

Issues facing dermatology in the United States^{*}

Questões enfrentadas pela dermatologia nos Estados Unidos^{}*

Bruce H. Thiers¹

During my four years on the Board of Directors of the American Academy of Dermatology (AAD) and two years as the organization's Vice-President Elect and Vice-President, I had the opportunity to work with many Academy leaders in identifying and attempting to resolve many of the important issues facing our specialty in the United States. In this manuscript, I attempt to identify 13 critical issues (a "baker's dozen") facing dermatology and the progress, or lack of progress, we have experienced over the past several years. It is quite likely that many of these problems are not unique to the United States but are experienced by dermatologists worldwide.

THE DERMATOLOGY WORKFORCE

Few would disagree that there is a shortage of dermatologists in the United States, with patients often waiting months for an appointment. The severity of the shortage differs from region to region, and it is most acute in poor, rural areas and less so in more wealthy, heavily-populated cities. The scarcity of dermatologists can be attributed to a number of factors which are listed below.

1. Insufficient number of residency positions.

There are approximately 300 residency positions per year available to train new dermatologists. This number has remained fairly constant over the past decade despite an ever-increasing demand for dermatology services. Why has the number of dermatology residency positions not increased? First, residency positions need funding to pay the salary of the trainees. This funding ultimately comes from the US government, which returns money collected from the Medicare program for the elderly to academic medical centers to pay trainees. The US government and

the Medicare program are burdened by large deficits, which prevent the funding of additional residency positions. Moreover, there is a trend to favor funding residency positions in general practice over those in specialties like dermatology. The AAD attempted to create a mechanism for funding dermatology residency positions which would be partially financed by the Academy and partially financed by industry. This initiative was substantially scaled back when it came under attack from a small but vocal minority of Academy members.

2. Increased number of women in the dermatology workforce.

Women make up an increasing percentage of medical students and residents in dermatology. Because of often substantial family obligations including child rearing, many of them are forced to take extended periods of time off or work part-time, often during the most productive years of their careers. Thus, a part-time female physician may take the place of a full-time male physician in a group practice. With a large number of dermatologists working part-time, this further exacerbates the shortage of trained physicians to treat skin disease.

3. Early retirement of dermatologists.

Many established dermatologists, disenchanted with the burdens placed upon them by managed care (discussed later), choose early retirement. This moves many quite capable, highly-trained individuals out of the dermatology workforce. As noted above, these physicians are often replaced by others who are unable to make a full-time commitment to patient care, at least during a substantial part of their careers.

The shortage of dermatologists has had effects

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¹ MD, Professor and Chairman Department of Dermatology.

beyond those of patients simply having to wait longer to see a physician. It has caused encroachment into dermatology of physicians without specialty training in dermatology, such as general practitioners and individuals from other specialties. Anyone with a medical degree can restrict his practice to dermatology; he simply cannot call himself a "board-certified" dermatologist without having passed the certifying examination of the American Board of Dermatology (ABD). Thus, we now have many physicians from specialties as diverse as nephrology and obstetrics/gynecology performing sclerotherapy, and general practitioners opening "skin disease treatment centers" to attract patients who are unable to get appointments with trained dermatologists. Many patients who see these individuals really have no knowledge that they do not have specialty training in dermatology, and any mistakes or mistreatment they experience cast a black mark on our specialty as a whole. Additionally, many "physician extenders," such as nurse practitioners and physician assistants, now restrict their care to dermatology. Having individuals treated by lesser-trained nonphysicians is neither good for our specialty nor for our patients.

THE PERCEPTION OF DERMATOLOGY

Who are we? Dermatology has become a much more diverse specialty over the years. While many individuals perhaps rightly thought of us as wart/acne doctors in the 1960's and 1970's, dermatology has now evolved into a specialty that treats a wide range of medical, surgical and cosmetic complaints. Some of our colleagues include all of these in their practices, whereas others simply restrict their practice to medical, surgical or cosmetic dermatology. Are those of us who do medical dermatology comfortable that we are physicians in the same sense as our colleagues who treat more serious internal diseases? Are those of us who practice primarily dermatologic surgery comfortable that we are equal in ability and talent to our colleagues in other specialties such as plastic surgery and otolaryngology? How about those that practice only cosmetic dermatology?

Are they really physicians or just expensive cosmeticians? Are all the years of rigorous medical training wasted on them? Should we be training individuals to specialize in cosmetic dermatology when there is such a shortage of medical and surgical dermatologists? How many of us chose dermatology because they truly love the specialty and not because it was perceived as a road to the "easy life," without 24-hour call or very sick patients. How others perceive us is important. How we perceive ourselves is even more important.

INTERPROFESSIONAL RELATIONSHIPS

Clearly, the evolution of dermatology into a diverse specialty has strained relationships between "competing" specialties such as plastic surgery and otolaryngology. Other specialties claim that our training is not as rigorous as is theirs. We claim that nobody knows more about the skin than dermatologists. "Turf wars" have broken out among the various specialties who feel only they are adequately trained to do a specific procedure, e.g. liposuction. Political and administrative tactics have been used in an attempt to deny dermatologists the ability to perform certain procedures either in hospitals or in outpatient settings. For the most part, with the help of the AAD, these efforts have been unsuccessful, but we must continue to be vigilant.

The same issues have strained relations between the AAD and the subspecialty societies, such as the American Society for Dermatology Surgery (ASDS). Who best represents dermatologic surgeons, the AAD or the ASDS? Who best represents research in dermatology, the AAD, the Society of Investigative Dermatology (SID) or the Dermatology Foundation? When we fight among ourselves there are no winners.

RESEARCH IN DERMATOLOGY

The primary funding organization for dermatologic research in the United States is the National Institutes of Health (NIH). Because of massive government deficits, NIH funding has been increasingly more difficult to come by, and many well-deserving research projects fail to get funded. Often, industry, i.e. pharmaceutical companies, has stepped in to fill the void. Is this a blessing or a curse? Is the best research being funded, or only research that will result in a marketable product? Is industry-funded research unbiased? Are the results of the research being presented fairly to physicians and to the public? Are negative results being properly publicized and are adverse events being duly documented? These are all questions that must be addressed when conflicts of interests (also addressed later) may exist.

More recently, the AAD has been asked to fund research projects that lose or do not receive government funding. Is this part of the mission of the AAD? If so, the concept of the AAD as a funding organization for research is novel that will require a whole new infrastructure within it to assess the merits of various grant applications.

INDUSTRY RELATIONSHIPS/CONFLICTS OF INTEREST

The issue of industry-funded research has already been discussed. During the drug development process and after drug approval, many pharma-

ceutical companies employ dermatologists to advise and assist them in publicizing and marketing their products. It is critical that these individuals disclose these conflicts of interests when presenting at meetings or when publishing in journals. Listeners and readers must be aware of these conflicts which, of course, do not mean that the presentation or paper is biased. However, the potential for mischief is there, and must be disclosed. Similarly, dermatologists in leadership positions at the AAD must provide a detailed conflict of interest statement in conjunction with their serving in any position of influence within the organization.

The AAD receives a substantial degree of funding from industry sources, much of which is in the form of "unrestricted grants." The Academy must be diligent in assuring that the grantors have no influence on the presentation of scientific information at Academy meetings or in Academy publications. With this in mind, the Academy's conflict of interest policies and disclosure statements have recently been updated.

MANAGED CARE ISSUES

To some patients and physicians, "managed care," as the term is used in the United States, more accurately means denial of care. Managed care organizations, also called health maintenance organizations, provide relatively low-cost health insurance to their subscribers. With this lower cost comes restriction of access to physicians and reduced benefits to their subscribers. In some managed care contracts, a "gatekeeper" requirement exists which mandates that any patient wishing to see a specialist must first obtain a referral from his primary care physician. This is a form of restricted access, since the patient does not have the right to choose a specialist with the highest degree of training to treat his problem. Once a patient actually gets to see a dermatologist, there may be a requirement for procedure authorization. For example, a primary care physician may refer a patient to a dermatologist, but if a biopsy is necessary, additional authorization from the insurance provider may be necessary. In a sense, then, managed care cuts costs by providing obstacles to effective, and often more expensive, patient care. In addition, many managed care organizations designate a limited number of specialists as their "preferred providers." This has two effects. It may cause patients to experience extended waits for an appointment to see a specialist, and it gives these insurance providers bargaining leverage in which they designate as "preferred providers" those specialists who offer their service at the lowest cost. Unfortunately, the lowest cost service is often not the best service, and such physicians may

not provide the most effective healthcare. Moreover, some managed care organizations use a process called capitation, in which they pay a physician a set amount per year to provide healthcare for each of their clients. If their clients are largely a group of young, healthy persons, who rarely visit doctors, such contracts can be quite profitable to the physician. On the other hand, if their clients are elderly and ill, requiring multiple, lengthy office visits, the physician's cost of providing such care could substantially exceed the revenue obtained from the insurer. Thus, with capitation, the risk is borne by the physician, not by the managed care organization.

REIMBURSEMENT ISSUES

These have been discussed in part above. There is a constant tug of war between physicians and insurance organizations regarding appropriate reimbursement. Patients want the best healthcare. Insurance companies are interested in making a profit. Physicians are interested in maintaining their income. These goals are largely incompatible unless there is an honest discussion among all interested parties. The concept that patients can receive unlimited high-quality healthcare at a low cost is a fantasy, yet many patients are unwilling to share in the cost of modern healthcare technology which, as we all know, is very expensive to deliver. Insurance companies are in the business to be profitable and thus want to ration healthcare to keep their expenses to a minimum. This is a constant struggle whose end does not appear near.

THE COST OF PRESCRIPTION MEDICATIONS

The cost of prescription medications regularly increases at a rate far exceeding that of inflation. The profit margins of pharmaceuticals companies are the envy of American industry. The cost of drugs often exceeds the cost of the office visit. Because many patients do not have medication coverage as part of their health insurance, treatable diseases may remain untreated.

Drugs traditionally have been priced based on cost plus a reasonable profit margin. Costs have increased markedly in recent years, due in large part to incredibly high marketing budgets at most pharmaceutical companies. These companies spend millions to market their products to physicians. Direct to consumer advertising of prescription drugs (Americans are bombarded with prescription drug advertising on television) has only made things worse. More recently, drug companies have abandoned the "cost plus" pricing formula in favor of a more abstract "value to society" approach. Hence, a biotech company with a new drug to stimulate the bone marrow claims the drug will make the need for transfusions a thing of

the past. The price: \$75,000 per year, about the same as the cost of transfusions. Another biotech company has a drug to treat macular degeneration. What does any person value more than his sight? Not much, so the drug is priced 100 times higher than a similar drug the same company already markets for another indication.

With drug prices out of control, one would think the government would step in to protect the public interest. After all, as the largest purchaser of healthcare (through its Medicare program), the government has used its bargaining power to reduce physician and hospital reimbursement to the bare minimum. When a new Medicare plan for prescription drug coverage went into effect early in 2006, many optimists thought that the government would take a similar hard line with the pharmaceutical companies. Unfortunately, this was not to be. Why? These same companies contribute heavily to the political campaigns of our congressmen and senators, and thus the final legislation for Medicare drug coverage was written more to protect the companies' interests than the public interest. The final result was a poorly conceived, hopelessly confusing set of rules and regulations that provides incomplete drug coverage at a high cost, with taxpayers paying up to 80% more for drugs purchased under this plan than under other government health plans.

THE RISK OF LITIGATION

Malpractice insurance rates in the United States have skyrocketed, a result of large jury awards for what are perceived by the medical profession as relatively minor practice missteps. Years ago, the birth of an abnormal child was considered to be an act of God. Now, it is considered to be the fault of the obstetrician. As a result, more and more obstetricians are leaving practice, creating a severe shortage of this specialty in many areas. States in which litigation issues are most severe are experiencing a loss of physicians to other states in which the practice environment is more favorable. Specialties with the highest rates of malpractice insurance, such as obstetrics/gynecology and neurosurgery, are finding it difficult to recruit young physicians. This is a true crisis in the United States for which government relief has been sought but, in most cases, not received.

FOOD AND DRUG ADMINISTRATION (FDA) ISSUES

The mission statement of the FDA (<http://www.fda.gov>) says that the "FDA is responsible for protecting the public health by ensuring the safety, efficacy and security of human and veterinary drugs, biologic products, medical devices, our

nation's food supply, cosmetics and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer and more affordable, and helping the public get the accurate, science-based information they need to use medicines and foods to improve their health." Unfortunately, those noble goals have been impinged upon by political forces with a certain agenda to advance, and the recent controversy involving Vioxx® has put the FDA on the defensive. Thus, we have programs such as iPledge to track patients taking the teratogenic but highly effective acne drug, isotretinoin. The iPledge program is so poorly conceived and difficult to manage that many dermatologists have simply abandoned prescribing the drug. Who loses? Our patients. The "black box" warnings on the topical calcineurin inhibitors have frightened parents into refusing their use on their children, who would otherwise benefit greatly from these drugs. There is an equivalent to the FDA in most other countries. Dermatologists there would do well to monitor the activities of these organizations to be sure that they act rationally and in the public interest.

REGULATORY COMPLIANCE

Government regulation certainly has its place in the practice of medicine. There is a need to be certain that physicians act in the public interest and not in their own interest. However, at some point regulations become unnecessary and burdensome. Is it really advancing public welfare for my office laboratory to be inspected on a regular basis (at a cost of several hundred dollars) to be certain that I am capable of doing a KOH examination? There are regulations in the United States for virtually everything impacting the practice of medicine, from privacy laws to procedural credentialing (see below). Some of these are necessary and beneficial; others are an example of the government run wild. Many regulations are placed on physicians by government agencies which simply create them to justify their own existence. They add little to the quality or safety of healthcare.

PROCEDURE CREDENTIALING

All of us are taught to do minor procedures such as biopsies and excisions during our residency training. Many of us who have been trained more recently are quite skilled in laser therapy and sclerotherapy. Probably fewer have extensive experience in more complicated cosmetic procedures such as liposuction. How does the public know which physicians are qualified to do which procedures? Is it merely by having completed a residency in dermatology or ano-

ther specialty? What procedures require training beyond residency? How does one demonstrate competence? If an individual is competent in a certain procedure when finishing residency, is he still considered competent 20 years later without reexamination? Many of these issues are legitimate, others are simply outgrowths of the previously described "turf wars" between dermatology and other specialties. For example, plastic surgeons may argue that they are trained to do flaps and grafts during residency whereas dermatologists are not (an argument that certainly is not true in our training program, where these skills are taught and taught well by our dermatologic surgeons). Some hospital-based specialists, such as surgeons, argue that an individual should not be considered qualified to do a procedure (even a simple excision) in his office if he is not qualified to do the same procedure in the hospital (knowing full well that many dermatologists do not get hospital privileges because their practices are limited exclusively to the outpatient setting). These are issues that are continually being addressed by the AAD and the ASDS. It is likely that some form of procedure credentialing will be required by government authorities so that physicians can demonstrate competence. Whether the regulations that are subsequently adopted will in fact achieve this goal is uncertain.

RECERTIFICATION AND MAINTENANCE OF CERTIFICATION

Years ago, passing the certifying examination of the American Board of Dermatology meant that one was "certified" as a specialist in dermatology for his entire career. Beginning in 1990, certificates were no longer valid indefinitely, but were restricted to 10 years, after which the dermatologist would have to take an examination to prove his continued competence. This has been referred to as "recertification" or "maintenance of certification." The usefulness of such an examination has been hotly debated, with many dermatologists believing that no written exami-

nation can fairly measure their ability to care for patients. As a consequence, the ABD has made great efforts to make its examination more practical and a better measure of physician competence. Still, many dermatologists argue vehemently that these examinations have no correlation with their ability to deliver high quality, professional care to patients with diseases of the skin, hair and nails. Although many dermatologists, such as myself, who were certified before 1990 have lifelong certificates, the medical licensing boards of the various states still reserve the ability to require recertification to continue to practice medicine within their borders, and insurance organizations may require recertification to maintain the aforementioned "preferred provider" status to treat their clients. The debate over recertification and maintenance of certification is one of the most controversial issues among dermatologists in the United States and shows no sign of early resolution.

Finally, it should be noted that many of the issues discussed in this paper involve regulation of our specialty by outside organizations, be it private organizations such as health insurance providers or federal or state governments. There is a clear need for dermatologists to assume positions of influence in regulatory bodies to present our case in an unbiased and favorable manner to our colleagues in the medical profession and to the public. □

Corresponding Author:
Bruce H. Thiers,
Medical University of SC
135 Rutledge Avenue; 11th floor
PO Box 250578 Charleston, SC 29425
Phone: 1-843-792-5858
Fax: 1-843-792-9804
E-mail: thiersb@musc.edu