Under My Skin

But Enough About You

A recent news headline read: "Study Says Chatty Doctors Forget Patients."

"How are we today, Mr. Troldhaugen?"

"Well, doctor, I have this itch. You know, down below."

BY ALAN ROCKOFF, M.D.

"Oh, don't I know it! I've been fighting that for years. Itch can drive you crazy. It's embarrassing too. I mean scratching in public is always awkward, but when you're a dermatologist … What have you been doing for it?"

"I have this fungus cream the druggist gave me."

"That figures. Fungus is usually the first thing everybody thinks of. I guess it could be a fungus, but if treating that does not work you have to think of other conditions. I had the same experience last time I tried to treat myself. I have all these samples, so I tried one. It was hard to remember to put it on twice a day—made me more sympathetic when my patients don't always follow instructions exactly the way I give them. Anyhow, after a while it got pretty obvious that I was going to need something different, so I took a different sample and sure enough that did the trick."

"Maybe you can prescribe that for me."

"It's interesting how common these symptoms are. People often come over to me outside the office to ask pretty much the same questions, about itch and rashes and so forth. Of course, I can't exactly examine them there in the street, but I can get a pretty good idea of what they have and what they need. After all, I've had the same symptoms myself."

"So, doctor, what would you recommend?"

"And sometimes I've tried to share my experiences when I've had the same things as my patients do, just to show them that their situation isn't as strange or as frustrating as they might have thought. Take my wart, for instance …"

"But I don't have a wart."

"I had a wart on my left thumb. Now that's interesting right there, because I'm right-handed. People always assume that warts are a virus so they must be contagious, but if they were—and I certainly shake hands with a lot of wart patients every day—why would they spread to my left thumb? But in any case it took me 4 years to get rid of mine, even though I have liquid nitrogen so I can freeze myself anytime I want, and I did too. So I used to tell that to people with resistant warts, so they wouldn't feel quite so frustrated."

"Doctor …"

"And you know what? I found that people really didn't want to know about my problems, whether they were the same kind as they had or not. In fact, patients weren't all that interested in what was going on with me in general. Of course, there are some people who've been seeing me for almost 30 years, who are old friends by now. They know the names of my grandchildren and ask after them, that sort of thing. But most other patients don't really want to know what I've been up to, where I'm going on vacation, or what staffing and administrative hassles I'm dealing with. Which kind of seems right, when you consider that they've come not to find out what's wrong with me, but what's wrong with them. Doesn't that make sense?"

"Yes, but …"

"And then I read in the paper that they did this study in Rochester, with hidden mikes or something, and they found out that doctors were gabbing about their own weight problems and exercise programs, apparently with the thought that this would produce greater rapport. Instead, when the doctors heard tapes of what they said, they realized that maybe not 100% of the time, but most of the time talking about themselves had more to do with the doctors than with the patients. Can you believe that?"

"To tell the truth, I can."

"It's amazing how people can see faults in other people but not notice it in themselves. Isn't that right, Mr. Trondheim?"

"Troldhaugen."

"Right. Well, it's been nice chatting with you. Did I give you the prescription?" ■

Dr. Rockoff *practices dermatology in Brookline, Mass. To respond to this column, write Dr. Rockoff at our editorial offices or e-mail him at sknews@elsevier.com.*

Guest Editorial

Training Program Changes Could Splinter Dermatology

The process of credentialing has taken on new gravity in modern times. Credentialing confirms our years of training, which sets us apart from others. However, it also has the potential to divide us into those dermatologists who are allowed to do procedures and those who are not.

This recent division is based on the opinions and motives of a select few and is being carried out with neither the consent nor full knowledge of the dermatology community as a whole.

BY PAUL A. STORRS, M.D.

To date, our credentials have allowed us to speak as a unified body offering relief from these challenges.

But over the last several years, a movement has developed attempting to separate dermatology into two groups: general dermatology and procedural dermatology.

This separation would splinter both dermatology and the American Academy of Dermatology and impede our ability to speak as one voice in a sea of challenges. Dermatology residency training has always included both general and procedural dermatology.

Concerns regarding dermatologic subspecialty accreditation/certification (procedural dermatology) have been voiced repeatedly in recent years. The response of policy makers has always been that changes are designed to enhance training and to not have any adverse impact on practicing dermatologists. Recent events, however, have not borne this out.

The Resident Review Committee (RRC) has recently cited several dermatology residency programs for not having a director of surgery meeting the new requirement, which states the surgical director must have "advanced surgical training."

In my case, I have been a full-time academic dermatologist and dermatologic surgeon for 10 years, during which time I have served as director of dermatologic surgery for the University of Illinois at Chicago. Over that 10-year span, the program underwent three RRC reviews in which there were no questions raised regarding my credentials as director of surgery. My credentials include Diplomat of the American Board of Dermatology, Fellow of the American Society for Mohs Surgery, and Fellow of the American Academy of Dermatology. In addition, I have had 3.5 years of formal surgical residency training, including 1 year of general surgery training and 1 year of plastic surgery training.

When the executive director of the RRC was asked to clarify "advanced surgical training," he wrote that "only a dermatologic surgeon with 12 months' fellowship would be acceptable with only rare exceptions." He further responded that formal surgical training in any other specialty such as general surgery or plastic surgery would not qualify as advanced surgical training.

Acting on this information, the university removed me as surgical director and replaced me with a recently fellowship-trained physician who is in private practice and works part-time 1 day a week in our department. I would point out that this situation falls under RRC training requirements in effect prior to July 7, 2007. New requirements that went into effect after that date are even more restrictive in this matter. They specify 12 months of fellowship training and eliminate the term "advanced surgical training."

I am not conveying my personal experience as a criticism of the RRC. However, I think it lays a new foundation in the direction of dermatologic training. This entire process seems to be a major step in the effort of some to split dermatology into medical dermatology and procedural dermatology.

Last September at the Academic Dermatologic Surgeons meeting in Chicago, several attendees spoke of a plan to make procedural fellowships board certified. One speaker said that general dermatologists should be limited to only simple procedures such as biopsies and excision of nevi and that general dermatologists and residents should not be doing flaps and grafts. A show of hands from the audience indicated that approximately 80% agreed. Another speaker indicated procedural training for residents should only be in pigs' feet sessions and actual patient procedures reserved for fellows.This represents a clear attempt to make procedural dermatology an area of specialization distinct and separate from general dermatology.

Here are the possible ramifications of such a move:

► Third-party payers may refuse reimbursement to non–fellowship-trained dermatologists, including non-Mohs treatment of skin cancer.

► We can expect to see more dermatologic physicians advertising their "superior skills" in various dermatologic procedures over other dermatologists. This has happened several times in the past, but such dermatologists have previously recanted when challenged by other professional organizations such as the American Society for Dermatologic Surgery.

► Fellowship-trained Mohs surgeons may be required to send patients to plastic surgeons or ENT specialists for closures. Far-fetched? Recent attempts by third-party payers to restrict care via credentialing are a growing trend.

► A more formal separation of general dermatology from procedural dermatology could also impact medicolegal actions. Any dermatologist who routinely performs procedures, including cosmetic procedures, should expect to face questions regarding his or her qualifications based on RRC recommendations and American Board of Dermatology certification.

Dermatology training should be broad based from both academic and clinical perspectives. The AAD and all dermatologists need to be aware of these profound changes in dermatology training, how such training impacts the scope of the profession as a whole, and how each of us will be adversely affected in our ability to care for the patients entrusted to us. ■

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