Policy & Practice

Sunscreen Claim Crackdown Urged

The Food and Drug Administration needs to stop sunscreen manufacturers from making "false and misleading" claims about their products, according to a petition filed by the Connecticut Attorney General. "Products with false labels give consumers a false sense of security—screening out UVB rays that cause burning or reddening, but possibly not UVA rays that damage deeper layers of the skin, where they can lead to melanoma and other deadly cancers," said Attorney General Richard Blumenthal in a statement. Mr. Blumenthal said the FDA was supposed to implement rules in 1999 that would have prohibited sunscreen makers from claiming their products "block all harmful rays," or are "waterproof," or have SPF ratings above 30. Also, there is no rating system for UVA rays, but many sunscreen makers advertise UVA protection, Mr. Blumenthal pointed out. While an FDA spokeswoman said the agency cannot comment on the petition, she did say a sunscreen regulation addressing UVA testing and labeling as well as other issues is in final clearance at the agency.

D.C. Tops in Sun Savvy

The nation's capital has been ranked No. 1 in terms of its population's knowledge of sun safety, according to a survey from the American Academy of Dermatology. Nearly half of Washington residents said that people do not look healthier with a tan, 66% knew that a base tan is not a healthy way to protect skin from sun damage, and 68% knew that it is not smarter to tan indoors using a tanning bed. Residents of New York City were the second-most knowledgeable, followed by Miami, Tampa, Los Angeles, Dallas, Salt Lake City, San Francisco, and a three-way tie among Idaho, Atlanta, and Philadelphia. Despite its sunny, warm climate year-round, Miami managed to come in third because 45% of residents there did not get a tan last year, according to the AAD. Attitudes and behaviors varied widely. Overall, a majority of Americans (73%) agreed that people looked more attractive with a tan, 42% said they had sunbathed in the last year, and 65% got a tan last year. But 65% knew that sun exposure during childhood is related to skin cancer in adulthood, and 58% knew that indoor tanning is not smarter. The results were based on an online survey of 3,342 randomly selected men and women in 32 U.S. metropolitan areas and states that was conducted in February.

Ranbaxy Buys BMS Derm Brands

Ranbaxy Laboratories Inc. has purchased 13 dermatology products from Bristol-Myers Squibb: Balnetar, Desquam-E, Desquam-X, Eurax, Exelderm, Halog, Kenalog Spray, Lac-Hydrin, Lowila, Pernox, Sebulex, Ultravate, and Westcort. The products are used for acne, dermatitis, psoriasis, fungal infections, and scabies. Ranbaxy, a subsidiary of the India-based Ranbaxy Laboratories Ltd., has what it calls the largest-selling isotretinoin formulation, Sotret. In a statement, Venkat Krishnan, Ranbaxy's regional director for North America said that the acquisition would help the company build its dermatology franchise, and, "it enables Ranbaxy to establish an immediate presence in the high-value segments of dermatitis, psoriasis, antifungals, and scabies," he said. Ranbaxy will start promoting the products immediately, according to a company spokeswoman.

New FDA Risk Panel

Following an Institute of Medicine recommendation, the Food and Drug Administration has created a new advisory committee that will be charged with helping the agency better communicate the risks and benefits of pharmaceuticals and other products it regulates. In 2006, the IOM's report, The Future of Drug Safety: Promoting and Protecting the Health of the Public, urged Congress to establish a new advisory panel that would weigh in on FDA's communications about safety and efficacy to health care providers and the public. The agency found an administrative process that let it establish the committee without congressional action. FDA is now seeking 15 members to serve on the Risk Communication Advisory Committee, including experts on risk communication, social marketing, health literacy, journalism, bioethics, and cultural competency.

DTC Ads Still Fall Short

Direct-to-consumer (DTC) advertisements emphasize individual drugs over conditions, don't do enough to emphasize risk, and minimize the importance of underlying health issues, according to a panel that reviewed such advertisements for the Pharmaceutical Research and Manufacturers of America. The review was undertaken to determine if consumer-directed marketing is meeting PhRMA's voluntary guiding principles, which were adopted in 2005 to address "many of the concerns publicly expressed about DTC advertising." The four volunteer panelists—a pharmacist, a nurse, and two family physicians—also urged drug makers to include more information in their ads about assistance programs that provide low-cost or free medications. In a separate report, PhRMA said that comments it received from consumers on DTC ads indicated that many were confused about the ads' contents and thought they did not present a balance of risks and benefits. The organization received 458 comments from July to December 2006, mostly from consumers; 10% were from health professionals. The comments go to PhRMA's Office of Accountability, which forwards them for responses from individual drug makers.

—Alicia Ault

Make Your Extender a Dermatologist Clone

BY JANE SALODOF MACNEIL
Senior Editor

PHOENIX — Physician assistants and nurse practitioners should be trained to treat, biopsy, and bill patients as if they were the physicians for whom they work, Dr. Allan Wirtzer said at a clinical dermatology conference sponsored by Medicis.

"Your extender should be your clone," said Dr. Wirtzer, who has a practice in Sherman Oaks, Calif., and endorses the hiring of physician extenders as an alternative to recruiting first-year dermatologists.

Extenders can enable a practice to see more patients and to significantly increase revenues, he said. Patient acceptance is critical, however, and can be undermined if the extender is not consistent with the physician.

As an example, Dr. Wirtzer offered the hypothetical situation in which an extender recommends a course of treatment for a skin condition. For the dermatologist to disagree and suggest changing the plan on a follow-up visit could be worse than embarrassing, he warned: "It is not going to bode well for the patient's confidence in the practice."

Here are more of Dr. Wirtzer's tips on how to incorporate a physician extender into a dermatology practice:

Whom to Hire

A third of dermatologists are seeking associates, he said. Not only is patient demand for services high, but also dermatologists are in short supply. As a result, he contended, some new dermatologists are pricing themselves out of the market with unrealistic expectations of their first-year earnings.

Physician assistants and nurse practitioners are easier to find, according to Dr. Wirtzer. They also can be easier to work with and may contribute more to a practice. He cited a 2002 survey that found the average extender was paid $100,000 annually while revenues increased by $500,000 each year.

He said that he has chosen to hire physician assistants because they "are trained to be physician assistants—exactly what it says" as opposed to nurse practitioners who can work independently and want to expand the number of states in which they can practice without physician supervision. A physician assistant cannot establish a competing practice.

Another consideration, he added, is whether your patients and staff will accept an extender. Be sensitive to the feelings of long-term employees who might see their turf as threatened, he advised. Provide patients with literature describing what a physician assistant does and the professional biography of the person hired.

How to Train

In 2004, 38% of physician assistants had less than 2 years' experience and 23% had more than 6 years, according to unpublished data cited by Dr. Wirtzer. Education levels ranged from an associate's degree (16%) to a bachelor's degree (41%) to a master's degree (43%). He said he prefers to hire an extender who has just completed schooling rather than risk hiring an experienced extender introducing incompatible treatment approaches from another practice.

Most training is by direct observation and proctoring, he said. He recommended that the new extender follow the physician for 3-6 months. The person also might attend courses or use continuing medical education materials. If the extender is experienced, the training period could be shorter, Dr. Wirtzer said, but oversight should be greater to ensure compatible approaches to treatment.

Training should include coding and office management, he added, again to ensure consistency when dealing with patients. He advocated developing clear treatment plans for common conditions, policies on when biopsies are appropriate, and fee schedules.

Rules to Know

Dr. Wirtzer noted that state regulations vary on how many extenders can be supervised by one physician and whether the physician must be in the office or available by phone when the extender sees a patient. Medicaid covers physician assistants and nurse practitioners, he added, but policies vary and there are no set rules for private insurers.

Medicare has strict requirements on "incident to billing," he continued. It requires that the physician examine the patient on the first visit for a particular condition. The physician assistant can provide subsequent care as long as a physician is in the office.

If these criteria are met, services provided by a physician assistant or nurse practitioner can be billed at 100% under the physician's name, according to Dr. Wirtzer.

If the physician is not on site or the physician assistant treats a new Medicare patient or a Medicare patient with a new problem, then only 85% can be billed and it must be done under the physician assistant's name. Defining a new condition can be "a gray area," he warned, suggesting a check with the local Medicare carrier.

Smart Practices

Design a contract that covers the initial mentoring period, starting salary, and bonus arrangement, Dr. Wirtzer advised. He suggested putting a dollar value on training and including a noncompete clause in case the person leaves the practice. "Don't be cheap," he said, warning that inadequate compensation can lead to loss of valuable staff members.

Consider paying for employee practices insurance, he added. It covers the practice against lawsuits by employees.

These are not covered by malpractice or office overhead insurance, and can be expensive to fight even when the practice is in the right. ■