Dermatology – A Popular Specialty in the USA

Ruth Gilboa
Solana Beach, California, USA. E-mail: rgilboa@roadrunner.com

Ruth Gilboa, a dermatologist in a private practice in sunny California, USA, knows about the conditions for dermatologists in the USA.

Hello!

My name is Ruth Gilboa. My maiden name was Steinkeller and I grew up in Malmö. Whilst studying medicine in Lund I met my future husband, Martin, who is from the USA and who was doing a residency in paediatrics at UCLA in Los Angeles. To cut a long story short, we married in 1974 and Martin moved to Sweden to work as a paediatrician while I finished my education. In 1987 we moved to San Diego with our two children, then aged 6 and 9 years, and with my brand new specialty diploma in dermatology and venereology. I had completed most of my dermatology training at Karolinska Institutet. I had already passed all the theory tests for foreign students, and I had to complete a one-year internship (an "AT" in Sweden) in order to be allowed to practise in California.

Having survived the internship, working 100 h/week in all areas except dermatology, I could finally start work as a dermatologist. I had several job offers and I chose to work with Dermatology Specialists Inc. (www.dermspec.com), a group with three very professional dermatology colleagues.

Time flies, and I have now worked here for 19 years. I would like to tell you a little about what it is like being a dermatologist in private practice in the USA.

Firstly, in the USA venereology is not part of the specialty. We do see an occasional patient with a sexually-transmitted disease (STD), but basically they are all dermatology patients. Secondly, and perhaps surprisingly, dermatology is the most popular specialty of all; doctors wait years to be able to do a dermatology residency. While they are waiting they become pathologists, internists, PhDs, etc.

There is a lack of dermatologists across the whole country and 70% of all dermatology practices have vacancies for dermatologists. As it is a question of supply and demand, salaries are high. My group is currently seeking another dermatologist, to work with the eight doctors we already have. We are offering a starting salary of USD 275,000 for 4.5 days work per week, and it is highly likely that we will have to increase that figure to fill the post. There are practices that offer more than USD 300,000 per year and in Los Angeles and New York one can earn an even higher amount. In the USA there is no "ceiling" to how much money a private practice doctor can make.

To explain why dermatology is so popular it may be sufficient to tell you that, by comparison, the starting salary for a paediatrician is USD 115,000 per year, for at least 5 days work per week.

My group now comprises eight dermatologists and three "physician assistants". Physician assistants can write their own prescriptions and see patients independently, but do everything under the supervision and responsibility of the dermatologists. Between us we see approximately 55,000 patients a year.

We always try to work efficiently, and follow the maxim that "doctors should only have to do what only doctors can do", since it is more economical for other people to perform routine tasks. I see 5–6 patients per h and I have two nurses working solely with me; one to receive patients and one to take care of the previous patient, while I see the current patient. We perform a great deal of skin cancer surgery and all excisions are scheduled for 30 min or longer. We have our own Mohs' surgeon and have trained nurses to be Mohs' technicians. We have a dermatopathologist, who also sees patients. We also have our own histology laboratory where we examine all the biopsies.

At meetings of the American Academy of Dermatology (AAD) these days, one might get the impression that American dermatologists treat only cosmetic problems. Indeed, we do perform Botox, collagen, filler and sclerotherapy procedures, etc., but 85% of what we do is still traditional dermatology, which is what our group prefers.

We also enter patients into clinical trials and we have participated in many of the trials on, for example, etanercept (Enbrel)

and imiquimod (Aldara). Because we see so many patients it is usually quite easy to find an appropriate patient for a study. Each of the practice partners has a specific area for which they are responsible; for me this is clinical studies. We have two full-time study co-ordinators and it is stimulating to study what is up and coming within the specialty.

My group has contracts with about 70 different insurance companies, which means that the patient has a book with a list of "preferred providers". In order to be included on the list, we reduce our fees slightly to these insurance companies. How much can be charged for procedures is partially regulated by the government, through Medicare, the governmental medical insurance that everybody in the USA is given as they turn 65 years old; it is not based on prior income. Medicare publishes a list at the beginning of each year of every conceivable computer code used by doctors. Every code has a "Medicare allowable" attached to it and that is the amount that doctors will be paid. The insurance companies study this list carefully and often follow it, especially if prices are going down.

The sun shines most of the time in San Diego; there are about 10 days of rain per year. Consequently, approximately one-third of our patients have skin cancer and a large proportion have actinic keratosis. We perform a lot of biopsies of suspicious looking naevi, etc., and the main reason why dermatologists can make so much money compared with paediatricians and internists is because of all the procedures we carry out.

For a new patient, a visit is charged at USD 120, a return visit costs USD 65, but each additional procedure costs extra. For example, to treat warts with liquid nitrogen costs USD 110, one actinic keratosis USD 100, up to 14 actinic keratosis USD 220, a biopsy USD 230, etc. The prices for surgery are likewise determined by the government (through Medicare). The cost depends on the size, as well as the exact location, of the lesion. Surgery on a malignant lesion costs more than that on a benign lesion of the same size and in the same location. Excision of a small basal cell cancer on the forehead, which does not need Mohs' surgery, could cost around USD 800.

The practice has a lot of expenses: our group has eight dermatologists, six are equal part-owners of the practice and two are employed physicians. We have five different offices and

Fig. 1. Ruth Gilboa in San Diego, USA.

a total of 65 employees. The largest expenses are office space and office staff. I do not know what office rent in Sweden is currently, but in San Diego it is about USD 45 per m^2. We have to pay employment taxes for our employees, although to a Swede these seem very low, and the practice also has other expenses that you do not have in Sweden. The practice has chosen to pay for medical and dental insurance, provide paid sick days, paid vacations, and invest in a pension plan for all employees, although this is voluntary and not every doctor in the USA does this.

To summarize, I am lucky to have such a fantastic job as a dermatologist in the USA. Having been in the same practice for 19 years, many of my patients are like old friends. As I perform so many procedures and in order to take their minds off the surgery, I talk with them a good deal and discuss news of their family events, trips, etc. I have entire families who come to see me; aunts, uncles, three generations in the same family, and so on. Among the cosmetic patients, many of them are referred by word of mouth from friends, which makes the waiting room a sociable place. Swedish colleagues who have shadowed me at work for a day or two at a time always comment "you have such nice patients" and "you have such nice staff". I am indeed fortunate to have such an enjoyable job.

Sending you some sunshine,
Ruth Gilboa