

dermatologists who agreed to participate in the survey during a national meeting on skin cancer diagnosis that occurred in Rome on November 22, 2019. The attendees were asked to provide demographic information, including age, sex, and geographic area of practice in Italy. They were then asked to answer to 5 multiple-choice questions that were prepared by 3 of us (E.M., G.A., and C.L.) (Table I).

Interestingly, 47% of participants declared not to have a close referral center for RCM vs 44.0% who indicated they had a referral center in their region (39.0%) or outside their region (5.0%). Only 9.0% of participants declared to have a RCM available in their practice. In all, 65% of dermatologists indicated they did not use RCM for their patients, because of lack of a close referral center (45.0%) or because they find it useless (20.0%). Of the 168 participants (35.0%) who suggested RCM to their patients, 139 (82.7%) found it useful in most cases.

Correct indications for the use of RCM (doubtful lesions of the head/neck, trunk and extremities, pigmented or not) were mentioned by most clinicians (question 4 in Table I). Only approximately 2% believed that it can be used in acral, ungual, or ulcerated lesions, which are actually areas not suitable to RCM imaging.<sup>3</sup> This highlights that most dermatologists have a certain knowledge of the tool and its potential benefits and best indications.

The results of our survey pointed out that in Italy, a country where RCM is an established and well-known diagnostic technique, still only a minority of dermatologists use it routinely for their patients. Most of the dermatologists referring to RCM declared to refer 1 to 5 lesions per month. For RCM to become available to a larger number of patients, research and education will play an important role. More studies are needed, particularly data from large multicenter studies on the clinical advantages of RCM.

In addition, a better distribution of the tools in the territory is warranted, along with a better knowledge of location of referral centers. But more importantly, a network connecting dermatologists from private practice to referral centers is strongly needed to improve the use of this diagnostic technique in the clinical routine.

*Elvira Moscarella, MD,<sup>a</sup> Marina Agozzino, MD,<sup>a</sup> Caterina Longo, MD,<sup>b,c</sup> Giovanni Pellacani, MD,<sup>b</sup> and Giuseppe Argenziano, MD<sup>a</sup>*

*From the Dermatology Unit, University of Campania, Vanvitelli, Naples<sup>a</sup>; the Department of Dermatology, University of Modena and Reggio Emilia, Modena<sup>b</sup>; and Centro Oncologico ad*

*Alta Tecnologia Diagnostica, Azienda Unità Sanitaria Locale—Istituto di Ricovero e Cura a Carattere Scientifico di Reggio Emilia, Italy.<sup>c</sup>*

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*Correspondence to: Elvira Moscarella, MD, Dermatology Unit, University of Campania Vanvitelli, Via Pansini 5, Naples, Italy, 80138*

*E-mail: [elvira.moscarella@gmail.com](mailto:elvira.moscarella@gmail.com)*

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#### Assessing the role of physician-selected quality improvement measures in patient encounters



*To the Editor:* In recent years, physicians have faced a growing demand to optimize patient experience with the emergence of Yelp, HealthGrades, and other consumer feedback platforms.<sup>1</sup> As previous reports have importantly shown, productivity need not improve at the expense of patient satisfaction or the quality of care provided.<sup>2</sup> We assessed physician perception of patient response to simple behavioral modifications and the impact on productivity.

The Office of Patient Experience at Massachusetts General Hospital proposed 25 interventions based on review of patient experience literature, such as that by Boffeli et al.<sup>2</sup> Faculty in the Department of Dermatology were instructed to select 2 or 3 communication habits they wanted to adopt but felt they may need reminding with, and they trialed these using these in their encounters over 3 months of clinical activity (Table I). At the end of the trial, providers submitted written feedback on their experience.

All 40 participating providers selected a minimum of 2 interventions to trial during patient encounters, and 26 providers selected an additional third intervention. The top 3 most successful and least

**Table I.** Proposed behavioral modifications by frequency of selection

Intervention	Number of times selected, n
When running late, always apologize and thank patient for waiting	13
Knock/greet patient pleasantly and by name	12
Paraphrase the patient history: "I reviewed your medical history..."	9
Ask "What questions do you have for me?" (stay seated)	8
Sit so that you are at eye level	8
Introduce yourself by name and role	6
Query understanding: "What would you like me to go over again?"	6
Introduce all members of the care team in the examination room	6
Establish and use eye contact (with patient and family)	5
Show you are listening and check for understanding: "Here is what I heard you say. Did I get it right?"	4
Turn computer screen toward patient/family	4
Build an agenda: you and the patient identify and prioritize issues to address during the visit	4
Let the patient's agenda, concerns, and questions drive the visit	3
Stick to the agenda and strategically interrupt patient if necessary	3
Use nontechnical terms to explain diagnosis	3
Make bridging statements when you are using computer: "I am going to take a minute to record this information in your record."	2
Know referring clinician and reason for referral	2
Be sure to let patient/family know to contact your office if something comes up	2
Clear summary of treatment plan: "The plan is...", "Do you feel comfortable with this?"	2
Never be out of eye contact for more than 10 seconds while typing, and always make eye contact when asking questions	1
Clearly state what will happen next: appointments, tests, new medication (medication name, purpose, potential adverse effects, duration of therapy)	1
Thank the patient and family	1
Ask permission from patient to examine him/her and set expectations for the examination	1
Allow patient to tell story, do not interrupt (2-minute rule)	0
Use agenda to plan the visit before doing a diagnostic dive	0

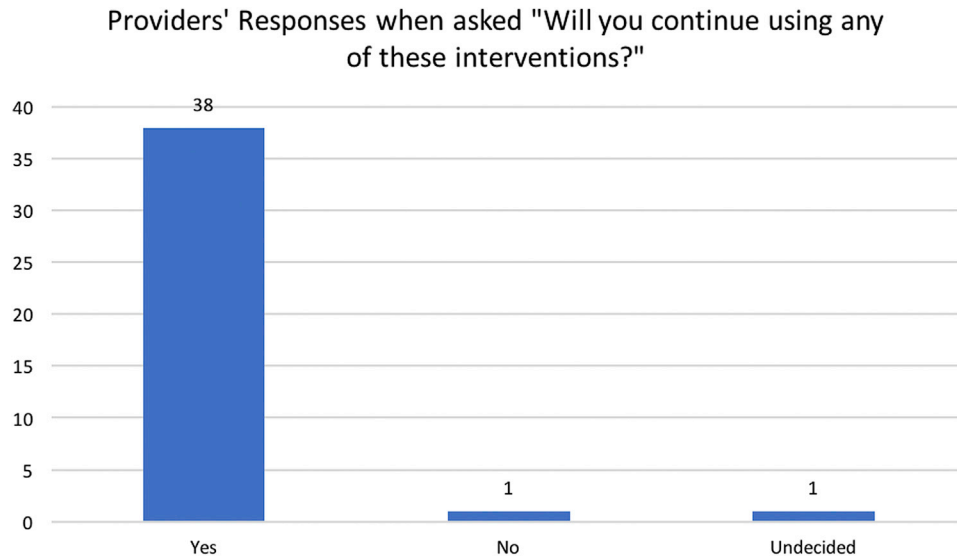
**Table II.** Most helpful and least helpful interventions based on provider feedback

Most helpful interventions (n ≥ 5)	Least helpful interventions (n ≥ 4)
Apologizing to and thanking the patient when running late (n = 13; 100%)	Build an agenda: you and the patient identify and prioritize issues to address during the visit (n = 4; 50%)
Asking "What questions do you have for me?" (n = 8; 100%)	Introducing yourself by name and role (n = 6; 66.6%)
Introducing all members of the care team in the examination room (n = 6; 100%)	Turn computer screen toward patient/family (n = 4; 75%)

successful interventions are summarized in [Table II](#). In their written feedback, 38 out of 40 providers indicated that they believed these interventions had a positive impact on the encounter and intended to continue using any or all of the 3 interventions.

The results of our study suggest that physician-selected communication habits can improve the quality of patient encounters and provide meaningful structure to the visit from the physician's perspective. Overall, 95% (38/40) of participants responded in their feedback that they would continue to use at

least 1 intervention that they trialed in future patient encounters ([Fig 1](#)), and most further specified that they would continue to use all of them. Physicians hold legitimate concerns about how ineffectual changes may hinder their productivity for no additional benefit. Thus, they may be reticent to incorporate measures for which there is little justifiable advantage. In this model, because physicians themselves are both the architects and implementers of simple interventions in the realm of communication, their clinical experience can inform



**Fig 1.** Providers' responses when asked, "Will you continue using any of these interventions?"

**Table III.** Top 5 characteristics of physicians with strong productivity and satisfaction

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Conveys warmth and respect from the start of the encounter
Focused on teaching and planning
Conveys familiarity with patient's story
Extremely personable and sits at patient's eye level
Familiarizes patient with care team and flow of visit

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meaningful improvements to both interpersonal and workflow-related characteristics of the patient encounter. Per our survey, the most successful interventions are those that afford warmth and respect from the start of the encounter, focus on teaching and planning, and provide structure to the visit (Table II), corresponding to a number of broad communication characteristics in physicians with strong productivity (Table III). All of these measures required adding only a brief dialogue or behavioral modification to the visit; highlighting the ease with which this quality improvement model can be used by providers across institutions.

Afsheen Sharifzadeh, BA,<sup>a,b</sup> Mary O. Cramer, MBA,<sup>c</sup> and Gideon P. Smith, MD, PhD, MPH<sup>ad</sup>

From the Department of Dermatology, Massachusetts General Hospital, Boston<sup>a</sup>; University of Massachusetts Medical School, Worcester<sup>b</sup>; Office of Patient Experience, Massachusetts General Hospital, Boston<sup>c</sup>; and Harvard Medical School, Boston, Massachusetts.<sup>d</sup>

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Correspondence to: Afsheen Sharifzadeh, 50 Staniford St, Ste 200, Boston, MA 02114

E-mail: [afsheen.sharifzadeh@gmail.com](mailto:afsheen.sharifzadeh@gmail.com)

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#### Dermatologist appointment access and waiting times: A comparative study of insurance types



*To the Editor:* The current relationship between patient insurance type and dermatologist access has not been evaluated. In 2004, lower dermatologist acceptance rates and higher waiting times were documented for patients with Medicaid compared with private insurance or Medicare.<sup>1</sup> Since 2004, there have been several notable changes to government health care plans, including the 2010 Affordable Care Act, which expanded Medicaid coverage and enhanced primary care access for its beneficiaries.<sup>2</sup> However, recent data suggest that greater primary care demand from this expansion has increased waiting times for all patients.<sup>3</sup> As such,