her favor by having staff members rather than patients complete surveys with uniformly high marks. Given the high levels of patient satisfaction currently observed, one would hope that this would be unnecessary. Certainly this type of data manipulation would not be motivated by the ABD, whose DMOC program requires participation in quality assurance programs; however, the ABD does not review data from individual dermatologists. In addition, an important question currently not included in the DrScore survey is "How likely would you be to recommend this practice and/or physician to others?" The addition of this question would likely make the tool even more useful to the subscriber.

A multitude of factors affect patient perception of quality health care. Some dermatologists might find it difficult to accept criticism of errors made by office staff. Nonetheless, physicians are ultimately held accountable by patients for the actions of new and inexperienced office staff members. The physician is the "ship's captain" and is ultimately responsible for the patient's satisfaction with the entire office visit. In a recent study focusing on the relationship between patient wait times and patient satisfaction, Anderson et al\(^6\) reported that the time spent with the physician is of utmost importance to the patient and was the most powerful predictor of patient satisfaction, even greater than wait time. Satisfaction surveys providing insight into patient perceptions of time spent with the dermatologist would likely prove to be a valuable tool for any practicing dermatologist.

The cost of such a system will certainly be of interest to those implementing a quality improvement assessment program. The DrScore service costs $149.00 for the first year of membership and includes 4 quarterly reports. The Internet-based patient satisfaction surveys are cost-effective, and there is no limit to the number of surveys that can be conducted per medical office. The American Academy of Dermatology might also develop quality assurance tools designed to assess patient satisfaction and meet DMOC requirements for peer performance review similar to the systems under development by other specialty boards.\(^6\)

**Conclusions.** The potential for identifying valuable information with a quality assurance tool such as the online service used here must be weighed against its cost. The minimal financial cost and small investment in time required to use this system suggests that many dermatologists will find that the benefits outweigh costs.

Dermatologists in the United States continue to strive toward the ultimate goal of providing the highest quality of care. One measure of quality care remains the satisfied patient. Though curing and controlling disease is the most critical component of our work, the satisfied patient may be the key to successful outcomes through improved compliance, practice growth, and reduced liability. We believe that both physicians and patients benefit when physicians receive feedback on their patients' satisfaction.

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**Enhancing Patient Motivation to Reduce UV Risk Behaviors: Assessing the Interest and Willingness of Dermatologists to Try a Different Approach**

Patients who continue to engage in high-risk UV behaviors despite being informed of the risk of developing skin cancers can be a source of frustration for many dermatologists. Typically, dermatologists attempt to educate and advise their patients about the dangers of UV exposure and the importance of using protective strategies, particularly if the patient has indicators of risk for developing skin cancer. Unfortunately, a substantial number of patients ignore this information and continue to engage in high-risk UV exposure, resulting in dermatologists feeling a sense of inadequacy in changing patients’ UV behaviors.\(^1\)

Physicians generally do not receive formal instruction related to behavioral change during their training and often provide educational information and direct advice to their patients hoping to promote behavior change. However, research from numerous health-related domains has routinely demonstrated that such educational approaches are not as efficacious as alternative approaches that enhance individuals’ motivation to change, particularly in modifying resistant behaviors such as smoking, alcohol abuse, exercise, and eating and/or dieting.\(^2\) Arguably, UV exposure could be classified as a resistant behavior because a substantial percentage of individuals engage in intentional UV exposure despite known risks, and a significant number of individuals continue to intentionally tan even after being treated for skin cancer.\(^3\)

Efficacious behavioral interventions based on motivational interviewing (MI)\(^4\) have been developed by psychologists to be used in the context of a 50-minute session, which is much longer than physicians typically spend with their patients. Over the years, these interventions have been dramatically condensed and modified to fo-
cuss on a variety of health behaviors (eg, smoking) and have been successfully used in health care settings by physicians; however, they have not been adapted by dermatologists for use in preventing UV risk behaviors. Two questions arise: Can dermatologists promote healthy behavior change among their patients, particularly those who are at risk and most resistant to change? And is there an overall interest among dermatologists in learning to use MI techniques with their patients?

Methods. We conducted a focus group to assess dermatologists’ interest in learning and using MI. The research protocol was approved by the institutional review board of Northwestern University, and all subjects gave their informed consent prior to participating in the focus group. Twenty dermatology residents and faculty members at a large, urban, academic hospital participated by attending a 1-hour session. A role play example of an adapted dermatological brief negotiation interview (BNI)5 based on the principles of MI6 was demonstrated. The role play lasted for 10 minutes, and the content consisted of a physician discussing UV risk and protection with a teenaged patient seeking treatment for acne. After watching the BNI, focus group participants completed anonymous questionnaires asking about their comfort and willingness to learn and use MI as a behavioral intervention with their patients.

Results. Eighty-five percent of participants reported that they would feel comfortable performing the MI techniques demonstrated (n=17), and 75% endorsed willingness to try them (n=15). Furthermore, 100% of the dermatologists reported that they felt MI techniques would be useful when working with 17- to 24-year-old patients (n=20). In addition, 100% of the dermatologists expressed interest in learning MI techniques and would be willing to spend an average of 2 hours in a formal training (n=20).

Comment. The results of this brief study highlight both dermatologists’ willingness to learn and perceived usefulness of MI behavioral interventions to reduce patient risk behaviors. Dermatologists in the study unanimously felt that MI would be useful when working with patients in high-risk age groups (eg, young adults). These results are not surprising in that college-aged women consistently felt that MI would be useful when working with 17- to 24-year-old patients (n=20). In addition, 100% of the dermatologists expressed interest in learning MI techniques and would be willing to spend an average of 2 hours in a formal training (n=20).

Encephalocraniocutaneous Lipomatosis With Didymosis Aplasticopsilolipara

Report of a Case. An 11-day-old boy born to noncon-sanguineous Vietnamese parents presented to our pedi-atric dermatology outpatient department with a congenital linear scalp and face lesion. This soft, skin-colored plaque following the lines of Blaschko was devoid of terminal hair growth and extended from the left upper eyelid up to the ipsilateral vertex. At the vertex were 3 round, elevated, bald, bullous patches and 2 round scars and hair collars (Figure 1). On the upper eyelid, 2 soft, skin-colored papules were seen. Based on the clinical evaluation, encephalocraniocutaneous lipomatosis (ECCL) was suspected.

Neurologic and ophthalmologic examination at age 8 weeks revealed a proximal hypotonic and distal hypertonic motoric dysfunction, proptosis of the left eye with caudal displacement of the globe, and optic nerve pallor. Magnetic resonance imaging of the cranium revealed thickened adipose tissue extending extracranially from the left parietal area to the left orbit. Within this tissue, cystic areas could be delineated. The underlying meninges were slightly thickened (Figure 2). Hi-