Dermatology in the Cross Hairs of Private Equity and Greed

A critical assessment of the state of dermatology, after a *New York Times* expose.

BY JOEL SCHLESSINGER, MD

The recent *New York Times* piece on skin cancer, entitled, "Skin cancers rise, along with questionable treatments" (November 20, 2017) provided a much needed but difficult view into dermatology as it is now being practiced in the corporate-medicine version. Sadly, it isn't pretty and doesn't have very good optics when put under the lens.

There have been several responses to this article by organizations ranging from the American Academy of Dermatology (AAD) to the American Society for Dermatologic Surgery (ASDS), and the Society of Dermatology Physician Assistants (SDPA), but the common theme among them has been that of denial, which won't help or improve the wrongs that the *Times* article addresses, most of which are perceptive and reasonable.

Let me preface this by stating that every dermatologist, including me, lives in a glass house. The same article, with some differentiating points, could have been written about my practice had the author been so inclined: I have employed PAs for more than 20 years, and I perform Mohs surgery and biopsy many lesions every day (though certainly not in the manner described in the *New York Times* piece). Therefore, given the opportunity, a negative commentary could probably be generated from many interactions in my practice. The challenge lies in delineating right and wrong from our respective glass houses. No one wants to be the one to call out a fellow colleague as "beyond the pale." That isn't helped in the least by our societies' relative silence or deflection.

Additionally, I should make clear that the vast majority of PAs seem to adhere to the team approach of care advocated by the SDPA, and that is a tremendous asset to responsible dermatologists and their patients. This has been my experience: Regardless of the extent of their experience and training, the majority of dermatology PAs seem eager to learn from their supervising physicians so that they can indeed extend the quality and style of care that the physician provides, rather than operate independently alongside the physician. On the other hand, there are some who never achieve the requisite training or who train in questionable environments and then go on to perpetuate that for their entire career. It goes without saying that there are dermatologists who have the same exact issues (this article highlighted questionable practices that were clearly top-down).

Many questionable practices are reported in the *Times* article including:

1. One of the practices in the article is run by a dermatologist who practices in three states at one time (and signed a chart of a patient he had never seen), overseeing four PAs in just the one state. This is a recipe for disaster, leading to missed melanomas as documented, and the style of practice that invited exposure in the first place.
2. The PA in the article biopsied 10 areas at one time. Clearly, this is unusual, but it appears to be common in this practice. Given the chances for mislabeling and misidentification of the biopsy areas, this practice should be abandoned in most, if not all, circumstances.
3. Several of the biopsied areas were to be treated with radiation, presumably without benefit of ever having seen a dermatologist. While radiation may be useful for some skin cancers, corporations who provide the resources to turn a dermatologist's office into a bona fide radiation center regularly tout its use as a profit enhancement tool to upcharge a simple skin cancer from $200 to over $2,000. Radiation's utility in this practice appears to be more of a profit motive for

unscrupulous physicians than a serious modality.

4. It is unclear whether the PAs ever explained that they were not dermatologists to the patients in question. This is an ongoing and serious issue with practices that essentially abdicate the role of the dermatologist to a bevy of extenders and threatens to harm the integrity of our relationship with patients and the trust when seen by a "dermatologist."
5. The PAs who examined the patient in question missed a melanoma, despite performing four skin exams over four months. Surely any one of us could miss a lesion, but missing a lesion over multiple, closely-spaced exams is a cause for concern. This same lack of clinical acumen makes it more concerning that these same patients never saw a dermatologist prior to being referred for Mohs.

As AAD past-president Brett Coldiron says in the *Times* article, "Ads will say 'See our dermatology providers.' But what's really going on is these practices, with all this private equity money behind them, hire a bunch of PAs and nurses and stick them out in clinics on their own. And they're acting like doctors."

In the same article, current AAD president Henry Lim states, "The AAD believes the optimum degree of dermatologic care is delivered when a board-certified physician dermatologist provides direct, on-site supervision to all non-dermatologist personnel."

Why aren't we, as a specialty, working to make sure this is the case? Why are the mega-corporations allowed to purchase and barter dermatology practices like so many bushels of corn and then install what may be questionably trained and poorly supervised PAs and NPs in these same practices with the main goal being profit, rather than patient wellness? To me, these are the most important questions, and neither of them has been adequately addressed by our dermatology governing bodies, perhaps because it is a difficult and uncomfortable subject to discuss.

Some things are clear. As much as the SDPA will deny it, articles like the one in question prove that there are PAs and NPs who are acting as dermatologists with inadequate supervision (essentially none in this case). Just because a PA is working in dermatology does not mean that that PA is a member of or adhering to the principles of the SDPA. Like the dermatologists and corporations in the article, they are currently the outliers—but I fear these groups are quickly becoming the norm. If the SDPA, and indeed dermatology governing bodies, do not continuously emphasize the team approach to care, then more and more PAs and NPs will seek additional autonomy with less oversight. Eventually, this will boomerang on the entire specialty. It may have already happened with the publication of this article.

This cries out for a statement from the AAD. These practitioners must be denounced and reoriented to the concept of dermatology as it should be practiced. They, as well as the large corporations that have invaded our specialty, have lost their way and won't be brought back without rules, guidelines, and a thorough analysis of what we need to do to make this right. Our field must develop definitive practice guidelines through serious introspective evaluation of where we are as a specialty and where we want to go. Without clear standards, the corporations who now own a significant portion of dermatology practices won't ever stop diluting our standard of care. To summarize Jack Resneck's timely *JAMA Dermatology* editorial[1], the rapid growth of investor-owned dermatology conglomerates is not only legally problematic, but it risks the loss of our (and our patients') autonomy, devaluation of our expertise, and existential commoditization of our art.

I employ two PAs in my practice whom I trust and respect. I would not employ them if I did not and I am sure that other dermatologists feel the same way about their PAs and NPs. Still, more than 95 percent of all patient visits are with me. My ideal PA, in keeping with the standards of the SDPA and the generally accepted norms of dermatology practice, acts as an extender/assistant (rather than a fully-practicing and independent practitioner) who organizes patient needs and serves as another pair of eyes before I enter the room and after I leave. Many would say (#glass-houses) that this is not their idea of perfect, but it is what works best in my practice to maximize efficiency while still ensuring the patients actually see a board-certified dermatologist when they visit a dermatology practice. My point here is that most PAs and NPs are well-educated, talented, and able clinicians who can be used to increase efficiency and profitability while remaining ethical and enhancing, rather than worsening, the patient experience. As stated before, there are also dermatologists who could learn from a well-trained and ethical PA or NP. In short, it should be a partnership with ongoing interaction.

Again, this editorial is not meant to say that my way is the only way to practice—there are numerous ways to practice dermatology effectively—but it is meant to start a specialty-wide debate. And lest we forget, there are many other specialties (i.e., plastic surgery, infectious disease, orthopedics, etc.) with the same exact problem as we have! We have a proud history as a specialty and an enviable status (for the most part) when it comes to public perception. Therefore, we have more to lose than other specialties if a visit to a dermatologist becomes a cringe-worthy experience as it was in the *New York Times* article. It is time to mend our house. ■

1. Resneck JS. Dermatology Practice Consolidation Fueled by Private Equity Investment: Potential Consequences for the Specialty and Patients. JAMA Dermatol. Published online November 21, 2017. doi:10.1001/jamadermatol.2017.5558