

## SPECIAL REPORT: INSIDER LOOK AT ACADEMY LOBBYING

**Dermatologists advocate for their interests in D.C.**

On September 20, 2007, American Academy of Dermatology members met to advocate for the interests of their specialty on Capitol Hill as part of the Academy's 2007 Washington Conference. Included in that contingent were a number of young physicians eager to become involved in the regular lobbying efforts of the Academy. As experienced member physicians retire or cut back on regular travel, this new generation of dermatologists represents the future of the Academy's efforts to influence policy makers — not only on a national level — but on state and local levels, as well. Issues facing young dermatologists are important and they are significantly affected by members of Congress.

And while some misperceptions about lobbying persist, it has become an essential part of the American political system, and has a long and rich history. One popular (if ill-supported) legend holds that the practice began during the presidency of Ulysses S. Grant. The president was forbidden from smoking in the White House by his wife, and as a result enjoyed his cigars with a glass of brandy in the lobby of the nearby Willard Hotel. Fellow lawmakers and favor seekers began to approach him during this time, and a new industry was born — at least, allegedly. No matter the origins of the term, it's undeniable that direct appeals to legislative leaders have become an effective way to espouse the views and protect the interests of an organization.

Today, the practice is undertaken by any number of organizations, but the healthcare industry spends the second largest amount of money

annually — over \$2.2 billion dollars per annum, according to OpenSecrets.org. With so many organizations vying for both time and money, the general perception of lobbying is one of secret meetings and clandestine agreements. In reality, Academy physicians have seen great success meeting with representatives and stating the facts clearly and honestly, and most say that their representative or senator proved approachable and down to earth. Getting involved in federal advocacy often means letting go of more than a couple of preconceived notions.

"As a fan of The West Wing when it was on television, I had some vision of the Senate office buildings and erudite, witty staff members supporting movie star-like congressmen," said Jeffrey Benabio, M.D., who recently became involved with Academy lobbying efforts. "It turns out the office buildings are not as glamorous as they are portrayed on television, the congressmen are much more down-to-earth than they might seem, and the staff members are a lot younger than I expected. Still, the whole experience is not unlike meeting your favorite football player or movie star, except in some instances, the congressman actually sits down and talks with you." Another unfortunate result of the lobbying boom of recent decades is that a general attitude has developed of lobbying as a full-time job, or an extremely labor-intensive effort. Instead, Academy members arrived in Washington on the 19th, and were given a quick primer on the four main issues that they

would be lobbying about during the following day (see sidebar p.3). Further, lobbying expert Christopher Kush of Soapbox Consulting coached the dermatologists in attendance to pick a single issue or pair of issues and focus on highlighting the most salient points in a concise and simplified manner.

One of the most important points for the physicians to learn was that medical knowledge doesn't necessarily translate to lobbying prowess, and a new skill set is required.

"The organizers conducted issue briefings that were clear, concise, and convincing. I used much of the data provided to present a cogent argument to the elected officials on Capitol Hill," Dr. Benabio said.

The majority of physicians who decide to become advocates for their specialty do so with the assistance and encouragement of mentors encountered during the formative medical school or residency years. Often, an off the cuff suggestion of gentle push toward becoming involved with one pursuit or another — be it academia, research, or advocacy — can profoundly in-

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fluence a young doctor's career. Dr. Benabio traces his current passion for advocacy back to his days at Brown University working with a physician who was similarly passionate in his pursuit of results on the Hill.

Dr. Benabio worked with David Lewis, M.D., who is a physician in addiction medicine. "At the time," Dr. Benabio said, "he was working to change the widespread perception that addiction was a social and law enforcement problem rather than a medical problem. I saw him present before Congress, write editorials in national newspapers, and even work with [well-known journalist] Bill Moyers. His charisma, work ethic, and confidence made an impression on me that continues to define who I am today."

With his involvement in the April 2007 Skin Disease Research Day, Dr. Benabio's first foray into Academy advocacy, he found the experience of lobbying to contain an entirely new set of challenges and rewards.

"At the time, Congressman Dana Rohrabacher was my representative. He took the time to meet with me personally and engaged me in a twenty minute long discussion about funding for research, balancing the budget, and working in Congress," he said. "It was at once intimidating and inspiring. I was honored by his genuine interest in me and the cause I was advocating. When I left his office, I was already thinking about how I would approach him if I had the opportunity to meet with him again."

Despite his brief experience lobbying with the Academy, Dr. Benabio has already amassed a cache of communication skills and lobbying tactics — not the least of which is to learn how to put a positive spin on any situation.

"I was scheduled to meet with Congresswoman Davis in person. She regretfully was unable to keep that appointment ... I saw the congresswoman walking by accompanied by a highly decorated military officer," he said. "Apparently I had been bumped for a ranking member of the military — at least he wasn't a plastic surgeon."

Academy members departed the 2007 Washington Conference having gained valuable lob-

bying experience, attended a dinner with Sen. Ron Wyden (D-OR), and been given the opportunity to meet and network with a diverse

cross-section of colleagues from across the nation. As with any

lobbying effort, there were gains made and setbacks weathered, but without exception, each dermatologist took something positive away from the experience.

"Learning lobbying is not unlike learning dermatology. You start off as a first year and struggle just to get the basics," Dr. Benabio said. "But over time you begin to understand the big picture and to know the small details. The better you know the subject, the more effective you will be as a lobbyist. I hope to continue to grow and learn with each visit." ●

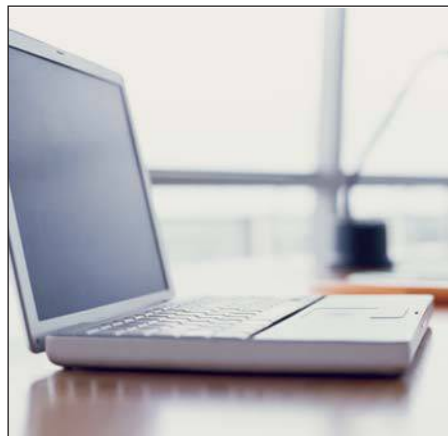
## 2007 WASHINGTON CONFERENCE ISSUES

Dermatologists from across the United States gathered in Washington, D.C., Sept. 19-20 to ask lawmakers to support the following:

- Taking action to forestall deep cuts in Medicare Physician Pay for 2008 resulting from the much criticized sustainable growth rate (SGR) formula used by the Centers for Medicare and Medicaid Services (CMS). Practice costs are projected to rise 20 percent during that time. Academy members were asked to encourage their representatives to halt the cuts and work toward positive changes to the program.
- Retaining the exemption from the Medicare multiple surgery reduction rule for Mohs surgery.
- Lifting the 1996 residency cap by supporting the bipartisan Residency Physician Shortage Reduction Act of 2007, which would incrementally increase the residency training cap.

## FIRST EVER ELECTRONIC HEALTH RECORD VENDOR DEMONSTRATION

Is your dermatology practice considering implementing or upgrading an electronic health record (EHR) software system? Do you wish you could get a preview of some products commonly used by dermatology practices? If so, plan to attend the first ever "Dermatology EHR Demonstration Challenge." The event will be held on Saturday, Feb. 2, from 5:30 - 8 p.m. at the Marriott Rivercenter,



Rooms 1 and 2. A number of EHR vendors have been invited to demonstrate their product functionalities and benchmark them against simulations of typical dermatology clinical patient encounters. The Demonstration Challenge is free to all attendees on a first-come, first-serve basis, up to the maximum capacity of the room. Space is limited, but there is no need to RSVP or register to attend. Please note that this event will not be available for either AMA PRA Category 1 Credits or AAD Category 1 Recognition Credits.

The demonstration session will offer dermatologists the opportunity to learn more about the functional aspects of EHR systems and how these systems compare in terms of performance from a dermatologic practice standpoint. The demonstration challenge will provide dermatologists a chance to familiarize themselves with EHR software packages using realistic and simultaneous real-time mock patient charting and docu-

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## INTERNET ACCESS IN THE OFFICE CAN BE A DOUBLE-EDGED SWORD

Granted, the last time I looked at the Bill of Rights was a long, long time ago in U.S. History 101, but I don't seem to recall the inalienable right to surf the Internet. Some of your own office employees, however, may beg to differ. Internet access is so pervasive in our culture that it's hard to imagine not being able to send an e-mail, check a credit card statement, Instant Message (IM) a friend, send a SMS/text to a cell phone, or look at the local weather forecast whenever the spirit moves us. Unfortunately, in the office environment, this can quickly get out of hand, cut into office efficiency, and take a toll on production, with hundreds of lost hours spent on non-work related, clandestine Internet surfing.

In the same vein as Asboe-Hansen and Auspitz's signs, I submit for approval into the dermatology lexicon, the "minimize me" sign. This is pathogenomic for "slack staff disease" and occurs when you unexpectedly walk by the computer workstation of one of your staff and they quickly click the mouse to minimize whatever browser window they are currently using to surf, confident that you are none the wiser. In the advanced version of this disease, they have memorized the Windows-key-M keystroke and can do it without touching the mouse! Internet surfing is not an empirically bad thing and we shouldn't penalize the motivated employee who wants to, for instance, use Google or the Academy's "Find a Dermatologist" Web site to locate a referring physician's mailing address or check the online PDR for drug interactions. For those in private practice or in non-academic group practices without an information technology (IT) expert on staff, where do you turn for help? In this issue, I offer strategies to combat the war on inappropriate Internet surfing in the workplace.

### Establishing a Connection

These days, Medicare and many third-party insurers require electronic claims submission, so having a connection to the Internet in the office is practically a necessity. Although connection to the Internet

can be done via a dial-up connection with a modem, this often requires a dedicated phone line. Connecting to the Internet via your office local area network (LAN) can be more reliable and is usually more cost effective. If you don't have an Internet connection in the office yet, the first step is to choose an Internet Service Provider (ISP). ISPs connect your office to cyberspace in a manner very similar to setting it up a home connection; with the distinction that it is typically a business account and your ISP must be scalable to serve the bandwidth needs of your entire office, and not just you. An ISP can also provide e-mail accounts for your staff, designate remote server space for Web hosting, utilize voice over IP (VOIP) for Internet telephone use, and other useful functions.

### Limiting Access

But whether you get a DSL service, cable modem, or fractional/full T1 connection, the ISP installation process is your first chance to regulate unauthorized Internet access in your office. It starts with the network hardware that your ISP will use or has already installed in your office to distribute Internet access in your office computer network.

Your ISP may also install a router that serves as a gateway for all the Internet traffic coming from and going to your office. Depending on the style and cost of the router, it can function in both wired and wireless mode, so even laptops and tablets being carried around the office will have Internet/network access. My suggestion is to assess your needs and then inquire and consider some of the higher-end routers provided by ISPs, which can be configured with many powerful features, such as blocking all outgoing/incoming Internet traffic that is going to selected Web sites (domains) or funneling through certain virtual channels, called "ports." For example, any requests made from browsers to connect to Internet

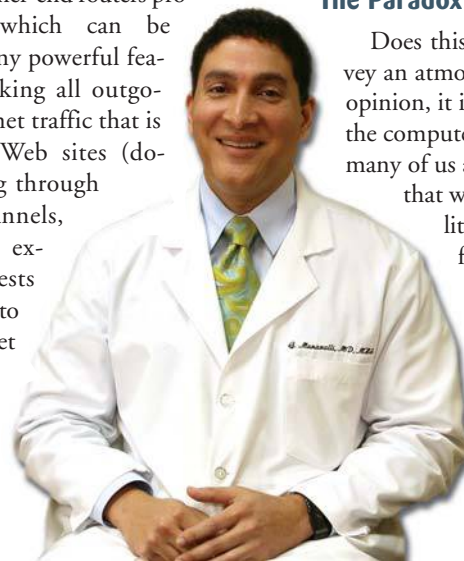
sites like facebook.com, myspace.com or hotmail.com can be transparently blocked at the level of the router. Likewise, messages sent from Yahoo or AOL Instant messaging through standard ports can be blocked. Conversely, you can simply configure the router to allow access to certain Web sites, like your practice Web site, the Academy's Web site, pdr.net, emedicine.com, your ISP Web mail site, or yahoo.com and block everything else. It is important to check with your ISP to verify the type of router present or being installed, and check that it can be configured by you or someone you designate. Configuration can get somewhat complex, so get help from your ISP service provider or an IT professional if you don't understand how routers work. Thankfully, ISP business plans tend to provide somewhat better technical support than home ISPs.

There are other software programs which are designed to block unauthorized Internet access. In fact, some of the same software applications that are used for parental control in the home, like Netnanny, and other similar applications can be configured to block access at the level of each individual computer workstation. Other applications, such as Network Magic can be used to map, configure, and monitor your network in an easy-to-understand fashion. It can even auto-e-mail you every evening with a daily report on your Internet traffic so you can see if anything strange is going on! Do some online research for other Internet-restricting applications or ask your IT consultant, nerdy siblings or technophile friends. It will be well worth your time.

### The Paradox of Trust

Does this type of monitoring convey an atmosphere of mistrust? In my opinion, it is an unfortunate reality of the computer age. The paradox facing many of us and our office managers is that we want to hire computer literate medical and front office staff so that inevitable transition to Electronic

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Healthcare Records (EHR) will happen smoothly, but it is this same computer literacy that will empower your staff to abuse the system.

As with all of life, you have to balance the good with the bad and ultimately you must decide what sort of Internet access you want to allow for your employees. A reasonable approach in any scenario, however, would be to clearly outline in your employee handbook that “non-work related Internet surfing will not be tolerated.” Furthermore, outline disciplinary measures that will take place if the rules are violated. Don’t forget to gently remind staff that legally, they have no recourse or right to privacy for any computer work that is done during work hours using your office computers. Any e-mail, Word documents, or digital images present on office computers are subject to review at any time. Give it time and see if these rules sink in. If not, consider the above options. You might also consider setting up a single dedicated workstation (protected with up-to-date anti-virus and anti-spyware software) in a common area that staff can use during lunchtime and breaks to surf, send e-mail, and conduct personal business.

I’ll conclude with a story from the annals of my own office years ago. One day, I heard many of my employees complaining that the network was unusually slow and they had problems accessing the Internet, printing to network printers, and submitting electronic claims. Before calling the ISP, I suspected that something was soaking up all the bandwidth, and I proceeded to check all the workstations in the office. Ultimately, I found that an employee had set up a bittorrent (type of file-sharing) client on an office computer and was downloading two applications, five divx-encoded movies, and three FLAC-encoded music files. In addition to opening the office network up to potential infection by numerous malicious virii, infringing on several copyright laws and potentially incurring the wrath of the Recording Industry of America (RIAA), and all from *my* office, the employee was also slowing down the productivity of many others. To throw insult upon injury, his choice in music was Yanni. How lame is *that*? But seriously -- I realized that besides the inevitable disciplinary action, something had to be done to prevent this from occurring in the future. That’s when I started investigating software options and imposing clear rules in the employee handbook. All in a day’s work for a young dermatologist! ○

## SURGICAL COMPLICATIONS: THE TERRIBLE TETRAD

by Ali Hendi, M.D., F.A.A.D.



Although rare, complications are a part of practicing dermatologic surgery. As statistics would dictate, the more surgical cases you perform in your practice, the more likely you are to run into complications. There are four interrelated complications which account for the bulk of the complications in surgery. These four complications, referred to as the “terrible tetrad,” are bleeding, infection, dehiscence and necrosis.

Bleeding can be the most serious complication of the “terrible tetrad.” Bleeding as a complication can be attributed to inadequate intra-operative hemostasis, coagulopathy, poor pressure dressing, and exertion by patient or manipulation of surgical site. Hematomas can be divided into acute/ expanding and stable hematomas. An acute hematoma occurs within hours after surgery and is a true surgical emergency. Patients often complain of throbbing pain, and evaluation of the surgical site reveals significant bruising and swelling of the surgical site. The treatment of an acute or expanding hematoma is to open the wound, visualize the source of the bleeding and obtain he-

mostasis either by suture ligation of the bleeding vessel or electrocautery. In cases where there is diffuse and continuous bleeding uncontrollable by the above modalities, application of hemostatic agents — such as absorbable gelatin powder or micro fibrillar collagen powder, or similar products — may be helpful.

Stable hematomas usually present days after surgery. These are hematomas where the post operative bleeding stops spontaneously. Such hematomas undergo an evolution from amorphous, to organized and firm, and finally to a liquefied hematoma that has dissolved. Most stable hematomas can be treated conservatively by observation. Aspiration of a stable hematoma in the amorphous or liquefied state is another option. Patients with either type of hematomas should also be treated with antibiotics as the devitalized, extra-vascular blood under skin can be a nidus for an infection. Surgical techniques that minimize the incidence of hematoma formation include meticulous pinpoint cautery, suture ligation of “pumpers,” and elimination of dead space.



**Stable hematoma on the cheek one week after surgery (above).**

**Complete spontaneous resolution of stable hematoma within 6 weeks (below).**



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The rate of infections in dermatologic surgery is reported to be approximately 2-3 percent. A post-operative infection is seen 5 to 7 days after surgery and should be associated with *increasing* redness, pain, swelling, and warmth. Drainage and fever may also be present. The causes of post operative infection can be divided into technique-related or patient-related factors. Technique-related factors include inadequate surgical prep/contamination, traumatic tissue handling (i.e. with forceps), excess cautery, excess tension, and presence of dead space which can lead to hematoma formation. Patient-related factors include: inadequate post-operative wound care and colonization by higher than normal number of normal skin flora (Staph aureus) or other pathogenic bacteria (i.e., MRSA). Patients with psoriasis, eczema, seborrheic dermatitis, or dry/scaly skin are often colonized by a higher than normal number of skin flora. Petroleum ether or rubbing alcohol can be used to remove the dead corneocytes around the surgical site. *All* wound infections should be cultured and treated with antibiotics which can later be adjusted, based on the sensitivity



**Allergic contact dermatitis may mimic a wound infection.**

results. Minor/nonfluctuant wound infections do not need to be opened, whereas major/formal fluctuant wound infections should be partially opened to allow for drainage of the pus. The resulting open wound is then allowed to heal by second intention.

There are conditions that may mimic wound infections. The first step of wound healing, the inflammatory phase, is associated with erythema, minor swelling, and warmth and should not be confused with an infection. Contact dermatitis at the surgical site may be associated with redness, swelling, and drainage similar to an infection. However, contact dermatitis is not associated with increasing pain, and often accompanied by itching.

Dehiscence is the separation of sutured wound edges. Technique-related causes include excess tension/inadequate undermining, inadequate suture selection, and early suture removal. Patient-related causes include early post-op exertion or traumatization of the wound. Yet, the most common causes of

dehiscence include infection, necrosis, and hematoma, the other members of the "terrible tetrad." Early and large wound dehiscence (i.e., post op day 1-2) can be re-sutured under sterile conditions. Small/superficial or late wound dehiscence can be allowed to heal by second intention.

Post op wound necrosis can be divided into superficial and full thickness. Superficial/epidermal necrosis or sloughing is frequently seen in skin grafts. Full thickness necrosis can occur at the edge of a closure under tension, at the distal tip of a flap, or in a thick skin graft on a poorly vascularized wound bed. As with the other complications, the causes of necrosis can be divided into technique-related causes and patient-related causes. The technique-related causes of necrosis include poor flap design, excess tension on wound margins (due to improper/inadequate undermining or suturing the wound edges too tightly). Of course the other three complications of the terrible tetrad can also be the cause of necrosis. Patient-related causes of necrosis include smoking, location (such as the legs), arterial disease, and history of radiation. Smokers have a significantly higher risk of necrosis. Allowing patients to switch from smoking cigarettes to using nicotine patches in the post op period may not do enough to decrease the

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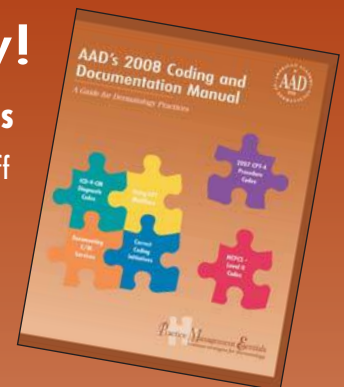
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#### General Information

##### Location

Marriott Rivercenter  
Salon E&F  
101 Bowie  
San Antonio, TX 78205

**Date** Friday, February 1, 2008

**Time** 5:00pm – 7:00pm



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likelihood of necrosis. This is because nicotine itself is a vasoconstrictor. Post-operative wound necrosis can be managed conservatively with daily moist dressings. Debridement is not recommended as it will likely remove more than just devitalized tissue.

When it comes to complications, prevention is the key. Good surgical technique will minimize the likelihood of most surgical complications. Yet despite good surgical technique, we all have our run-ins with the "terrible tetrad." When this happens, knowledge of these complications and their management allows us to stay calm, manage the complication, and reassure our patients. Remember, our caring and compassionate demeanor is invaluable to patients when dealing with post-op complications. In the next issue, we'll cover the surgical complications beyond the "terrible tetrad."

*Dr. Hendi is an assistant professor of dermatology at the Mayo Clinic in Jacksonville, Fla. ●*

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mentation scenarios. Following this informational session, attendees will be able to:

- Understand and analyze practice-specific needs by viewing real-world demonstration scenarios.
- Make an informed decision on how to evaluate EHR software product options for the dermatology practice.
- Determine how to assess options and product performance when choosing an EHR system for the dermatology practice.

Based on your personal evaluation of these presentations, you can decide whether to include these vendors on your short list of candidates for your practice. Time permitting, audience members may pose additional treatment options based on the scenarios presented and ask questions of the vendor. All audience members will be asked to score each vendor's presentation.

*The "Dermatology EHR Demonstration Challenge" is designed to provide dermatologists with more transparent and comparative information about EHR software systems, including costs, functionality, and usability. It is intended strictly as an informational session. The EHR software vendors and products in no way represent an endorsement and/or recommendation by either the Academy or its representatives. ●*



**66th ANNUAL MEETING**  
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## YOU'RE INVITED – SHARE THE EXPERIENCE OF MENTORING

In conjunction with the Intersociety Liaison Committee the Academy is co-sponsoring a mentoring event during the Academy's 66th Annual Meeting, including a panel discussion and interactive session on "Sharing Mentoring Experiences" will take place Friday Feb. 1, from 7:30 a.m. to 9:00 a.m. at the Marriott Rivercenter in San Antonio. The event is designed for dermatologists to network with potential mentors and discuss thoughts and experiences with colleagues. Attendance is highly encouraged for all physicians, and registration for this event is free, but space is limited, so act now. Sign up at <http://www.aad.org/forms/mentorbreakfast/> by Jan. 18. ●

## EXPLORE VOLUNTEERING OPPORTUNITIES

Before the 66th Annual Meeting "officially" begins, there are several noteworthy events that take place on Thursday, Jan. 31. The daylong Volunteers Abroad Course on Wednesday has been split into two sections — a Beginner Course from 8 a.m. to 1 p.m. and an Advanced course from 12 p.m. to 5 p.m. The beginner session will detail the needs and roles in international outreach and teaching for dermatologists, while the advanced section will include topics for more experienced volunteers, such as working in disaster areas or in humanitarian relief efforts. Each course can be taken as a stand alone course. Wingfield Ellis Rehms, M.D., will be the director for both courses. You can also learn more about volunteering by visiting the AAD Resource Center, Booth #3617, during the Annual Meeting. ●

*See Message From the Chair on page 8 to learn about more events for young physicians at the 66th Annual Meeting.*

## MESSAGE FROM THE CHAIR

by Elizabeth Martin, M.D., F.A.A.D.



Last week I spent an afternoon at the office of a fellow dermatologist in Birmingham. This dermatologist is a good friend of mine who recently left her academic appointment to open a private cosmetic dermatology practice. I was there to learn some tricks with fillers, which my friend was willing to teach me, even though I practice just across town. While I was there, another mutual friend of ours — a dermatologist who practices about 75 miles away — happened to drop by to tour the new office. For an hour or so, the three of us talked about interesting cases, taught each other some clinical pearls we'd recently learned, imparted coding tips and really enjoyed just catching up with each other.

Driving home that afternoon, I thought about how fortunate I am to have such good friends as my colleagues. I also realized that although didactic teaching is certainly important, time spent discussing real issues with others who are experiencing the same challenges is also just as important. I learned a great deal from my colleagues that day, as always seems to be the case whenever dermatologists get together.

With that in mind, I want to personally invite you to two events scheduled for the Academy's 66th Annual Meeting in San Antonio, Feb. 1-5. Both are designed to give young physicians an opportunity to discuss some of the challenges unique to the early years of practice and to learn from each other.

The Young Physicians Discussion Group has been scheduled for Friday, Feb. 1, from 2:30 p.m. to 4 p.m. This discussion group features young dermatologists who will talk about opening a

new practice, integrating cosmetic procedures into your existing practice, and financial planning for young physicians, among other topics. There will be plenty of time for Q & A so bring your questions and be ready to share your ideas with your colleagues!

Also, the Young Physician Reception has been scheduled for Friday, Feb. 1, from 5 p.m. to 6:30 p.m. in Salons M & G at the Marriott Rivercenter. Please come and enjoy some snacks and drinks with friends! With no formal agenda, this is the perfect venue for you to network with other young physicians, to exchange stories and to share pearls. Meet your friends and unwind at the end of a long day or get your energy up for a fun night in San Antonio! Mark your calendar now for these not-to-be-missed events.

Finally, as you plan for the upcoming meeting, it's vitally important that you schedule time to vote for the officers and Board of Directors of the Academy — our future leaders — and the Nominating Committee member representative. Information on candidates will be available online at the Academy's Web site at the end of January. Voting opens worldwide Saturday, Feb. 2. For those who wish to vote on-site while in San Antonio, on-site voting opens Saturday, Feb. 2 and continues through Monday, Feb. 4. There will also be proposed articles of incorporation and bylaws amendments on the 2008 ballot. Your vote really does matter and young physician participation in the selection of our leadership is key to our future. I look forward to seeing you in San Antonio! ●

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YOUNG PHYSICIAN  
**focus**

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