

***AAD Past Presidents***  
*aadpastpresidents@gmail.com*

June 28, 2009

Sheldon D. Horowitz, MD  
Special Advisor to the President  
American Board of Medical Specialties  
222 North LaSalle Street, Suite 1500  
Chicago, IL 60601

By Surface Mail and Email

Re: Procedural Dermatology Certification

Dear Dr. Horowitz:

We are writing to you about our major concerns regarding the potential certification of Procedural Dermatology. As former Presidents of the American Academy of Dermatology who were elected by a vote of the full membership, we believe that we have insight into the concerns and needs of our dermatology colleagues and our specialty and we understand what would best benefit our patients.

We have stayed in the background on the discussions related to this issue to this point. However, **in our experience, there has never been this great a level of concern and opposition to any issue or proposal in Dermatology.** We strongly feel that you need to understand the depth and breadth of opposition to this proposal within our specialty. For all of the reasons that we review below, we strongly believe that a certification in Procedural Dermatology would be detrimental to our specialty and urge you reject this proposal.

**The reality is that there is no need to have a “procedural dermatology” subspecialty.** In fact, Dermatology is already fundamentally both a medical and surgical specialty. The basic 3 year residency requires both substantial medical and documented surgical training. Dermatology residency includes training in dermatopathology, cutaneous oncology, flaps, grafts, lasers, botulinum toxin injections, dermal fillers, Mohs surgery and liposuction (these topics are already tested for in the regular dermatology board examination). Many residents graduate prepared to perform these procedures and some choose to proceed to an optional pgy-5 procedural dermatology fellowship to avail themselves of additional training. However, the fact that thousands of board certified dermatologists are safely and effectively practicing those procedures demonstrates that an additional level of sub specialization is not necessary.

**We believe that at your last meeting you may not have gotten an accurate picture as to where the overwhelming majority of dermatologists stand on this issue.** We strongly believe that you need to know how intensely this is being opposed by Organized Dermatology and dermatologists.

Because of widespread concerns, this proposal has been discussed at many of the recent local and regional dermatology society meetings this spring. **It was unanimously**

## *AAD Past Presidents* *aadpastpresidents@gmail.com*

**opposed by the 300 member Texas Dermatological Society, 400 member Florida Dermatology and Dermatologic Surgery Society and the New York Dermatological Society. The 1000 member American Society for Mohs Surgery and many other local and regional dermatology societies (Pennsylvania, New Mexico, Illinois, Alaska, Arkansas, Arizona and California among others) have gone on record in opposition to this proposal.** In a formal polling of members of the American Society for Dermatologic Surgery on this specific issue only (and with the ballot, members were provided a statement of the “pros” of the issue from a member of the ABD), **69% of over 1200 dermatologists surveyed were opposed.** Equally importantly, to our knowledge NO dermatological society has gone on record as supporting it.

Creating a board certification in procedural dermatology would divide the house of dermatology and create opportunities for third parties to aggressively pursue economic credentialing. Economic credentialing has been opposed by the AAD, ASDS and ASMS because it splinters and weakens the specialty of dermatology and harms our patients by limiting and delaying access to care. Efforts to fracture our specialty into medical and surgical dermatologists have been roundly rejected by the House of Dermatology. This sub-specialization fragmentation is not even consistent with other specialties. For example, Ophthalmology, similar to dermatology in being both medical and surgical, has chosen not to fragment itself into medical and surgical parts.

**You may have been told that there has been no evidence of insurance companies discriminating based upon “procedural dermatology” credentialing. This is simply not true.** Our major societies have already seen multiple examples of insurance companies proposing to limit certain procedures performed to those who have completed a “procedural” fellowship although the standard 3 year dermatology residency has comprehensive training in dermatologic surgery. There is already strong evidence that this credentialing will be used by insurance companies to create 2 “classes” of dermatologists and will limit the ability of some dermatologists to perform even basic surgical procedures. Our societies have already had to expend substantial resources to fight this with these companies. We believe that this is only the “tip of the iceberg” and that **the institution of an unnecessary formal certification process will only exacerbate this problem.**

**You may have been told that the concerns that are being raised are the same ones that were raised when dermatopathology was being considered for sub-specialty certification. This is also not true.** At that time, the potential impact was only on a small minority of dermatologists (those who read their own slides) and the concern was limited to that one thing only. Also, managed care did not exist then and concerns about reimbursement and economic credentialing were non-existent. In contrast, **what is of concern now is the risk of a limitation on the ability of dermatologists to perform multiple aspects of dermatologic surgery** (something that is a fundamental part of our specialty and performed by virtually all dermatologists) beyond those items focused on in a procedural fellowship. Given the experience of the past year, that concern and potential risk to our specialty has been demonstrated to be real.

## **AAD Past Presidents** *aadpastpresidents@gmail.com*

The ABD has made multiple public statements when formally presenting this proposal in public forums that there would be a “grandfathering track” where any non-fellowship trained dermatologist could obtain the certification in the same way this occurred for Dermatopathology – statements that now appear to also be factually untrue. Originally, what was presented to dermatologists was that 50% of the content of the examination would consist of MOHS surgery related questions. Since only a minority of dermatologists are MOHS surgeons, **this proposal would disenfranchise the majority of dermatologists who practice all other aspects of dermatologic surgery but not MOHS.** Dermatologists at multiple forums were told that “people will be able to learn enough MOHS in a weekend of study to pass the MOHS half of the exam”. We do not believe that this is so (or even realistic) as any member of the MOHS college will tell you that it takes at least a year of fellowship to achieve competency in MOHS surgery. And, if that is not the case, why have a one year fellowship at all?

However, **controversy related to the examination content has been overshadowed by a more important new concern that directly differentiates this proposal from the dermatopathology certification** and has outraged our colleagues. Attached is a copy of the document (*Guidelines for Procedural Dermatology Subspecialty Certification via the “Grandfather Clause”*) which has already been provided to you by the ABD listing the requirements to be considered. As you can see, the requirements listed basically ignore the vast majority of surgical procedures performed by our colleagues with the only quantitative requirements being MOHS cases and repairs. As opposed to what dermatologists were told multiple times by ABD representatives and **in direct contrast to what occurred with dermatopathology, it is clear from the document that the vast majority of dermatologists** (who according to practice surveys by the ASDS perform non-Mohs dermatological surgery procedures in an overwhelming greater number than Mohs procedures) **would be specifically excluded.** Dermatologists are concerned with what appears to them to be a direct attempt to mislead. It is also clear from the manner in which this proposal has been structured that **this is primarily MOHS certification alone** that is being called by another name. As you are aware, a specific **MOHS certification was proposed a decade ago** but not adopted for many these same reasons. This proposal appears to some to be an “end run” to try to achieve that same undesired outcome that **was rejected at that time.**

This specific issue of the risk of having 2 “classes” of dermatologists has been raised at society meetings where members of the ABD have presented this proposal. When confronted with the above data, the response from ABD spokespersons have been that “it’s the job of the ABD to make the test and they are not responsible for how it is used” and “it’s the responsibility of the AAD and ASDS to deal with any ramifications or ‘misuse’ of the certification.” This is the same (fallacious and not supported by the courts) argument gun manufacturers make (“we make the guns, we aren’t the ones that cause the injuries or have to deal with them”) and is equally irresponsible.

**This unprecedented level of opposition to this certification has other serious ramifications.** In addition to the opposition to the proposal itself, dermatologists and

***AAD Past Presidents***  
*aadpastpresidents@gmail.com*

dermatologic surgeons are also strongly opposed to the term “Procedural Dermatology” as it does not reflect the scope of the surgical aspects of what we do. There is deeply held resentment that the ABD acquiesced to the use of this inappropriate terminology. For all of the aforementioned reasons, many dermatologists are feeling that the ABD is demonstrating a crass disregard for and lack of understanding of dermatologists and our specialty. And these concerned colleagues are not “radicals” or “rabble rousers”. Rather, most are average grassroots practitioners who typically never get involved in these types of issues but are so outraged at this point by what they see as the lack of listening by the ABD that they feel that they must do something. Perhaps, even more disturbing is the fact that **there are many serious conversations that are now occurring suggesting that a new Dermatology board be formed** that can realistically set standards in a relevant way and this sentiment is starting to “virally” spread on the internet. This alone should demonstrate to you the depth and breadth of the opposition to this proposal and the risks if it should be approved.

In sum, we have joined our colleagues to oppose board certification of procedural dermatology because it is opposed by the overwhelming majority of dermatologists and dermatologic surgeons, is unwarranted and unnecessary. It is already clear that such certification would splinter and weaken the specialty of dermatology and lead to payer and government interference in the practice of dermatology, thereby having the real potential to reduce access to dermatologic care for our patients and communities.

In addition, at a time where we should be focused on what will be happening on national healthcare reform and how it will affect our patients, the distraction that this issue is causing is especially not warranted nor helpful.

Thank you for your consideration of our concerns. For all of the above reasons, **we strongly urge you to reject the procedural certification proposal**. We would be happy to speak with you directly on this issue and/or participate in your upcoming August 7<sup>th</sup> hearing should you request us to.

Sincerely,



Roger Ceilley, MD  
President, American Academy of Dermatology 1997-1998  
Des Moines, IA



Darrell S. Rigel, MD  
President, American Academy of Dermatology 1999-2000  
New York, NY

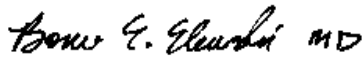
**AAD Past Presidents**  
[aadpastpresidents@gmail.com](mailto:aadpastpresidents@gmail.com)



Fred Castrow, MD  
President, American Academy of Dermatology 2002-2003  
Houston, TX



Ray Cornelison, MD  
President, American Academy of Dermatology 2003-2004  
Oklahoma City, OK



Boni Elewski, MD  
President, American Academy of Dermatology 2004-2005  
Birmingham, AL



Clay J. Cockerell, MD  
President, American Academy of Dermatology 2005-2006  
Dallas, TX

Encl. "Guidelines for Procedural Dermatology Subspecialty Certification via the  
'Grandfather Clause' " (American Board of Dermatology)

# AMERICAN BOARD OF DERMATOLOGY

## Table of Qualified Cases **Guidelines for Procedural Dermatology Subspecialty Certification** via the “Grandfather Clause”

- I. Fellowship Trained Track: At least 300 cases per year for 2 years (600 total cases) conforming to the following mix:
1. Mohs Surgery – At least 200 of the total cases.
    - a. Location:
      - i. At least 60 of the total must be facial sites (superior to the mandible)
      - ii. At least 120 of the facial sites must be on the eyelid, ear, nose, lip
    - b. Size: At least 90 of the total must have a postoperative size greater than 2 cm
    - c. Tumor Composition: At least in 10 cases the tumor should be other than a BCC or SCC
  2. Cutaneous Reconstructive Surgery – At least 200 of the total cases.
    - a. Reconstructive Modality: At least 100 of the total must utilize a random-pattern flap, skin graft (full- or split-thickness), composite grafts or staged interpolation flaps EXCLUDING heterograft or biologic dressings
    - b. Reconstructive Dimensions: At least 50 of the cases must have primary closure length of at least 10 cm or the flaps/grafts cover a surgical defect of at least 10 sq. cm.
  3. Cosmetic Surgery – No minimum.
    - a. Qualifying Procedures:  
Class IV laser treatments directly performed by the surgeon  
Soft-tissue augmentation with fillers  
Liposuction  
Hair transplantation  
Sclerotherapy  
Dermabrasion involving at least 25% of the facial surface  
Chemical peels directly performed by the surgeon  
(Other cosmetic procedures may be considered with appropriate documentation)
- II. Practice Experience Track: At least 500 cases per year for 4 or 5 years (2000 total cases over 5 years) conforming to the following mix:
1. Mohs Surgery – At least 750 of the total cases.
    - a. Location:
      - i. At least 600 of the total must be facial sites (superior to the mandible)
      - ii. At least 500 of the facial sites must be on the eyelid, ear, nose, lip
    - b. Size: At least 400 of the total must have a postoperative size greater than 2 cm
    - c. Tumor Composition: At least in 25 cases the tumor should be other than a BCC or SCC

2. **Cutaneous Reconstructive Surgery – At least 750 of the total cases.**
  - a. Reconstructive Modality: At least 400 of the total must utilize a random-pattern flap, skin graft (full- or split thickness), composite grafts or staged interpolation flaps EXCLUDING heterograph or biologic dressings
  - b. Reconstructive Dimensions: At least 200 of the cases must have primary closure length of at least 10 cm or the flaps/grafts cover a surgical defect of at least 10 sq. cm.
  
3. Cosmetic Surgery – No minimum.
  - a. Qualifying Procedures:
    - Class IV laser treatments directly performed by the surgeon
    - Soft-tissue augmentation with fillers
    - Liposuction
    - Hair transplantation
    - Sclerotherapy
    - Dermabrasion involving at least 25% of the facial surface
    - Chemical peels directly performed by the surgeon
    - (Other cosmetic procedures may be considered with appropriate documentation)