You found an iffy mole. It might be cancerous—and could become deadly within weeks. Yet the dermatologist will not see you now, or possibly even for months. As melanoma rates skyrocket, a shocking derm shortage is putting millions of women’s lives at risk. But what’s more frightening, sinister even, is the underlying cause, one that’s being prioritized over your health: money.

By Melinda Wenner Moyer
A single black dot on her right breast, the size of the tip of a Sharpie marker. That’s what Amanda Greene noticed as she was getting out of the shower one morning in 2010. “I was standing about five feet away from the mirror and I thought, ‘That’s weird—I don’t remember that being there before,’” she recalls. Amanda, then 24, a radio host and producer in Pittston, Pennsylvania, had never had any skin problems. “It didn’t scare me or anything. I just went on with my life.”

But the mark grew bigger. Darker. So at her annual gyno checkup, Amanda showed it to her doctor, who insisted she see a dermatologist right away. Yet when she called a local derm’s office, explaining that her gynecologist recommended she be seen immediately for a changing mole, she was told that the first open appointment was in two months. Surely, if the problem were urgent, she thought, the derm would have squeezed her in.

That wasn’t the case. When Amanda finally saw the dermatologist, he biopsied her mole and diagnosed her with melanoma. But many women in rural locations and medium-size towns across the country, including Amanda, have faced an even harder, and more invasive, operation, with more time and money.

A study published in February in the journal JAMA Dermatology explored this further. The report found that among areas of the country with at least one dermatologist, three-quarters of women would need to travel more than 100 miles, or one with a menacingly low number of these docs per 100,000 persons. “Their findings included a top 10 list of what they referred to as the ‘least dermatologist-dense areas’ in the U.S. But even in the number one (i.e., worst) area, the lowest number of derms was one. None of the listed areas had zero dermatologists.”

In late fall of 2016, WH beauty director Maura Lynch learned her mother had to wait more than three months for the earliest appointment with her dermatologist in suburban Philadelphia. Around that time, another editor visited a pop-up skin clinic in an underserved community on a press trip with a beauty company. They brought up the issue to WH’s editor-in-chief, who wondered how widespread this shortage was and whether there was a correlation between melanoma rates and dermat saturation. In January 2017, WH senior deputy editor Marina Khidekel began digging deeper.

Khidekel had already found statistics showing a national dearth of dermatologists. In February, the journal JAMA Dermatology released a report from a group of NYC dermatologists. They had analyzed the AAD’s national database, which lists virtually all practicing American derms, and cross-referenced that with U.S. Census population data to come up with the number of derms in each “section” of the county (as determined by a three-digit zip code). The study authors wrote: “Of the 712 section codes containing at least one dermatologist, 515 (72.3 percent) had fewer than four dermatologists per 100,000 persons.” Their findings included a top 10 list of what they referred to as the “least dermatologist-dense areas” in the U.S. But even in the number one (i.e., worst) area, the lowest number of derms was one. None of the listed areas had zero dermatologists.

This was perplexing, since in the report’s west color map showing derm density, there were areas—represented as white splotches—indicating places with no derms (the only reference to those zero areas in the paper). We wondered: How many cities and towns had zero derms, which cities and towns were they, and why hadn’t they made the “least dermatologist-dense areas” list? When our writer, Melinda Lynch, began focusing on the issue, she said she had already spoken to two nearby lymph nodes, requiring a harder, and more invasive, operation, with more potential for recurrence. Though the surgeon was able to remove the cancer along with the affected lymph nodes, questions such as why these death rates were high remained unanswered.

Getting an appointment quickly can be the difference between life and “there’s nothing we can do.” For many women in rural areas, an urgent appointment may be months away. Those women who wonder how widespread this shortage is and whether there’s a correlation between melanoma rates and dermat saturation.

What started as a casual conversation with a family member turned into an examination involving 50 studies, dozens of derms, and thousands of calls and e-mails to uncover and corroborate facts.

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Mapping Out the Problem

The worst derm deserts—where it’s impossible for many women to get even emergency skin care—are in rural areas, but in some cities, there aren’t enough derms to accommodate the large population. Urban derms are often affiliated with universities, splitting their days between patients and research, so wait times in cities and small towns are often almost the same, per a 2009 study. We plotted out specifics for a few of the deserts.*

**DEPOLE, ALABAMA**
Population: 7,182
Nearest derm: 59 miles away in Sheridan, MS

**WOODWARD, OKLAHOMA**
Population: 10,963
Nearest derm: 64.5 miles away in Elk City, OK

**GALLUP, NEW MEXICO**
Population: 22,469
Nearest derm: 111 miles away in Farmington, NM

**LA GRANDE, OREGON**
Population: 13,026
Nearest derm: 84 miles away in Walla Walla, WA

**CAMDEN, ARKANSAS**
Population: 11,569
Nearest derm: 84.6 miles away in Hot Springs, AR

**EL PASO, TEXAS**
Population: 819,000
Though the city has 10 dermatologists, according to the four-derms-per-100,000-people rule, they should have nearly three times that many.

**JAMAICA, QUEENS, NEW YORK**
Population: 247,000
One of the worst urban derm deserts in the U.S., Jamaica is a populous community in the NYC borough of Queens, and it has just two dermatologists. One of them is Jeffrey Weinberg, M.D., who opened up his office three years ago after hearing about the shortage from Jamaican residents he saw at his Manhattan office (an hour’s subway ride away). “A lot of them were waiting months,” he says. “Jamaica office is now my busiest.”

Steep obstacles to lifesaving skin care: a bleak reality for millions

**THE WEIGHT OF THE WAIT**

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<td><strong>35 DAYS</strong></td>
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<td>The average wait time in a midsize city to get an appointment with a derm for a skin exam to detect a suspected melanoma.</td>
<td>The average for large cities is 32 days.</td>
<td>How long 20 percent of Medicare patients with melanoma had to wait to get their melanoma removed, according to a 2015 study published in JAMA Dermatology. Eight percent had to wait more than three months.</td>
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*All information current as of press time.*
It’s not because dermatology is undesirable as a profession. The average income is $381,000—more than even anesthesiologists and emergency medicine docs make—and in 2013 study ranking the desirability of 18 specialties, students placed dermatology number one in terms of “best lifestyle.” What’s really amiss?

### Why Can’t I Get an Appointment?

Some insurance companies don’t want to pay dermatologists.

The irony: Derms don’t rack up enough bills for hospitals, but they rack up too many for insurance networks, way more than GPs do. And fewer patients get reimbursed those bills. So some insurance companies decide that “if they block a little bit of access,” according to a 2014 UCF study, of the 18 specialties derms and their patients deal with, on their plans, they’ll cut premiums from people but not have to pay doctors. Some experts say the toughest psoriasis patients and the toughest patients overall will wind up with dermatologists on their plans, they’ll collect premiums from people but not have to pay out doctors. Some say, “We’ll delist the 50 most expensive treatments,” says Kevin Lucia, project director at Merritt Hawkins. But doctors get to choose how much of the Medicare money they allocate to each specialty. And it’s not in a hospital’s best interest to train doctors in the top residency programs for training, because “dermatologists don’t offend many patients for hospital stays and don’t order a lot of tests or imaging.” says Cincinnati dermatologist Brett Coldiron, M.D., who serves as president of the AAD in 2014 and 2015. In other words, derm residents don’t generate much revenue for hospitals, Coldiron says. A 2014 report published by the National Academy of Sciences—a nonprofit organization that advises the government on scientific issues—concluded that the financial benefit to hospitals of having on-call dermatology residents is “minimal,” while surgery residents provide considerable revenue. (The American Hospital Association and the American Medical Association of College Doctors declined to comment for this issue, for the story.)

### The doctors in your insurance network may not even exist.

Cosmetic patients get choice appointments.

Patients with a possible melanoma wait more than three times as long for an appointment than those looking for lower-risk surgery. According to a 2007 UCF study in which researchers posed as patients called 800 dermatologists around the country. When they said they wanted warned injections, they were given appointments within 16 days. But if the patient called for a medical visit, opposite to an average of 26 days when they called complaining of a mole, that fit the description of a melanoma. And the appetite for cosmetic procedures has exploded. According to the American Society of Plastic Surgeons, facial injections have jumped 7,000 percent (not a typo) between 1997 and 2016. More pointedly: During the past few years, as injection rates have increased by 10 percent, Americans are waiting a very similar 12 percent longer for dermatologist appointments, according to doctor recruitment firm Merritt Hawkins. The issue isn’t the cosmetic treatments or injections themselves. It’s the old law of supply and demand—more people want cosmetic appointments, more need medical appointments, and there just aren’t enough doctors to go around. Some experts point money as a motive.

“Dermatologists may want to selectively improve access for these patients because of higher relative payments for cosmetic services,” the UCSF study authors write. As Bobby Bukas, M.D., a New York City dermatologist, explains, “with cosmetic patients, dermatologists get paid up front by the medical visits, which involve insurance companies. The average time for a dermatologist to collect from insurance companies is 34 days, and oftentimes it can be a challenge to collect at all.”

There is a faction of derms who don’t think cosmetic appointments influence medical wait times at all. “I truly don’t believe that’s a reason,” says Sarnoff. “For the vast majority of derms doing cosmetic work, it would be 10 percent or less of their practice. It’s important to note that [the UCSF research] is just one study and over a decade old.” But seven derms around the country—several of whom practice in or near deserts—told WNY that some dermatologists do prioritize cosmetic appointments over medical ones, and that most derms who offer cosmetic treatments now block off specific appointment slots for cosmetic versus medical patients. “Especially in slower economic times,” says Flint, Michigan, dermatologist Bish Al-Dabagh, M.D., “to stay competitive in cosmetic dermatology, a derm must schedule a sooner appointment or risk losing that patient to a med-derm or another practice. And he himself doesn’t offer cosmetic services.”

One dermatologist, who practices in the Northwest and asked to remain anonymous, noted that many derms are proactively trying to grow the cosmetic aspect of their practice even as medical appointments can’t be accommodated. “One potential reason,” he says, “is that many dermatologists can’t stay in business because they can’t manage all the government and health-insurance mandates. It’s become very cumbersome—the amount of things we have to report and document and follow.”

AHIP’s Donaldson acknowledges that insurance companies give for erroneous listings: “last-minute changes to federal networks.” But according to the 2014 UCSF study, the issue, “it’s not publicized enough for people to understand what’s going on,” Sarnoff says.

### More people need derms than ever before.

People are living longer. Skin conditions that once were terminal diagnoses are now treatable. Both good things, but they’ve also contributed to the crisis. Sixty-eight percent of dermatologists are 40 years or older. Approximately 870,000 cases of invasive melanoma will be diagnosed in 2017 alone, and more cases of skin cancer are detected every year than cases of breast, prostate, lung, and colon cancers combined. All that leaves patients jockeying for space on an already congested schedule. “It requires more output from physicians to treat a patient over a longer period,” and “this field wasn’t built for that war from a labor standpoint,” says Travis Singleton, senior vice president of physician recruitment firm Merritt Hawkins. It’s smoke and mirrors: “It’s not a federal solution. We need some sort of oversight of insurance networks’ adequacy. But that’s not in a hospital’s best interest to grow the cosmetic aspect of their practice, even as medical appointments can’t be accommodated. One potential reason: ‘It’s become very cumbersome—the amount of things we have to report and document and follow.’”

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### Hospital residency programs may keep derms away.

Some insurance companies don’t want to pay dermatologists.

Aspiring derms face a hurdle. There aren’t enough training programs for the biggest specialty. In 2006, of the nearly 30,000 total residency spots available to graduating medical students in the U.S., only 420 were in dermatology, the top residency was internal medicine, which had 7,024 positions, followed by family medicine with 3,238 and pediatrics with 2,668.

Granted, all training programs at teaching hospitals are valuable because they depend largely on support from Medicare. “That funding stream for medical education has not seen meaningful growth in about two decades and, in fact, is often under threat,” says Jack Resneck, Jr., M.D., vice chair of the University of California at San Francisco (UCSF), department of dermatology and a health policy expert. “But hospitals do get to choose how much of the Medicare money they allocate to each specialty. And it’s not in a hospital’s best interest to train doctors in the top residency programs for training, because “dermatologists don’t offend many patients for hospital stays and don’t order a lot of tests or imaging.” says Cincinnati dermatologist Brett Coldiron, M.D., who serves as president of the AAD in 2014 and 2015. In other words, derm residents don’t generate much revenue for hospitals, Coldiron says. A 2014 report published by the National Academy of Sciences—a nonprofit organization that advises the government on scientific issues—concluded that the financial benefit to hospitals of having on-call dermatology residents is “minimal,” while surgery residents provide considerable revenue. (The American Hospital Association and the American Medical Association of College Doctors declined to comment for this issue.)

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Resneck, too, is “concerned that some insurers may be removing those dermatologists from their networks who take care of the sickest or most vulnerable patients with the most complex challenges.”

Another tangle in the web: Physicians’ contacts “are being terminated without causes,” according to a 2014 UCF study. Trade publications, like Dermatology Times, have noted that the most expensive dermatologists—who are frequently dropped from insurance networks. (Mohs surgery is the standard and most effective way to remove basal cell and squamous cell carcinomas—the two most common types of skin cancer—and is increasingly used to treat melanoma.)
I fought for a biopsy, and it was basal cell carcinoma.

In the summer of 2007, then, 26-year-old Arielle Driscoll discovered a tiny dot on her chest that itched and bled when she scratched it. “It just wasn’t right; it wasn’t healing,” recalls Arielle, now 36, and a pediatric sleep consultant in Bolton, Massachusetts. So she went to see her primary-care doctor, who was sure it was nothing to worry about. Still, the doc offered to refer Arielle to a dermatologist, and she agreed. But she couldn’t get an appointment until January. When it finally happened, the dermatologist, too, didn’t think it was cause for concern. Arielle continued to press, so the doc offered to biopsy the mole to quell Arielle’s fears. The mole turned out to be basal cell carcinoma, a slow-growing form of skin cancer, which she then got surgically removed.

The takeaway: Convinced something is wrong and your doctor isn’t taking you seriously? Don’t waver. “This taught me it is that you have to be your own health advocate,” Arielle says.

I almost died from my melanoma while I waited—now I’m struggling to get the right care again.

Three years after her first cancer incidence, Amanda Greene—the woman at the start of our story—noticed another dot on her stomach that was growing in size, so she called her dermatologist’s office and asked for an appointment. This time, she was told to wait not two, but three months. “I was like, ‘Um, wait. You know I have a history of melanoma—you’re going to be kidding me?’” Amanda recalls. The receptionist didn’t change her tune, so Amanda hung up and this time immediately called another dermatom, who was able to squeeze her in the next week. Her mole, she learned, was pre-melanoma, and the doctor scheduled her for surgery the next day.

The takeaway: If the receptionist isn’t helping you secure an appointment and you’ve explained that your condition is potentially serious, insist on speaking to the doctor or a nurse, who should better understand symptoms that need immediate care. You can also ask your GP to call the dermat on your behalf, which may help.

“I had to wait to see a Derm and…”

Last year, Anna—who asked to remain anonymous—developed a sore on her lower back and saw her primary-care physician, who thought it might be a fungal infection and wrote her a prescription for a topical cream. By the next weekend, the rash had spread, so Anna went to a local urgent-care clinic. The clinic didn’t have the facilities to run tests, so the doctor gave her a high-priority referral to a dermatologist. “When I called the dermatologist’s office on Monday, they offered me an appointment five weeks out,” she recalls. It was raining the day she called, so Anna demanded that they fit her in if someone canceled—which the receptionist did. It turns out Anna had MRSA, a bacterial infection that can kill within a week. Thankfully, she recovered quickly with the right antibiotics and is no longer contagious—but had she been forced to wait five weeks, the infection could have infected her blood and organs, increasing the chances that she could die.

The takeaway: Never accept a delay on your complete recovery. If the receptionist isn’t helping you secure an appointment and you’ve explained that your condition is potentially serious, insist on speaking to the doctor or a nurse, who should better understand symptoms that need immediate care. You can also ask your GP to call the dermat on your behalf, which may help.

“For a biopsy, and it was basal cell carcinoma.”

For many Americans, skin infections are a daily concern. In 2017, a report from the American Academy of Dermatology (AAD) found that 40 million Americans suffered from skin infections in 2013, and that many of these infections were caused by bacteria that are resistant to antibiotics. The report also found that MRSA, a type of bacteria that is resistant to antibiotics, is a growing concern in the United States. In 2011, the Centers for Disease Control and Prevention (CDC) reported that MRSA infections had increased by 25% since 2005.

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Yes, There’s Some Good News
Five glimmers of hope for better skin care

Continuing-ed classes in dermatology are drawing GPs in droves. Exhibit A. The dermatology course at the National Procedures Institute, an organization that trains GPs around then world in specialist medicine, “sells out at all of our Continuing Medical Education conferences,” says its program specialist Heather Osborne. Ask your primary-care doc about her training, but if she prefers that you see a dermatologist, she can provide an urgent referral to help secure a faster appointment.

Another training program that’s helping? Project ECHO. Since the first Project ECHO hub specializing in dermatology started in Columbia, Missouri, in 2015, GPs “have already found three early melanomas, so that’s three lives saved,” says dermatologist Edison, the Missouri hub’s team leader. One limitation: The doctors who have participated in Project ECHO can diagnose and treat many skin conditions, though the program doesn’t train docs in how to remove melanosomas.

Teledermatology is on the rise.

With one new approach called “live interactive teledermatology,” patients step into a local hospital or community center, and the staff takes pictures of their affected skin and sends the photos (via a secure tablet app) to an off-site dermatologist. Minutes later, patients have a video-conference appointment with the derm. This approach won’t help everyone. These centers aren’t widespread, and if the doctor thinks you need a procedure, you still have to get an in-person appointment with a derm. It’s also hard to accurately diagnose skin issues this way, says dermatologist Davey, and not all telederm skin docs are board-certified by the AAD. Still, many docs say that this technology can help get skin care to people who need it.

To find out if there is a teledermatology service near you, call your local hospital or community center.

A new bill could help.

In May 2017, Joseph Crowley (D-NY) and Ryan Costello (R-PA) introduced a bipartisan bill that would raise the number of overall medical residency positions by 3,000 each year between 2019 and 2021. (Bills have been introduced into Congress every year since 2009 to do this, but none have ever passed.) To help push through this attempt, call your U.S. representative (visit usa.gov/elected-officials to find their contact info), give your name, and tell your rep that you hope that he or she will support the Resident Physician Shortage Reduction Act because you’re worried about doctor—particularly dermatologist—shortages.

Skin clinics are popping up.

Dozens of hospitals have opened urgent care clinics for those worried about suspicious moles. The Cleveland Clinic has Growth of Concern and the University of Missouri in Columbia has What’s That Spot? Several organizations also sponsor traveling skin-cancer screening programs, where dermas volunteer to check patients at no cost. Look for one near you. AAD’s SkinCheck (at aad.org); The Skin Cancer Foundation’s Destinatıon Healthy Skin (at skincancer.org); The Melanoma Research Foundation’s Mark the Spot! (at melanoma.org).