Boards of Directors met on March 6 in Miami Beach, Fla., and the Association board engaged in a strategic discussion on the issue of non-physician scope of practice, a growing concern at the state level throughout the U.S.

The discussion kicked off with a presentation from Kai Sternstein, J.D., with the American Medical Association's Scope of Practice Partnership. She noted that the AMA is currently tracking more than 300 bills, and that many non-physician groups, including dentists, optometrists, nurse practitioners, and others, are working through their own regulatory boards rather than state boards of medicine to expand their scope of practice.

Initiatives like the AMA's Truth in Advertising Campaign, Sternstein said, are working on behalf of patient safety against these efforts. The Truth in Advertising Campaign seeks to push legislation at the state level requiring anyone offering medical services to disclose their credentials. Sternstein also described the AMA's Scope of Practice Data Series, which has been effectively used to counter claims made by non-physician practitioners.

Following Sternstein's presentation, the Board heard from Suzanne Olbricht, M.D., chair of the AADA's Ad Hoc Task Force on Non-Physician Clinicians. Dr. Olbricht presented the group's working draft of a position statement on the practice of cutaneous medicine. The statement, when final, will provide dermatologists with guidance on the practice of dermatology and the delegation of tasks and procedures. The Board provided feedback on the draft, which the task force will incorporate into a final draft that the Board can consider for approval.

The Association also considered and approved a motion from the Council on Government Affairs, Health Policy and Practice to send a letter to all members regarding the August 2009 report from the Office of the Inspector General (OIG) on the use of non-physician providers. That report found that when Medicare allowed physicians more than 24 hours of services in a day, half of the services were not performed personally by a physician. Further, surgical procedures performed by non-physicians included complex skin surgery, and according to the report all of the Mohs procedures performed by a non-physician were undertaken by a medical assistant. The Board also approved a motion to submit a Freedom of Information Act request to the OIG to obtain additional data on the methodology and findings of the report.

Motions approved by the AAD Board included one that the Academy consider developing, in collaboration with the American College of Mohs Surgery and the American Society of Mohs Surgery, appropriateness criteria for Mohs surgery.

The AAD Board also heard a motion that the Academy consider inclusion of a representative of the public on the Academy's Board of Directors and the need for more diversity on the board generally.

The Board also considered a number of housekeeping issues such as confirmation of Robert Greenberg, M.D., as the new secretary treasurer and Suzanne Olbricht, M.D., as the assistant secretary treasurer. The complete minutes from the March 6 meeting will be posted on the AAD Web site at www.aad.org/members/academy/minutes/index.html following their approval at the Boards' next meetings on May 22. •

Gold Triangle Awards presented in Miami Beach

By Rachel Simpson, communications program specialist

MEDIA, INDUSTRY, HEALTH community organizations, and health individuals who demonstrated excellence in furthering public understanding of dermatologic issues and encouraging healthy behavior in the care of skin, hair, and nails were honored when the American Academy of Dermatology presented its Gold Triangle Awards during the 68th Annual Meeting in Miami Beach, Fla. The Academy honored a prestigious list of 34 winners. (A list of winners appeared in the February issue of *Dermatology World.*)

The Academy recognized the individual, health community organization, and industry recipients during the AAD Recognition Luncheon; media recipients were acknowledged during the Media Appreciation Luncheon.

The Academy will present Gold Triangle Awards at the 69th Annual Meeting in New Orleans, Feb. 4-8, 2011. Entry forms for next year's Gold Triangle Awards will be available on the Academy's Web site in mid-July of this year and are due in September 2010. •

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IMAGING EXCELLENCE FROM CANFIELD

Outgoing president looks back on term, anticipates future challenges and opportunities

By Richard Nelson, managing editor

IN HIS FINAL SPEECH TO THE membership of the American Academy of Dermatology as president, David M. Pariser, M.D., discussed the Academy's achievements during his year in office and contemplated the landscape that his successor, William D. James, M.D., inherits. His President's Address, delivered on March 7 in Miami Beach, Fla., highlighted the Academy's health system reform efforts as well as issues that will face the specialty as the HSR debate wanes.

Dr. Pariser began his address by noting that Miami Beach was an appropriate place for his final address as president, as he both began his dermatology training and started dating his wife of 35 years in Miami.

Turning to health system reform, Dr. Pariser began by acknowledging the flaws of the current system. "We know that more than 40 million of our fellow citizens are uninsured or underinsured and do not have appropriate access to care," he said. "We know that the hospital emergency department is not a proper substitute for a doctor's office visit. Not the place for treating rashes, hives, or skin cancer, let alone the place for providing primary or preventive care. We know that cherry-picking by insurance companies — willing to cover only the young and the healthy — is wrong. A tort system that views physicians and their insurance companies as pots of gold and a shamelessly flawed reimbursement system is all wrong, so very wrong."

But the proposed reforms, Dr. Pariser warned, are problematic too. "It is naïve to think we can add more than 40 million to the ranks of the insured with no new infrastructure in place to care of them. There's a difference between giving health insurance and providing health care."

Outgoing Academy President David M. Pariser, M.D., closed his term with an energetic address that looked back at a busy year and reminded listeners of the important bond between them and their patients.

Dr. Pariser noted that the Academy has had a rapid response team in place since the HSR debate began; as a result of their efforts, he said, dermatology has been able to make positive contributions to the debate. "We convinced lawmakers that it would be wiser — and better health policy — to exchange a cosmetic tax for a tax on indoor tanning, putting tanning where it belongs, with smoking, alcohol and other dangerous behaviors," he said. "The added bonus for dermatology is that we were able to use it as a teachable moment for raising public awareness about the dangers of ultraviolet light and to encourage people to avoid tanning beds. This will go a long way to reducing the incidence of and mortality from skin cancer — one of our long-term goals." (That tax became law on March 23; see p. 1.)

Turning from health system reform to other issues, Dr. Pariser said that while the HSR debate kept many dermatologists busy, the Academy was busy accomplishing a variety of other things. "From education to advocacy to communications," he said, "we have continued to grow as an organization and to offer the tools we need to flourish in our practice."

Among the accomplishments he highlighted were:

- the Annual Meeting, which drew record attendance in San Francisco in 2009, then topped that record in Miami Beach this year;
- the publication of three new guidelines of care for the management and treatment of psoriasis;
- the conducting of the two-millionth skin cancer screening as part of the Academy's program, which celebrates its 25th anniversary in 2010;
- the continued success of Camp Discovery, which gave 250 children with serious and chronic skin conditions the chance to experience sleep-away camp last summer;
- shade structure grants to 34 organizations in 2009;
- an ad campaign that positioned dermatologists as the physician experts for the care and treatment of skin, hair, and nails; and
- participation by dermatologists in media interviews that helped the specialty reach the average American four times in 2009.

Going forward, Dr. Pariser said, the Academy will work on three strategic issues that have been "moved to the front burners." The first, workforce and scope of practice, is one that he acknowledged has been contentious in the past. He promised new policy on "the proper training and supervision of non-physician clinicians and how they are best integrated into a team approach to dermatologic care" will be forthcoming, along with "a new workforce section on the Academy's Web site that will aggregate resources related to decisions about where to establish practices, including a mapping function that shows the density of dermatologists in each county in the country."

The second strategic issue, conflict of interest and the relationship between physicians and industry, will be dealt with by a new task force, Dr. Pariser said, which "is already at work examining our current policies to see if we are in step with the ever-increasing external scrutiny of these relationships." The third issue, the Academy's system of

See **PARISER ADDRESS** on p. 17

72nd Academy president, William D. James, M.D., takes office

New officers, Boards installed

WILLIAM D. JAMES, M.D., OF Philadelphia took office on March 9 as the president of the American Academy of Dermatology and the AAD Association. He succeeds David M. Pariser, M.D., who turned over the office at the close of the AAD's 68th Annual Meeting in Miami Beach, Fla. Dr. James was elected in 2008.

Other new officers who were installed at the meeting were: Vice President Andrew P. Lazar, M.D., M.P.H., President-elect Ronald L. Moy, M.D., Vice President-elect Suzanne M. Connolly, M.D., Secretary-Treasurer Robert D. Greenberg, M.D., and Assistant Secretary-Treasurer Suzanne Olbricht, M.D.

Board members beginning four year terms are: Ilona J. Frieden, M.D., Dee Anna Glaser, M.D., Mark Lebwohl, M.D., and Ronald P. Rapini, M.D.

In his President-Elect's message on March 7, Dr. James discussed the opportunities and challenges that face dermatology and the busy year he anticipates. A transcript of his speech appears as his President's Views column on p. 4. •

The American Academy of Dermatology and AAD Association Boards of Directors are: Front row (l-to-r) Officers David M. Pariser, M.D., immediate past president; Suzanne M. Connolly, M.D., vice president-elect; Ronald L. Moy, president-elect; William D. James, M.D., president; Andrew P. Lazar, M.D., M.P.H., vice president; Robert D. Greenberg, M.D., secretary-treasurer; and Suzanne Olbricht, M.D., assistant secretary-treasurer. Second row (l-to-r) Mark Lebwohl, M.D.; Dirk M. Elston, M.D.; Vincent Muscarella, M.D.; Ilona J. Frieden, M.D.; Evangeline B. Handog, M.D., international board observer; David J. Goldberg, M.D., J.D.; Sandra I. Read, M.D.; Kenneth J. Tomecki, M.D.; Brian Berman, M.D., Ph.D.; and Margaret E. Parsons, M.D. Third row (l-to-r) Dee Anna Glaser, M.D.; Brett M. Coldiron, M.D.; Angela Kyei, M.D., resident observer; Elise A. Olsen, M.D.; Clarence W. Brown Jr., M.D., young physician observer; Ronald A. Henrichs, CAE, executive director; Victor J. Marks, M.D.; Darryl M. Bronson, M.D.; Ronald P. Rapini, M.D.; Theodore Rosen, M.D.; and Lisa A. Garner, M.D.

Advisory Board passes four resolutions at Annual Meeting

By Richard Nelson, managing editor

THE AMERICAN ACADEMY OF Dermatology and AAD Association Advisory Boards passed four resolutions at their March 7 meeting in Miami Beach, Fla., during the Academy's 68th Annual Meeting. The Board also elected Alexander Miller, M.D., to be a member of the Nominating Committee, which selects the candidates who appear on the ballot for the Academy's election each year. The Advisory Board also elected one member of its Executive Committee, Molly Hinshaw, M.D.

Passed resolutions, which will now be forwarded to the Board of Directors for consideration at its next meeting, include:

ABD transparency

Resolved, that the AAD support a resolution that the American Board of Dermatology (ABD) be made more responsive to the participation and opinions of the practicing dermatologists in policy development, and be it further resolved, that a task force established with members of the AAD and the ABD to identify strategies to enhance communications and increase transparency and representation between the AAD and the American Board of Dermatology.

Military dermatologists

Resolved, that the Association of Military Dermatologists representing Washington, D.C., and all federal properties should be admitted as a full voting member of the Advisory Board to enfranchise the dermatologists who are serving their country at home and abroad.

Electronic formats

Resolved, that the AAD investigate the feasibility of providing the *Journal of the American Academy of Dermatology* (*JAAD*) to AAD members in a format accessible on e-books such as available via Sony's e-book, Amazon's Kindle, iPAD and Barnes and Noble's Nook. And be it further-resolved, that we encourage the AAD to continue investigating the feasibility of providing access to attendees of the Annual Meeting the material currently provided by CD via the new electronics such as, but not confined to, those mentioned above.

Name change

Resolved, that the American Academy of Dermatology change its name to the American Academy of Dermatology and Dermatologic Surgery. •

PARISER ADDRESS from p. 16

elections for its officers and directors, is also being taken up by a task force that will the evaluate whether the Academy has "the best process in place for ensuring that our board and our officers are drawn from the best and the brightest of our specialty."

Dr. Pariser credited this strategic, forward-thinking approach for the Academy's current position. "We are doing so many things right and the proof is in the numbers: dermatology enjoys the highest percentage of membership of any medical specialty. We are financially sound and solvent with a $36 million operating budget with $23 million in reserve. And the last dues increase was approved in 2001," he said. He credited the Academy's staff, including Executive Director Ronald A. Henrichs, CAE, for making sure that the Academy's leaders know their backs are covered.

Dr. Pariser concluded his speech by recalling his father's career in dermatology, which began when he opened a practice in 1940. That practice, which Dr. Pariser and his brother operate today, started out drawing only a few patients a day; today, he said, what was once his father's solo practice employs 10 dermatologists and 5 physician assistants, along with a support staff of more than 100 people. For all that change, though, Dr. Pariser said his father would still recognize the heart of the practice: "Two chairs in a room. One for the physician, one for the patient. Working together in partnership."

That physician-patient relationship, he said, is what dermatologists must defend for the next generation, and as he looks back on his service as president, the most gratifying thing for him is to "see how this value is held as a universal constant by so many of us despite all the external pressures and distractions that we deal with every day." He concluded, "I feel confident that our profession can rely on all of us to "keep the faith" with the next generation." •

John Voorhees, M.D., honored as Master Dermatologist

By John Carruthers, staff writer

EVERY YEAR, THE AMERICAN Academy of Dermatology honors a single member whose career has embodied passion for the specialty and selfless care toward patients. These members, honored as Master Dermatologists, exemplify the best principles of dermatology. At the 68th Annual Meeting, held March 5-9 in Miami Beach, Fla., the Academy honored University of Michigan dermatology department chair John Voorhees, M.D. Dr. Voorhees has not only been a pioneer in psoriasis and skin aging research, but has also headed a world-renowned dermatology department that has continually produced both superb practitioners and academic dermatology chairs. According to a 1999 study in *Archives of Dermatology*, Dr. Voorhees' work has been cited in medical literature more often than any other dermatologist in the world.

Dr. Voorhees explained what motivated him to focus his investigation on psoriasis. "The chair of our department at the time, Whitey Curtis, said to me 'nothing is really known about psoriasis — why don't you go into the lab and see what you can find out,'" Dr. Voorhees said. "So that's what I did."

Dr. Voorhees' medical career began, fittingly enough, at the University of Michigan Medical School, following his time as an undergraduate at Bowling Green University in Ohio. He began his internship at the same institution after graduating summa cum laude. Following his internship, Dr. Voorhees served in France in the U.S. Army as the officer in charge of internal medicine and laboratories. Following his time in the Army, he returned to the University of Michigan, where he began a residency in internal medicine. He then switched to dermatology in 1967, and spent two years of study as a Carl Herzog Postdoctoral Scholar in biochemistry, after which Dr. Voorhees was appointed as an instructor in dermatology in 1969. He became a full professor in 1974, and attained the rank of chief of dermatology in 1975. In 1994, Dr. Voorhees was named the Duncan & Ella Poth Distinguished Professor, a title that he holds to this day.

"John has provided an environment that has stimulated many to enter and stay in academic medicine," Jeffrey P. Callen, M.D., said in support of Dr. Voorhees' nomination. "There are multiple chairs of dermatology who have been residents or junior faculty in his residency program."

As a researcher, Dr. Voorhees has been well-known for his groundbreaking work on both psoriasis and premature aging of the skin. His work showed psoriasis as a disease mediated by an overactive immune system, and treatable by immunosuppressive drugs, causing many of his colleagues to see the condition in an entirely new light. As a prominent biochemical researcher, he and his research partners were able to uncover the process by which UV light and time break down the skin's collagen support. This work was vital to the pharmacological treatment and prevention of premature aging. In 2009, he discussed this work as the recipient of the Eugene J. Van Scott Award for Innovative Therapy of the Skin and Phillip Frost Leadership Lecture at the Academy's 67th Annual Meeting in San Francisco.

The key to his success in dermatologic research, according to Dr. Voorhees, is that "I work seven days a week, and I have a very tolerant wife."

The professional accolades heaped upon Dr. Voorhees have been numerous. He has been elected to the Alpha Omega Alpha Honor Medical Society, won the Distinguished Achievement Award of the University of Michigan Medical Society, and was given the Henry Russell Research Award of the University of Michigan. He remains the only person to have been given the Taub International Memorial Award for Research in Psoriasis twice, having won the award in both 1973 and 1986. In addition to his Academy membership (and his time spent on the AAD Board of Directors), Dr. Voorhees is a fellow of the Royal College of Physicians in London, the Royal Society of Medicine, and member of a host of scientific societies.

As an editor, Dr. Voorhees has sat on the editorial boards of the *Journal of the American Academy of Dermatology*, *Archives of Dermatology*, and the *Journal of the European Academy of Dermatology and Venereology*, among others. His stints as a visiting professor and lecturer have taken him around the globe numerous times. He has spoken and taught at locations as far-flung as Stockholm, Seoul, and Sydney.

John Voorhees, M.D.

As a legend in both research and academia, Dr. Voorhees has achieved the rare balance of both bolstering his specialty and training the next generations of elite researchers, academics, and practitioners to continue its achievements well into the future. •

O. Fred Miller III, M.D., receives humanism award

By Richard Nelson, managing editor

O. FRED MILLER III, M.D., IS THE recipient of the American Academy of Dermatology's first Gold Foundation Humanism in Medicine Award. Dr. Miller, who served as the director of the dermatology department at Pennsylvania's Geisinger Medical Center for 28 years and director of its residency program for 18 years, received the award during the Academy's 68th Annual Meeting in Miami Beach, Fla.

Nominators enthused about Dr. Miller's contributions. Nektarios Lountzis, M.D., a former trainee at Geisinger, said, "With every patient he makes every effort to not only know what is wrong with them but to also know who they are as a person. He knows many of the clinic patients on a personal level and even those he does not know he makes them feel as if they were family. His affable approach to patient care is infectious and his leading by example approach has made many trainees become more empathic physicians. He has and always will do just about anything for his patients and I believe that his uncelebrated compassion for humankind should be recognized."

Another Geisinger colleague, Dirk M. Elston, M.D., noted that Dr. Miller has served as a role model for hundreds of other physicians, embodying empathy, respect, and understanding. As a result, residents and staff sometimes refer to him as "Saint Fred." "The term reflects both their deeply held regard for him, and his own approachability and sense of humor," Dr. Elston said.

A current colleague who trained under Dr. Miller, Tammie Ferringer, M.D., summed up why Dr. Miller received the Academy's first humanism award. "I consider humanitarianism an ethic of kindness, benevolence, and sympathy extended universally and impartially to all human beings," she said. "A CV cannot embody the numerous attributes of Dr. Miller that make him uniquely suited for this award." Crediting him for her decision to remain in academic medicine, Dr. Ferringer noted the example Dr. Miller set, from house calls to weekend consults to taking "genuine interest in the well being of the doctors, staff, and patients." Indeed, "His bedside manner has been a constant goal for which I strive to achieve. Through observing him, I have learned that the gentle touch of a shoulder or the back can be incredibly valuable in establishing a bond with patients," Dr. Ferringer said. "I hope everyone has an opportunity to be exposed to such a selfless person who makes them want to strive to be the best possible."

Nominator Mark Lebwohl, M.D., wrote, "his mentoring combines cutting edge science and compassion for the patient in a way that I am sure the grantors of this award would want." He added, "Dr. Miller's attitude to everyone involved in patient care — from colleagues to staff to the patients and their families — is one of caring and compassion. He sets an example of humanism in medicine that is contagious and that typifies the way his trainees treat patients."

To be eligible for the Gold Foundation Humanism in Medicare Award, nominees had to meet at least five of the following criteria:

- Demonstrate compassion and empathy in the delivery of patient care.
- Show respect for patients, families, and co-workers.
- 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.
- Is sensitive to the patient's psychological wellbeing and identifies the emotional concerns of patients and family members.
- Engenders trust and confidence.
- Displays competence in scientific endeavors.

The Academy is one of only five medical societies the Arnold P. Gold Foundation has authorized to grant the award. •

O. Fred Miller, III, M.D., receives the Gold Foundation Humanism in Medicine Award from David M. Pariser, M.D.

Bio-Oil® is a skincare oil that helps improve the appearance of scars, stretch marks and uneven skin tone. It is a combination of natural oils and vitamins, together with the breakthrough ingredient PurCellin Oil™. It was developed in 1987 and is today the number one selling scar and stretch mark product in 12 countries. It is available at drugstores at the recommended price of $11.99. For comprehensive product information, and details of clinical trials, please visit bio-oil.com.
Bio-Oil® is a product of Union Swiss, successfully treating skin since 1954.

Members Making a Difference

Dermatologist helps turn organization's focus to public service

By John Carruthers, staff writer

AS THE FIRST SERVICE CHAIR for the Women's Dermatological Society (WDS), Arizona dermatologist Suzanne Connolly, M.D., was thrust into the role of leader of the society's charge to embrace public service as part of its mission statement. With a collaborative style and invaluable help from fellow service-minded society dermatologists, Dr. Connolly was able to extend the success of the Play Safe in the Sun program begun by current WDS President Wendy Roberts, M.D., into a family-focused Families Play Safe in the Sun program that educates thousands of patients nationwide each year. Both programs have received the American Academy of Dermatology's Gold Triangle Award.

Dr. Connolly credits the society's successes in public service to conversations among WDS leadership at its 2004 meeting in Toronto.

"There was a decision made at that meeting to really embrace service as a new addition to our mission statement. This was something that the Women's Dermatological Society had not done before formally, though Dr. Roberts had previously spearheaded a number of very successful community outreach events," Dr. Connolly said. "Dr. Sandra Read was the president at that time and asked if I'd chair the task force for service, which was a wonderful opportunity."

Key to the society's early success was a grant application in 2005 that brought the WDS service program $1 million over three years for its public service efforts.

"Our first event was in Boston, July 4, 2005. One part of that was having a booth by the aquarium, and catching people as they went in. It was a whole different range of opportunities for us," Dr. Connolly said. "It was really targeted to local events where we knew a large number of the community would be coming through an organized area so we'd be able to capture a great number of people."

After the success of the Boston event, WDS members used the lessons learned to streamline the event planning and provide a greater array of educational offerings to the public.

"We developed a program of community outreach targeting young families with the aim to educate, empower, and encourage people of all ages and generations and ethnicities to practice good habits of skin health. We constructed a booth with activities, AAD brochures, sunscreen samples, and other things to entertain and educate people," Dr. Connolly said. "We also did skin cancer screenings at events if the setup allowed us to. We also had a black light exam available for the skin to be able to judge the sun damage. We were seeing families, so it would be moms, dads, young kids, grandparents, and teenagers. We as dermatologists don't always have that happen in the office where you get them all at one time. This presented a really wonderful opportunity to educate."

Key to the success of these events, according to Dr. Connolly, was not only Drs. Read and Roberts, but the society's public relations expert Nancy FitzGerald, as well as the members of the WDS, who quickly proved their commitment to the society's pledge to serve the public. Presumably they were inspired by the same thoughts as Dr. Connolly, who related the euphoric feelings she experiences while educating the public.

"It is such an opportunity to make a difference in someone's life, to reach outside of our office situation to those who may not have the wherewithal or money to make an appointment or ask questions about their skin," Dr. Connolly said. "A good segment of the population we'll never see in the office setting, and they may not have a particular awareness of skin, but you can catch them as they're out for other activities and let them know about good skin care practices. Just having the opportunity to engage them, to talk to people of different generations in one setting, is terrific. When you have these experiences outside of the office, one really does appreciate that there's so much more education that needs to be done. To be able to represent dermatology, and really all of medicine, is very special."

When she brings up public service, Dr. Connolly likes to bring up a quote from Indian poet Rabindranath Tagore, the first non-European to win the Nobel Prize for literature: "I slept and dreamt that life was joy. I awoke and saw that life was service. I acted and behold, service was joy."

That sentiment, she says, captures what service is all about. •

Suzanne Connolly, M.D., reviews warning signs of melanoma on a chart on UV reflectance with a young visitor at a Families Play Safe in the Sun event in Phoenix.

The American Academy of Dermatology's Volunteerism Committee is interested in receiving information about volunteer activities by AAD members. If you or a colleague has been involved in ongoing volunteer efforts serving the profession or its patients, please submit the name of the individual, contact information, and a description of 50 words or less of his or her activities to the Committee via e-mail at **volunteer@aad.org.** Subjects for *Dermatology World's* "Members Making a Difference" column may be selected from among the names submitted.

Academy seeks volunteers for committees and task forces

VOLUNTEERS ARE THE HEART of every association and the American Academy of Dermatology is no different. The Academy is a vibrant and successful medical organization because its members are willing to volunteer their time and energy to it. Each year, hundreds of dermatologists serve the Academy through its organizational committee structure. President-Elect Ronald L. Moy, M.D., is now accepting applications to fill rotating positions in that structure.

Applications and information about specific committees and task forces are available on the Academy's Web site. Applications must be received by June 30 and members who are selected to serve will be contacted in early winter. •

WEB INFO
www.aad.org/forms/CCTF/Default.aspx
Information and applications for committees and task forces

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DERMATOLOGY RESEARCH BRIEF

New research on vitiligo, SCCs, more

By Allen McMillen, research manager

Vitiligo patients have high prevalence of autoimmune, auditory disorders

Researchers from Turkey's University of Ankara School of Medicine investigated clinical and genetic characteristics of vitiligo, as well as the association of the disease with auditory abnormalities and other autoimmune disorders, and found that patients with vitiligo have a high prevalence of other autoimmune disorders and hearing problems. From January to December 2008, data was collected from 80 vitiligo patients to establish the clinical and epidemiological profile of the disease. Thirty patients were men and 50 were women, with a mean age of 37 years and a mean onset age of 10 years. Vitiligo vulgaris was the most common type, followed by focal, acrofacial, segmental, and universal types. Forty-four patients (55 percent) had an associated autoimmune disease. These associated diseases were Hashimoto thyroiditis in 25, alopecia areata in 10, pernicious anemia in 7, and diabetes mellitus in 2 patients. Statistically significant changes in human leukocyte antigen in patients with vitiligo were HLA A24,-30, B63, CW6, DR15, DR51, DQ5,-6. Auditory problems were observed in 37.7 percent of patients. Nine of the 20 patients showed unilateral minimal hearing loss (>30 dB), while the other 11 demonstrated bilateral hearing loss (>30 dB) over a large range of frequencies (2000–8000 Hz). Investigators note this study demonstrates that vitiligo is part of a systemic autoimmune process and suggest all patients be screened for auditory problems.

For more information on this study, visit http://www3.interscience.wiley.com/journal/123303242/abstract.

Citation: Akay B, et al. Journal of the European Academy of Dermatology and Venereology, *Feb. 25, 2010, published online ahead of print, doi: 0.1111/j.1468-3083.2010.03605.x.*

NSAID use does not reduce risk of cutaneous squamous cell carcinoma

Researchers from Kaiser Permanente Northern California (KPNC) examined the association between nonsteroidal anti-inflammatory drug (NSAID) use and cutaneous squamous cell carcinoma (SCC) and found that the use of NSAIDs does not reduce the risk of cutaneous SCC. This retrospective case-control study included a random sample of 415 KPNC members diagnosed as having a pathologically verified SCC in 2004 and 415 age-, sex-, and race-matched controls with no history of skin cancer. The main exposure measure was self-reported NSAID use in the 10 years prior to baseline. Use of NSAIDs was categorized based on type (any NSAIDs, aspirin, ibuprofen, and nonaspirin NSAIDs). Odds ratios (ORs) and 95 percent confidence intervals (CIs) were calculated using conditional logistic regression to estimate the association of SCC with regular use, dose, and duration of exposure to the different NSAID types. Information on pharmacy-dispensed NSAIDs was also examined to assess its association with SCC risk. Models were adjusted for all ascertained SCC risk factors (fully adjusted model) and only those variables associated with both SCC risk and NSAID use (parsimonious model). Fully adjusted analyses showed no statistically significant reduction in SCC risk with self-reported regular use of any NSAID (OR, 1.32; 95 percent CI, 0.92-1.89), aspirin (OR, 1.38; 95 percent CI, 0.96-1.97), ibuprofen (OR, 0.74; 95 percent CI, 0.46-1.19), or nonaspirin NSAIDs (OR, 0.84; 95 percent CI, 0.56-1.26). Analyses examining duration, dose, and variables combining duration and dose of NSAID exposure did not appreciably change results. An analysis using the parsimonious model showed similar results. The data on pharmacy-dispensed NSAIDs also showed no association with SCC risk. Neither self-reported nor pharmacy-dispensed NSAID exposure was associated with cutaneous SCC risk.

For more information on this study, visit http://archderm.ama-assn.org/cgi/content/abstract/2009.374v1.

Citation: Asgari M, et al. Archives of Dermatology, *Feb. 15, 2010, published online ahead of print, doi:10.1001/archdermatol.2009.374.*

Phototherapy for mycosis fungoides may induce IGH-like lesions

Researchers from Israel's Rabin Medical Center sought to determine clinical and histological features of phototherapy-induced idiopathic guttate hypomelanosis (IGH)-like lesions, their relation to ultraviolet dosimetry, and the course of this eruption in patients with mycosis fungoides (MF). They found that phototherapy treatment for MF may induce skin eruptions similar to those seen with IGH. Idiopathic guttate hypomelanosis is a common pigmentary disorder, the etiology and pathogenesis of which are largely unknown. The appearance of IGH-like lesions during phototherapy has been reported previously in only one patient. For this study, the files of all patients with MF who underwent phototherapy at Rabin Medical Center from 1992 to 2008 were searched to identify those in whom IGH-like lesions appeared during treatment. Among 87 patients with early-stage MF who underwent phototherapy, seven acquired IGH-like lesions during monotherapy with narrow-band ultraviolet B (NB-UVB; four patients) or psoralen and ultraviolet A (PUVA; three patients). All but one had a light complexion. The lesions appeared in areas exposed to ultraviolet light, and not exclusively on the skin previously involved by the disease. The mean number of exposures until appearance of the lesions was 92 for NB-UVB and 137 for PUVA. Biopsy study showed a decreased number of melanocytes. Phototherapy was discontinued in four patients, of whom three showed a partial or complete disappearance of the IGH-lesions. The other three patients continued receiving phototherapy, with no change in their IGH-like lesions. Findings indicate phototherapy may induce an eruption bearing similar clinical and histopathological features to IGH. The eruption is rare, appears to emerge only after prolonged therapy, and seems to be reversible upon discontinuation of phototherapy. The investigators suggest IGH-like eruption should be added to the list of side effects of phototherapy.

For more information on this study, visit http://www3.interscience.wiley.com/journal/123289657/abstract.

Citation: Friedland R, et al. Journal of the European Academy of Dermatology and Venereology, *Feb. 17, 2010, published online ahead of print, 10.1111/j.1468-3083.2010.03571.x.*

Ablative fractional resurfacing may improve atrophic scarring

Researchers from the Laser and Skin Surgery Center of New York assessed the safety and efficacy of carbon dioxide ablative fractional resurfacing (AFR) for non-acne atrophic scarring and found that AFR treatments represent a safe, effective treatment modality for improving atrophic scarring due to surgery or trauma. This before-and-after trial included fifteen women with Fitzpatrick skin types I to IV, aged 21 to 66 years, presenting with 22 non-acne atrophic scars between June 1 and Nov. 30, 2007. Three patients (three scars) were excluded from the study after receiving one AFR treatment and not returning for follow-up visits. The remaining 12 patients (19 scars) completed three AFR treatments, at one- to four-month intervals, and six months of follow-up. Erythema, edema, petechiae, scarring, crusting, and dyschromia were graded after treatment and through six months of follow-up. Skin texture, pigmentation, atrophy, and overall appearance were evaluated after treatment and through six months of follow-up by the patient and a non-blinded investigator. A three-dimensional optical profiling system generated high-resolution topographic representations of atrophic scars for objective measurement of changes in scar volume and depth. Adverse effects of treatment were mild to moderate, and no scarring or delayed-onset hypopigmentation was observed. At the six-month follow-up visit, patient and investigator scores demonstrated improvements in skin texture for all scars (patient range, 1-4 [mean, 2.79]; investigator range, 2-4 [mean, 2.95]), pigmentation for all scars (patient range, 1-4 [mean, 2.32]; investigator range, 1-4 [mean, 2.21]), atrophy for all scars (patient range, 1-4 [mean, 2.26]; investigator range, 2-4 [mean, 2.95]), and overall scar appearance for all scars (patient range, 2-4 [mean, 2.89]; investigator range, 2-4 [mean, 3.05]). Image analysis revealed a 38.0 percent mean reduction of volume and 35.6 percent mean reduction of maximum scar depth.

For more information on this study, visit http://archderm.ama-assn.org/cgi/content/abstract/146/2/133.

Citation: Weiss E, et al. Archives of Dermatology, *February 2010, 146:133-140.* •

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Selected findings to be highlighted in each month's Dermatology Research Brief are chosen by members of the American Academy of Dermatology's Council on Science and Research. If you are aware of a recently published piece of research that you think should be featured in this column, please submit the citation to the Academy's Science and Quality department for consideration.

California dermatologist wins Young Investigator award for genetic research

By Jennifer Allyn, lead public relations specialist and Wendy Smith Begolka, senior manager, guideline development

Kevin Wang, M.D., Ph.D., accepts the 2010 Young Investigators in Dermatology Award from David M. Pariser, M.D., at the American Academy of Dermatology's 68th Annual Meeting in Miami Beach, Fla.

AT THE AMERICAN ACADEMY OF DERmatology's 68th Annual Meeting, Kevin Wang, M.D., Ph.D., was presented with the 2010 Young Investigators in Dermatology Award. This award is given annually to dermatologists in training in recognition of their contributions to the specialty of dermatology, and is based upon the originality of concept, soundness of research design, and quality and clarity of the research report.

Dr. Wang is currently an assistant clinical professor in the department of dermatology at the University of California San Francisco (UCSF), and a post-doctoral fellow in the Stanford University Medical School department of dermatology's program in epithelial biology. He received his M.D. from UCSF and his Ph.D. in neurobiology from Harvard Medical School in Boston, and subsequently completed his residency in dermatology at UCSF.

Dr. Wang was recognized for his research in molecular genetics and the mechanisms underlying positional patterning of cells during development. His studies address a fundamental question in biology of how large groups of genes can be regulated (e.g., turned on or off) at the same time, and specifically how this occurs in the skin to specify positional identity with respect to the entire body. Dr. Wang's research investigated the regulation of expression of the HOX family of transcription factors in dermal fibroblasts, and discovered that a new class of molecules, called long noncoding RNAs, may serve as master regulators of gene expression by coordinating the activity of neighboring genes through binding to enzymes that modify chromatin, the protein-DNA complex that makes up chromosomes. This work promises to uncover the basis of many skin diseases that show site-specific development, and has implications for the targeted treatment of these diseases as well as regenerative medicine.

The Young Investigators in Dermatology Award is available to physicians currently enrolled in accredited dermatology residency programs or who have completed their residencies within the previous two years. The award committee included representatives from the Academy's Council on Science and Research, the *Journal of the American Academy of Dermatology*, the Association of Professors of Dermatology, the Society of Investigative Dermatology, a current dermatology resident, and an at-large member of the Academy. •

Young Investigators Award Nominations Sought

The American Academy of Dermatology's Young Investigators in Dermatology Award is given annually to recognize young dermatologists in the U.S. and Canada who make promising strides toward the improvement of diagnosis and therapeutics.

Nominations are accepted from either the head of a department of dermatology or a nominee's faculty advisor. Candidates who are currently enrolled in accredited residency programs or who have completed their residencies within the previous two years are eligible for the award. To nominate a candidate, complete the online submission form, and include a short description of the nominee's research, letter of recommendation, description of the residency program, and the applicant's abbreviated curriculum vitae. Winners will share the $5,000 prize with their nominating institution. Applications are due Aug. 31, 2010. •

CONTACT INFO
Allen McMillen
Phone: (847) 240-1724
E-mail: amcmillen@aad.org

WEB INFO
www.aad.org/education/grants/young.html
Young Investigators Award nomination information

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CME CALENDAR

Meetings listed are only those recognized for AAD category 1 CME credit (space permitting).

For information on other meetings, contact:

Joanna King
CME Specialist
Education Department
American Academy of Dermatology
PO Box 4014
Schaumburg IL 60168-4014
Fax: (847) 330-1135
www.aad.org/meetings/calendar.html

ACADEMY EVENTS

Practice Management Course, American Academy of Dermatology, Hyatt Regency Jersey City on the Hudson, Jersey City, N.J.

May 22-23. For information contact: American Academy of Dermatology, Meetings and Conventions; phone: (847) 330-0230, fax: (847) 330-1090; e-mail: registration@aad.org; or Web site: www.aad.org.

Summer Academy Meeting 2010, American Academy of Dermatology, Hyatt Regency Chicago, Chicago, Ill.

Aug. 4-8. For information contact: American Academy of Dermatology, Member Resource Center; phone: (847) 330-0230 or Web site: www.aad.org.

Derm Exam Prep Course, American Academy of Dermatology, Hard Rock Hotel, San Diego, Calif.

Nov. 19-21. For information contact: American Academy of Dermatology, Meetings & Conventions; phone: (847) 330-0230, fax: (847) 330-1090, e-mail: registration@aad.org, or Web site: www.aad.org.

APRIL

Annual Meeting, South Carolina Dermatological Association, Doubletree Hotel, Charleston, S.C.

April 9-10. For information contact: SC Dermatological Association, Debbie Shealy; phone: (803) 798-6207, ext. 223.

Concepts in Dermatology, American Osteopathic College of Dermatology, San Francisco Convention Center, San Francisco, Calif.

April 14-17. For information contact: American Osteopathic College of Dermatology, Becky Mansfield, executive director; phone: (660) 665-2184, fax: (660) 627-2623, e-mail: bmansfield@aocd.org.

Annual Spring Meeting, University of Louisville Division of Dermatology, 310 E. Broadway, Louisville, Ky.

April 16. For information contact: University of Louisville Division of Dermatology, Sandy Lingle; phone: (502) 852-7287, fax: (502) 852-4720, e-mail: Sandyl7447@aol.com, or Web site: www.louisville.edu/medschool/dermatology.

24th Tulane Dermatology Meeting and All That Jazz, Tulane University School of Medicine Department of Dermatology, Westin New Orleans Canal Place, New Orleans, La.

April 21-24. For information contact: Tulane Unversity Health Sciences Center, Center for Continuing Education, Anita Jobson; phone: (504) 988-5466, fax: (504) 988-1779, e-mail: cme@tulane.edu, or Web site: www.tulane.edu/cce.

Arkansas Dermatological Society, Annual Meeting, University of Arkansas for Medical Sciences, Little Rock, Ark.

April 23-24. For information contact: Trey Manning, M.D.; phone: (504) 664-4161, fax: (501) 664-6108, or e-mail: tmanning11@comcast.net.

42nd Annual Meeting, American College of Mohs Surgery, New York Marriott Marquis, New York, N.Y.

April 30-May 3. For information contact: American College of Mohs Surgery, Kim Schardin; phone: (414) 347-1103, e-mail: info@mohscollege.org, or Web site: www.mohscollege.org.

MAY

Cosmetic Dermatology Seminar 2010, Skin Disease Education Foundation, Loews Santa Monica Hotel, Santa Monica, Calif.

May 13-15. For information contact: Skin Disease Education Foundation, Terrie Rillo; phone: (240) 221-4405, fax: (866) 401-8609, e-mail: terries@sdefderm.com, or Web site: www.sdefderm.com.

51st Annual Meeting, North American Clinical Dermatologic Society, Bucharest, Romania, Sofia, Bulgaria, and Zagreb, Croatia

May 20-June 5. For information contact: North American Clinical Dermatologic Society, Judith Koperski, M.D.; phone: (858) 558-0677, fax: (858) 558-3077, e-mail: jakoperski@yahoo.com, or Web site: www.nacds.com.

Dermatologic Surgery: Focus on Skin Cancer, American Society for Mohs Surgery, Hyatt Regency Monterey on Del Monte Golf Course, Monterey, Calif.

May 27-30. For information contact: American Society for Mohs Surgery, Novella M. Rodgers; phone: (800) 616-2767, fax: (714) 379-6272, e-mail: execdir@mohssurgery.org, or Web site: www.mohssurgery.org.

2010 Annual Meeting, Florida Society of Dermatology and Dermatologic Surgery, Naples Grand, Naples, Fla.

May 28-31. For information contact: Florida Society of Dermatology and Dermatologic Surgery, Paula Baumgardner; phone: (904) 880-0023, fax: (904) 880-0034, e-mail: info@fsdds.org, or Web site: www.fsdds.org.

Seminar at Sinai, Alabama Dermatology Society, Mt. Sinai Medical Center, New York, N.Y.

May 28-31. For information contact: Eric W. Baum, M.D.; phone: (256) 543-2380, fax: (256) 543-2389, or e-mail: ericbillybaum@bellsouth.net.

JUNE

55th Annual CME Meeting, Georgia Society of Dermatologists, Ritz-Carlton, Amelia Island, Fla.

June 4-6. For information contact: Georgia Society of Dermatologists, Maryann McGrail; phone: (404) 310-5866, fax: (305) 422-3327, e-mail: maryann@theassociationcompany.com, or Web site: www.gaderm.org.

28th Annual Dermatology Teaching Day, Albany Medical College, The Desmond, Albany, N.Y.

June 11. For information contact: Albany Medical College, Jacqueline Rider; phone: (518) 262-5828, fax: (518) 262-5679, e-mail: RiderJ@mail.amc.edu, or Web site: www.amc.edu.

Dermatology on the Beach, Alabama Dermatology Society, Sandestin Beach Hilton Hotel, Destin, Fla.

June 24-27. For information contact: Eric W. Baum, M.D.; phone: (256) 543-2380, fax: (256) 543-2389, or e-mail: ericbillybaum@bellsouth.net.

The CDA 85th Annual Conference, Canadian Dermatology Association, St. John's, Newfoundland and Labrador, Canada

June 30-July 4. For information contact: Canadian Dermatology Association, Maura Hope; phone: (613) 738-1748/(800) 267-3376, fax: (613) 738-4695/(866) 267-2178, e-mail: mhope@dermatology.ca, or Web site: www.dermatology.ca.

JULY

Pacific Northwest Dermatological 77th Annual Scientific Conference, Washington State Dermatology Association, Hilton Hotel & Conference Center, Vancouver, Wash.

July 8-11. For information contact: Washington State Dermatology Association, Shannon McDonald; phone: (206) 956-3648, fax: (206) 441-5863, e-mail: smc@wsma.org, or Web site: www.washingtonderm.org.

Hugh Greenway's 27th Annual Superficial Anatomy and Cutaneous Surgery, UCSD School of Medicine, San Diego Marriott, San Diego, Calif.

July 12-16. For information contact: UCSD CME; phone: (858) 534-3940, fax: (858) 822-5908, or e-mail: ocme@ucsd.edu.

Society for Pediatric Dermatology 36th Annual Meeting, Society for Pediatric Dermatology, Hilton Portland & Executive Tower, Portland, Ore.

July 15-18. For information contact: Society for Pediatric Dermatology, Kent Lindeman, CMP; phone: (317) 202-0224, fax: (317) 205-9481, or e-mail: spd@hp-assoc.com.

109th Annual National Medical Association, Dermatology Scientific Meeting & Assembly, National Medical Association, Dermatology Section, Gaylord Palms Convention Center, Orlando, Fla.

July 31-Aug. 5. For information contact: National Medical Association, Amy McMichael, M.D.; phone: (202) 347-1895, fax: (202) 481-2367, e-mail: jordermassoc@gmail.com, or Web site: nmanet.org.

AUGUST

2010 Summer Meeting, North Carolina Dermatology Association, Grove Park Inn Resort and Spa, Asheville, N.C.

Aug. 6-8. For information contact: NC Dermatology Association, Nancy Lowe, CMP; phone: (919) 833-3836, fax: (919) 833-2023, e-mail: nlowe@ncmedsoc.org, or Web site: www.ncmedsoc.org.

Controversies and Conversations in Laser and Cosmetic Surgery, SkinCare Physicians, Four Seasons Aviara, Carlsbad, Calif.

Aug. 13-15. For information contact: Meetinguides, Ana Rabicoff; phone: (817) 922-0984, fax: (817) 922-0984, e-mail: Controversies@skincarephysicians.net, or Web site: www.skincarephysicians.net.

Annual Summer Meeting, West Virginia Dermatological Society, The Greenbrier Resort, White Sulphur Springs, W.Va.

Aug. 27-28. For information contact: Amy A. Vaughan, M.D.; phone: (304) 733-3333, fax: (304) 733-3666, e-mail: amyvaughan1@comcast.net.

SEPTEMBER

38th Annual Dermatopathology Self Assessment Workshop, Cleveland Clinic, Cleveland Clinic Lerner Research Institute, Cleveland, Ohio

Sept. 11. For information contact: Dermatopathology, Katherine Williams; phone: (216) 444-2168, fax: (216) 445-3707, or e-mail: williak@ccf.org.

Annual Meeting, Intermountain Dermatology Society, Sun Valley Resort, Sun Valley, Idaho

Sept. 17-18. For information contact: Intermountain Dermatology Society, Kathleen Lowry; phone: (801) 585-9624, fax: (801) 581-5972, or e-mail: kathleen.lowry@hsc.utah.edu.

Women's & Pediatric Dermatology Seminar 2010, Skin Disease Education Foundation, Grand Hyatt on Stockton, San Francisco, Calif.

Sept. 24-26. For information contact: Skin Disease Education Foundation, Terrie Rillo; phone: (240) 221-4405, fax: (866) 401-8609, e-mail: terrie@sdefderm.com, or Web site: www.sdefderm.com.

43rd Annual Meeting, Pennsylvania Academy of Dermatology and Dermatologic Surgery, The Westin Philadelphia, Philadelphia, Pa.

Sept. 24-26. For information contact: Pennsylvania Academy of Dermatology and Dermatologic Surgery, Jill Senior; phone: (866) 650-3376, fax: (717) 558-7841, e-mail: paderm@pamedsoc.org, or Web site: www.padermatology.org.

OCTOBER

27th Annual Meeting of the Ohio Dermatological Association, Ohio Dermatological Association, Hilton Columbus at Easton, Columbus, Ohio.

Oct. 1-3. For information contact: Ohio Dermatological Association, Cynthia Bartunek, executive director; phone: (330) 720-3847, fax: (330) 375-6734, e-mail: odaexec@neo.rr.com, or Web site: www.ohderm.org.

ASDP 47th Annual Meeting, American Society of Dermatopathology, Atlanta Hilton, Atlanta, Ga.

Oct. 7-10. For information contact: American Society of Dermatopathology, Deb Pederson; phone: (847) 400-5820, fax: (847) 480-9282, e-mail: info@asdp.org, or Web site: www.asdp.org.

29th Anniversary Fall Clinical Dermatology Conference, Foundation for Research and Education in Dermatology, The Encore at the Wynn, Las Vegas, Nev.

Oct. 8-11. For information contact: Foundation for Research and Education in Dermatology, Michelle Gratz, executive administrator; phone: (914) 923-9719, fax: (914) 923-9697, e-mail: FallClinicalDerm@aol.com, or Web site: www.ClinicalDermConf.org.

Annual Clinical Meeting, Massachusetts Academy of Dermatology, Portland Regency Hotel & Spa, Portland, Maine

Oct. 15-17. For information contact: Mass Academy of Dermatology, Paul Wetzel; phone: (781) 982-8899, fax: (781) 878-0838, e-mail: wetzelpaul@msn.com, or Web site: www.massacademyofdermatology.org.

18th Annual Scientific Meeting, International Society of Hair Restoration Surgery, Boston, Mass.

Oct. 20-24. For information contact: International Society of Hair Restoration Surgery, Liz Rice-Conboy; phone: (630) 262-5399 or (800) 444-2737, fax: (630) 262-1520, e-mail: info@ishrs.org, or Web site: www.ishrs.org.

2010 Annual Meeting, American Society for Dermatologic Surgery, Hyatt Regency, Chicago, Ill.

Oct. 21-22. For information contact: ASDS, Shonnie Shelton; phone: (847) 956-9120, fax: (847) 956-0999, e-mail: sshelton@asds.net, or Web site: www.asds.net.

2010 Annual Meeting, American Society for Dermatologic Surgery, Hyatt Regency, Chicago, Ill.

Oct. 21-24. For information contact: ASDS, Shonnie Shelton; phone: (847) 956-9120, fax: (847) 956-0999, e-mail: kweber@asds.net, or Web site: www.asds.net.

NOVEMBER

Las Vegas Dermatology Seminar 2010, Skin Disease Education Foundation, The Venetian, Las Vegas, Nev.

Nov. 4-6. For information contact: Skin Disease Education Foundation, Terrie Rillo; phone: (240) 221-4405, fax: (866) 401-8609, e-mail: terrie@sdefderm.com, or Web site: www.sdefderm.com.

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Suzanne M. Olbricht, MD,
Chair, Department of Dermatology
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Suzanne.M.Olbricht@lahey.org

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