

SPECIAL REPORT: ASSET PROTECTION PLANNING FOR DERMATOLOGISTS

Dermatologists consider themselves malpractice targets, and they are, but the average dermatologist is not likely to be successfully sued in excess of their reasonable medical malpractice insurance limits – such verdicts are actually very rare and nearly all could have been settled within the limits of their malpractice coverage.

Unfortunately, armies of promoters exist to market bad investments and asset protection schemes that simply do not work for dermatologists and other physicians. This article will briefly discuss which strategies to avoid and which should be part of an overall and holistic asset protection and estate plan.

Strategies to Avoid

Foreign Asset Protection Trusts (“offshore trusts”) are trusts that you create for yourself in a foreign jurisdiction, such as The Cook Islands, that cater to such trusts. The idea here is to put assets into an offshore trust, and then, when a creditor comes along, you claim that your offshore trustee will not give you the assets back. In the meantime, you control and invest the assets.

But there are problems with offshore asset transfers. The most practical one is that although your assets may be offshore, your body will probably stay here and be subject to court orders. This means that you can be subject to what is known as a Repatriation Order essentially demanding that you “bring the money back or go sit in jail.” Courts routinely grant these orders, and debtors routinely go to jail when they fail to comply.

In fact, out of over a dozen well-cited cases, the only one

which worked as advertised was that of Stephen J. Lawrence, who suffered a large arbitration award after losing his shirt in the 1987 stock market crash. Mr. Lawrence was willing to spend over six years in prison to convince the judge that either he couldn't bring the money back or wasn't willing to.

In the other cases, most people decided to cough up their money soon after being sent to jail or threatened with contempt. For those not willing to spend six or more years in prison, foreign asset protection trusts are a bad idea.

Nevertheless, some asset protection planners essentially run trust mills selling cookie-cutter structures involving Cook Islands trusts (and also Family Limited Partnerships, explained below) to physicians. If this is recommended to you: run!

Domestic Asset Protection Trusts (“Alaska Trusts” or “Delaware Trusts”)

Several large trust companies are now pushing the domestic variant of the offshore trust, which is a trust that you create for yourself in one of the states that allow what is known as a “self-settled trust.” The leading states for this type of business are Alaska, Delaware, Rhode Island, Nevada, Tennessee and Utah.

These trusts also do not work. In fact, the 2005 federal bankruptcy reforms created what amounts to a 10-year claw-back to transfers to self-settled trusts. This should have put an end to the Domestic Asset Protection Trust business, except possibly for the people living in one of those states who believe that they can keep themselves from ever being forced into bankruptcy.

Family Limited Partnerships (FLPs) and Family Limited Liability Companies (FLLCs)

Family Limited Partnerships (FLPs) and Family Limited Liability Companies (FLLCs) can work as effective asset protection tools – if they are used as vehicles for bona fide commercial ventures.

But don't think you can set aside purely personal assets (the family home, vacation homes or family financial assets) and think that they will be protected. In these cases, the theory of “reverse alter ego” has been successfully used to disregard the entity where no bona fide commercial venture was being facilitated and it

was clear that the entity was just the personal piggy bank of the debtor.

Again, if a limited partnership or LLC is a bona fide commercial venture, then the case law largely indicates that it will stand up to creditors. Thus, the family business might be protected. But simply creating a shell LP or LLC and placing assets into it probably accomplishes nothing.

Accounts Receivable Financing

These programs are widely sold to physicians as a means

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to protect the practice's accounts receivable. The idea here is that you borrow against your A/Rs and use the money to buy an insurance product that is exempt from creditors in some states, such as New York, Texas or Florida.

These programs can work — but with some significant limitations. First, these programs will only protect the accounts receivables as of the date that the creditor executes upon them. Therefore, it will not protect A/Rs on a “going forward” basis. Generally, A/R financing promoters will simply omit this fact and might even tell you just the opposite.

Second, the premise behind these programs is that they can fund retirement by creating an arbitrage between the amount paid on the loan and the investment returns of the insurance product. This sounds great, so long as the arbitrage is positive. If the cost of the loan exceeds 7 percent, it is highly unlikely that the arbitrage will be significantly positive.

A/R financing is one of those programs that sounds great in theory, but usually doesn't work because neither the physician nor the promoter really understands it.

“If it is so complicated that you can't explain it, it probably isn't going to work.”

What Works?

Personal Insurance

Periodically review your liability limits to see if they are adequate. The best asset protection you can buy comes in the form of personal “umbrella” insurance. For a few hundred dollars per year, you can purchase coverage into the millions against events where the limits of your auto or homeowner's insurance have been exhausted.

You should also make sure that your disability insurance is in line with your current income and you have the proper amount of life insurance to protect your family.

Professional Corporations

A professional corporation will not, by statute, shield a dermatologist from his or her malpractice act. However, the professional corporation might be useful in encapsulating within it the liability from other claims such as an employee's malpractice act, sexual harassment, wrongful termination or even certain toxic material claims. Additionally, the use of a professional corporation may later give tax planners some options if the practice is sold.

Exemption Planning

Exemption planning considers the use of certain exemptions permitted by state and/or federal statutes. The goal of such planning is to maximize the use of available exemptions. Potentially, one or more of the following might provide significant asset protection: retirement plans, Individual Retirement Accounts (IRAs), life insurance, annuities and homestead exemptions.

Keep it simple

Despite the many asset protection schemes thrust upon dermatologists, there are a great deal of options that have proven to be effective in protecting business and personal assets and promoting early settlements. Exemption planning still works in one form or another in many states, and all states allow people who have no current or suspected creditors to take “chips off the table” by transferring them to a trust for their children.

Whatever you do needs to be explainable to your average jury and judge. If it is so complicated that you can't explain it, it probably isn't going to work. So, keep your asset protection planning simple and explainable, but most of all, do it well in advance of problems.

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While all stories in this publication have been approved for inclusion by the Young Physician Committee physician editor, each article represents the perspective of the individual author and should not necessarily be construed as advice from the American Academy of Dermatology or the Young Physicians Committee.

AWARDS for YOUNG INVESTIGATORS in DERMATOLOGY

Call For 2009 Nominations

The AAD Awards for Young Investigators in Dermatology recognizes outstanding basic and clinical research by dermatologists-in-training in the U.S. and Canada for the advancement of diagnosis and therapeutics in the practice and science of dermatology. Two outstanding young investigators are selected annually as recipients of the \$5,000 award that is shared with the awardee and the mentoring research institution.

Nominations are accepted from the chair of a dermatology department or the nominee's faculty advisor. Eligible candidates include dermatology residents in an accredited residency program or those who have completed their residency within the previous two years.

Submission deadline for 2009 awards: September 30, 2008

For award details and submission information visit the AAD website at <http://www.aad.org/education/grants/young.html>



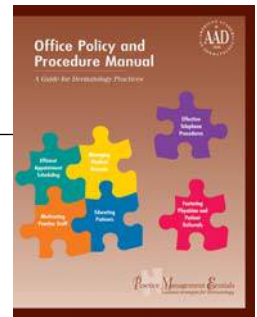
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E-COMMUNICATING IN THE OFFICE...TRY IT, YOU MIGHT LIKE IT!

I think we all can agree that communication is one of the keys to running a successful practice. As physicians, we can't (and don't want to) be involved in every administrative conversation/decision that goes on throughout the day. However, if you can't stay on the same page with your administrative and clinical supervising staff, things can quickly get out of hand, leading to inefficiency and frustration. What is the best way to communicate in the office? Unfortunately, there is no short answer to that question because everyone's level of technologic acumen is different.

Let's start with a quick comparison of communication methods in the office. Old tried and true ways to communicate include voice mail, fax, message pads/post-it notes, dry-erase boards, and that yellow perforated folder with the wrap-around string at the top. Newer electronic communication (e-communication) methods include e-mail, instant messaging (IM), Microsoft exchange server, e-faxes, voice over IP (VOIP) and blogging. We will focus on the latter group here and try to make a case for using some new technologies in your office to keep in touch.

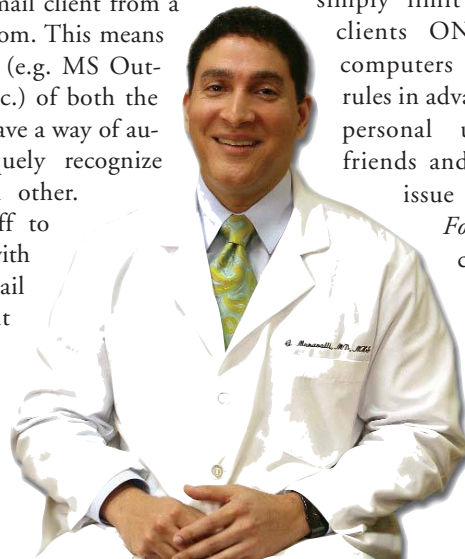
In my practice (and probably most practices around the country with computer access), anything that doesn't require an immediate answer is usually handled over e-mail. The beauty of e-mail is that two people don't have to be available at the same time in the same place to carry on a meaningful dia-

log. Is it an impersonal or distant way of communicating? In some cases, that is true. I certainly wouldn't fire someone over e-mail, but I have had employees resign over e-mail — and it hurts. Some general guidelines to follow regarding e-mail necessitate an understanding of its limitations. E-mail is not always an immediate delivery process, so don't trust time-sensitive communication to e-mail.

"...guidelines to follow regarding e-mail necessitate an understanding of its limitations."

Basic e-mail, by its very nature, is not secure. This means that its contents may be intercepted by anyone with enough experience. E-mail can be forwarded by anyone with limited experience. Therefore, resist the urge and don't put anything harmful, damaging, or insulting to an employee in an e-mail. It can (and will) come back to bite you. Don't put anything financially sensitive in an e-mail unless it is protected by password or some other security measure. If you do a lot of this sort of communicating, consider getting a secure certificate for your e-mail client from a Web site like thawte.com. This means that the e-mail client (e.g. MS Outlook, Thunderbird, etc.) of both the sender and recipient have a way of authentication to uniquely recognize e-mails sent to each other. Lastly, encourage staff to have or provide them with a separate "work" e-mail account and check it often, every day.

The above also holds true for IM. What separates chat/IM from technologies such as e-mail, is the perceived synchronicity of the communication by the user. We use IM all the time in our office to chat and share files. It is often faster than a phone call and a great way to get a response if someone is already on the phone. Phrases such as "R U in ur office?" "Patient is ready?" or "Wanted in room 2" are commonplace. Many free IM clients exist for use in the office, like Yahoo, MSN, AOL (AIM) and a free open-source client called Trillian (which works with almost all commercial systems). Of the major commercial ones, the free AOL offering — AIM pro is one of only a few to support secure encrypted communication "right out of the box." Of course you can argue, "Well how do I know that my staff aren't IM'ing their friends all day long?" The answer is that you don't. You could block incoming/outgoing IMs by changing firewall settings on your router, but then you would shoot yourself in the foot. Consider corporate IM services like MS Exchange or office-server based solutions like Jabber. Our policy is that we simply limit installation of IM clients ONLY on supervisor's computers only and clarify the rules in advance regarding limited personal use for contacting friends and family. In the next issue of *Young Physician Focus*, I'll discuss specific services that can be used to share calendars, tasks, and notes. ○





Are you implementing or upgrading your EHR system?

Electronic Health Record

VENDOR DEMONSTRATION CHALLENGE

SUMMER ACADEMY MEETING

HYATT CHICAGO REGENCY C

FRIDAY, AUGUST 1 5:30PM-8:30PM

Refreshments and hors d'oeuvres will be served

SPACE IS LIMITED, BUT NO NEED TO RSVP!

SURGICAL COMPLICATIONS: BEYOND THE TERRIBLE TETRAD

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



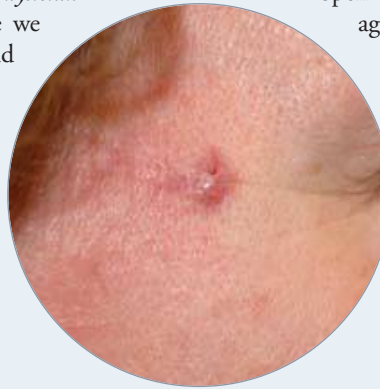
The “terrible tetrad” complications, namely bleeding, infection, dehiscence and necrosis, were reviewed in the last issue of *Young Physician Focus*. In this issue we will go beyond the “terrible tetrad” and review the less common yet equally important surgical complications. These include suture granuloma, epidermal arrest, neuropraxia, and free margin distortion. We will review these with emphasis on diagnosis, prevention and treatment.

Suture granuloma presents as a pink, tender papule within the incision line 4-6 weeks after surgery. It is essentially a sterile abscess formed around the buried suture material. Patients often mistake this for tumor recurrence or infection. It is self limited and will resolve spontaneously without a negative impact on the final cosmetic outcome. If suture material is starting to come out, it can be pulled out with fine-toothed forceps. This will expedite abscess resolution.

Epidermal maturation arrest, or re-epithelialization arrest (REA), is an

uncommon complication that can be problematic if it is not diagnosed. The hallmark of this complication is an open wound on sun-damaged skin (often scalp or forehead) that fails to completely re-epithelialize. There are no signs of infection and the wound bed has pink, glossy granulation tissue. The epidermis simply “stops” and does not completely cover the wound bed. Treatment of REA is with potent topical corticosteroids. Clobetasol 0.05% ointment applied twice daily for 1-2 weeks is usually effective in bringing about complete re-epithelialization. Use of Clobetasol should be avoided if there is exposed cartilage or bone. Non-steroidal anti-inflammatory drugs (NSAIDs) have also been reported to be effective.

Neuropraxia is a temporary nerve deficit that can be seen in the post operative period. It is caused by stretching or trauma to the nerve. The nerve function returns within 3-6 months. There are several ways to differentiate neuropraxia from permanent nerve



Suture granuloma on temple presenting six weeks after surgery (above); Neuropraxia of the temporal branch of the facial nerve causing self limited brow ptosis (below)

Photographs courtesy of Dr. Hendi.



See *Perspective* on page 6

clinical perspective

injury. Review of the pathology slides in cases of neuropraxia should *not* reveal a severed nerve trunk. Nerve conduction studies can also help with this diagnosis. The dermatologic surgeon needs to be aware of this to avoid early corrective surgery (i.e. a direct brow lift in case of temporal nerve involvement).

The free margins of the face are mobile landmarks that are prone to cosmetically unacceptable distortion in the course of reconstruction or wound healing. The free margins of the face include the eyebrow, eyelid, alar rim, and vermilion border. The position of the eyebrow can be elevated in horizontally oriented closures on the forehead. Although surgical dogma would dictate that closures on the forehead should be horizontal to follow the wrinkles on the forehead, this type of closure can have several unwanted effects. Horizontal closure of defects greater than 1 cm on the suprabrow region of the forehead can lead to a permanently elevated eyebrow. In addition, the supratrochlear and supraorbital sensory nerves, which provide sensation to the anterior scalp, ascend vertically on the forehead. A horizontal excision on the forehead is more likely to lead to permanent anesthesia, dysesthesia, or paresthesia of the scalp. For these reasons, suprabrow defect on the forehead are best repaired in a vertical fashion.

Older patients are prone to ectropion due to the increased laxity of the eyelid with age. Postsurgical ectropion is a complication that can be caused by improper orientation of closures on

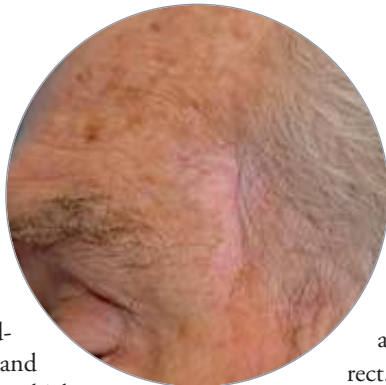
the cheek and eyelid or by wound contraction. This can be avoided by assuring that the tension vector of the closure is parallel to the lid margin. The tip of the superior burrow's triangle should point towards the lower lid or the inner canthus. The lazy-S type closure for defects on the cheek can minimize the incidence of ectropion. Cicatricial ectropion is due to scar contracture and may be self limited. It is important to prevent desiccation of the cornea by having the patient use a preservative-free tear solution during the day, and tear ointment at bed time. Oculoplastic referral is helpful in the management of patients with ectropion.

Pull on the ala can lead to ecnasion, an unwelcome complication for any surgeon as it can be challenging to correct. As the alar rim is a free margin, it can be displaced by an improperly oriented closure on the nose. The tension vector of a side by side or flap closure on the nasal sidewall should be parallel to the curvilinear border of the alar rim in order to avoid this complication.



Re-epithelialization arrest (REA) of open wound on left temple (above), after 2 weeks of Clobetasol 0.05% ointment (below).

Photographs courtesy of Dr. Hendi



The lip is one of the most cosmetically important structures on the face. The slightest distortion of the vermilion is readily noticeable as the lip is a primary fixation point in the visual perception of the face. The vermilion border can be displaced in two directions. It can be pushed in by a vertically oriented burrows triangle which is broad and short, and points to the vermilion without crossing it. Despite surgical dogma which holds that the vermilion border is inviolable, it is preferred to cross the vermilion and reapproximate it than to have a short burrow's triangle push in the vermilion border. Pull on the vermilion can occur if the tension vector of a closure on the lip, chin, or medial cheek is perpendicular to this free margin. As with other free margins, the tension vector should be parallel to the vermilion border to prevent distortion.

Suture granuloma, reepithelialization arrest, neuropraxia, and free margin distortion are less common complications encountered in dermatologic surgery. Just as with the "terrible tetrad", knowledge of these complications and their management allows us to best care for our patients.

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HIGHLIGHTS OF THE SUMMER ACADEMY MEETING 2008

Thursday, July 31

- Live Patient Demonstration
- Lunch and Learn: Maintenance of Certification
- Generational Conflicts in Dermatology

Friday Aug. 1

- Morning Plenary Session

- Live Patient Demonstration
- Electronic Health Records

Saturday Aug. 2

- Live Patient Viewing (at Northwestern Hospital in Chicago)
- Live Patient Viewing /beer and wine discussion



Sunday Aug. 3

- Laser Surgery
- Dealing With Difficult Patients

Registration opens May 14. For more information, go to www.aad.org.

EDUCATIONAL OPPORTUNITIES

SIGN UP NOW FOR UPCOMING PRACTICE MANAGEMENT REGIONAL COURSE IN ORLANDO

Leading and managing a dermatology practice is a learned skill that is important to the success of dermatology practices in the future. These practice management skills are rarely taught in residency or as part of other medical meetings. The AAD is hosting a Practice Management course at the Walt Disney World Swan in Orlando, Florida, May 17-18. This two-day course will present selected topics concerning employee management, legal issues, marketing, and coding and reimbursement. Many of the topics presented will be useful in strategic planning.

This Practice Management course is designed for dermatologists, physicians assistants, and office staff. The American Academy of Dermatology designates this educational activity for a maximum number of 16.25 AMA PRA Category 1 Credits™.

Topics include:

- Planning/Building a New Dermatology Office
- Physician Assistants in a Dermatology Practice
- Employment Manuals – Do You Need One?
- My Banker – My Practice's Best Friend
- Legal Considerations for Your Practice
- Patient Compliance
- Coding & Pay for Performance Update
- Dermatology is a Service Business
- Special Considerations for Cosmetic Patients
- Professional Liability Issues
- Managing & Motivating your Staff
- What to Look For in an EMR
- Managing Collections, Claims & Carriers

- Dermatology EMR Update
- Nuances of E/M & Surgical Coding
- E/M Coding Mistakes You Don't Want to Make
- Coding Challenges
- Setting Office Standards for Service Excellence
- Patient Satisfaction – Measurement & Improvement

On-site registration is available Saturday, May 17, from 7:00am-5:00pm and Sunday, May 18, from 7:00am-12:00pm.

For more information, visit the AAD Web site, www.aad.org and click on Practice Management under Scientific Meetings. Or contact Melissa Stein at mstein@aad.org or (847) 240-1485. ●



PICMED

PROGRAM FOR INNOVATIVE CONTINUING
MEDICAL EDUCATION IN DERMATOLOGY



Innovative Continuing Medical Education in Dermatology (PICMED). The program was established to facilitate the continuing education of dermatologists through support and development of innovative continuing medical education programs.

The endowment fund, to be awarded twice yearly, will be used to support the activities of PICMED, including but not limited to:

- Creative needs assessment mechanisms;
- Innovative uses of technology;
- Unique approaches to specific subject matter(s);
- Novel presentation techniques;
- Utilization of existing educational paradigms in new environments.

The deadline for submission of requests for the 2008 Call for Grants is September 3, 2008.

Successful applicants will be notified of their award by February 15, 2009.

For PICMED details and an application, visit the AAD website at www.aad.org/education/grantsandawards.htm

The American Academy of Dermatology (AAD) is dedicated to promoting the highest quality of dermatologic care through continuing medical education and research. The AAD is proud to announce that through a generous contribution by the Elsevier Foundation and the Skin Disease Education Foundation, who share with the AAD a commitment to continuing excellence in dermatology, the AAD has created an educational program called the Program for

MESSAGE FROM THE CHAIR

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



Young Physicians Committee Activity Update

The Young Physicians Committee (YPC) met during the AAD Annual Meeting in San Antonio and its members worked to formulate plans for the upcoming year. There were many exciting developments that came out of the meeting and I'd like to highlight a few of them for you.

While topics such as staff management, contract negotiation and coding are covered in the practice management course that most third year dermatology residents attend, once young physicians are out in practice we tend to develop a new perspective on these issues and perhaps better understand some of the challenges we face in the day-to-day operations of a practice. With that in mind, the YPC, in partnership with the Interdisciplinary and Post-Graduate Education Task Force, has submitted a proposal to the Scientific Assembly Committee for a course in practice management to be included in the educational offerings at the 2009 AAD Annual Meeting to be held in San Francisco. We plan to address issues that impact the daily management of a practice and give attendees better tools to effectively, efficiently, and successfully oversee their own practices at home. The YPC is excited about partnering with the Interdisciplinary and Post-Graduate Education Task Force for this project and hopes to develop collaborative relationships with other groups in the future to help us meet common goals.

In the spirit of collaboration, the Residents and Fellows Committee (RFC) approved the addition of the YPC chair as an ex-officio member of the RFC. The RFC feels that adding a

young physician to their committee will improve the working relationship between the two groups and will bring a different perspective to their committee discussions. I think that working together on common issues that residents, fellows, and young physicians all face will strengthen all our voices within the Academy and improve our services to our members. This change is pending approval by the Organizational Structure Committee and the Board of Directors. If approved, I will be very pleased that our two groups will have the opportunity to work together in this fashion.

Perhaps the most significant young physician-related event that occurred at the Annual Meeting was the AAD Board of Directors approval of the YPC's recommendation for a Young Physician Observer position on the Board. This observer will serve a two-year term on the Board of Directors and be expected to provide insight and opinion on issues relating specifically to young physicians. This approval by the Board speaks resoundingly to the Academy's emphasis on developing future leaders within the AAD and within our specialty. The committee is incredibly delighted with this approval and the opportunity to bring the young physician voice to the Board of Directors.

As always, the YPC wants to serve the needs of the young physicians of the Academy. Please let us know how we can better accomplish this goal. If you have any concerns, needs, or ideas that you'd like to convey to the committee, contact me at lizmartin410@bellsouth.net. It is a pleasure to serve as the YPC chair and I am eager to help our members in any way I can. ☺

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YOUNG PHYSICIANS COMMITTEE

MISSION STATEMENT:

The goal of the Young Physicians Committee is to represent the interests of young dermatologists by recommending educational programs and tools for young dermatologists to further their careers; presenting issues concerning this group to the American Academy of Dermatology Board of Directors and providing guidance to the AAD regarding implementation of new young physician programs; developing communication tools that provide a forum for discussion on issues pertinent to young dermatologists and promoting communication efforts and networking among young physicians; and fostering leadership among young physicians and helping prepare them for future roles in organized medicine and the Academy. Young Physicians are those up to age 40 or within eight years of completion of residency training.

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