

The Road Less Traveled: Why Rural Dermatology Could Be Your Path After Residency

Mary E. Logue, MD; Brandon R. Litzner, MD; Tara Gillespie, APRN

Rural dermatology is not as simple as it seems. For some, it means being the only dermatologist in a county where patients drive 3 hours for an appointment; for others, it means practicing in a mid-sized town and serving as both community doctor and regional referral point. Too often, rural dermatology is dismissed as isolating or career limiting, but the truth is very different. Rural dermatologists see plenty of common conditions such as acne and eczema, but they also see complex inflammatory diseases and advanced skin cancers that reflect delays in care for patients living in rural communities in the United States. Careers in rural dermatology can be flexible and creative, ranging from private practice to hospital employment to hybrid models that blend community and academic life.

The myths persist: *You will lack colleagues. Your practice will be thin. You must sacrifice academic engagement.* In reality, rural practice offers variety, leadership opportunities, and the chance to influence the health of entire communities in profound ways. In this article, we aim to unpack what rural dermatology actually looks like as a potential career path for residents, with a focus on private-academic hybrid and hospital-based practice models.

What Does Rural Really Mean?

Definitions of the term *rural* vary. For the US Census Bureau, it is synonymous with *nonurban*, and for the Office of Management and Budget, the term *nonmetropolitan* is preferred. The US Department of Agriculture's Rural-Urban Commuting Area codes recognize a continuum of classifications from *micropolitan* to *remote*. In

practice, the term *rural* covers a wide spectrum: the rolling farmlands of the Midwest, the mountains of Montana, the bayous of the South, the Native American reservations in New Mexico, and everything in between. It is not one uniform reality—rural America is diverse, resilient, and deeply connected.

A Day in Rural Practice

Daily clinic flow may look familiar: a full schedule, a mix of new and established patients, and frequent simple procedures such as biopsies and corticosteroid injections. But the scope of practice is wider. You become the dermatologist for hundreds of miles in every direction, managing most conditions locally while referring select cases to subspecialty centers.

Case variety is striking. Neglected tumors, unusual inflammatory presentations, pediatric conditions, and occupational dermatoses/injuries appear alongside the routine. Each day requires flexibility, judgment, confidence, and the ability to think outside the box. You must consider how a patient's seasonal work, such as ranching or farming, and/or their total commute time impacts the risk-benefit discussion around treatment recommendations.

Matthew P. Shaffer, MD (Salina, Kansas), who has practiced rural dermatology for more than 20 years, explained that the breadth of dermatologic cases in which he served as the expert was both exciting and intimidating, but it became clear that this was the right professional path for him (email communication, September 5, 2025). In small communities, your role extends beyond the clinic walls. You will see patients at the grocery store, the library,

Dr. Logue is from the Department of Dermatology, Monument Health, Spearfish, South Dakota, and the Department of Dermatology, University of New Mexico, Albuquerque. Dr. Litzner and Tara Gillespie are from Heartland Dermatology, Salina, Kansas. Dr. Litzner also is from the Department of Dermatology, School of Medicine, Saint Louis University, Missouri.

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Correspondence: Mary E. Logue, MD, 810 N Main St, PMB #138, Spearfish, SD, 57783 (admin@radsociety.org).

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and school events. That continuity fosters loyalty and accountability in ways that are hard to quantify.

Hybrid Partnerships and Hospital-Based Practice

Many practice structures exist: independent clinics, multispecialty groups, hospital employment, and increasingly, hybrid partnerships with academic centers.

Academic institutions have recognized the importance of rural exposure, and many now collaborate with rural dermatologists. For example, Heartland Dermatology in Salina, Kansas, where 2 of the authors (B.R.L. and T.G.) practice, partners with St. Louis University in Missouri to provide a residency track and rotations in rural clinics.

Rural-based hospital systems can create similar structures. Monument Health Dermatology in Spearfish, South Dakota, is integrated into the fabric of the community's larger rural health care model. The physician (M.E.L.) collaborates daily with primary care providers, surgeons, and oncologists through a shared electronic health record (sometimes even through telephone speed-dial given the close collegiality of small-town providers). Patients come from across 4 states, some driving 6 hours each way. Patients who once doubted whether dermatology was worth the trip will consistently return for follow-up care once trust is earned. The stability of hospital employment supports volunteer faculty positions and a free satellite clinic in partnership with a local Lakota Tribal health center. There is never a dull day: the providers see urgent add-ons daily, which keeps them on their toes but in exchange brings immense reward. This includes a recent case from rural Wyoming: a complex mixed infantile hemangioma on the mid face just entering the rapid proliferation phase. Propranolol was started immediately, as opposed to months later when it was too late—a common complication for the majority of rural patients by the time to get to a dermatologist.

The Hub-and-Spoke Model

Complex cases can overwhelm rural practices, and this is when the hub-and-spoke model is invaluable. Dermatologists embed in local communities as spokes, while subspecialty services such as pediatric dermatology, dermatopathology, or Mohs micrographic surgery remain centralized at hubs. The hubs can be but do not have to be academic institutions; for Heartland Dermatology in Kansas, private practices fulfill both hub and spoke roles. With that said, 10 states do not have academic dermatology programs.¹ Mohs surgeons and pediatric dermatologists still can establish robust and successful independent rural subspecialty practices outside academic hubs. Christopher Gasbarre, DO (Spearfish, South Dakota), a board-certified, fellowship-trained Mohs surgeon in rural practice, advises residents to be confident in their abilities and to trust their training, noting that they often will be asked to manage complicated cases because of patient travel and cost constraints; however, clinicians should recognize their own limitations and those of

nearby specialists and develop a referral network for cases that require multidisciplinary care (text communication, September 14, 2025).

The hub-and-spoke models—whether they entail an academic center as the hub with private practices as the spokes, or a network of private practices that include rural subspecialists—allows rural dermatologists to remain trusted local experts while ensuring that patients can access advanced care via a more streamlined referral process/network. The challenge is triage: what can be managed locally and what must patients travel for? As Dr. Shaffer explained, decisions about whether care is managed locally or referred to a hub often depend on the experience and comfort level of both the physician and the patient (email communication, September 5, 2025). Ultimately, continuity and trust are central. Patients rely on their local dermatologist to guide these decisions, and that guidance makes the model effective.

Finding the Right Fit

The idea that rural practice means being stuck in a small solo clinic is outdated. Multiple pathways exist, each with strengths and challenges. Independent private practice offers maximum autonomy and deep community integration, though financial and staffing risks are yours to manage. Hospital employment with outreach clinics provides stability, benefits, and collegiality, but bureaucracy can limit innovation and efficiency. Private equity platforms supply resources and rapid growth, but alignment with mission and autonomy must be weighed carefully. Hybrid joint ventures with hospitals combine private control and institutional support, but contracts can be complex. Locum tenens—to-permanent arrangements let you try rural life with minimal commitment, but continuity with patients may be sacrificed. A self-screener can clarify your path: How much autonomy do I want? Do I prefer predictability or variety? How important are procedures, teaching, or community roles? Answer these questions honestly and pair that insight with mentor guidance.

Getting Started: A 90-Day Outline

Launching a rural dermatology clinic is equal parts vision and structure. A focused 90-day plan can make the difference between a smooth opening and early frustration. Think in 4 domains: site selection, employment and licensing, credentialing and contracting, and operations. Even in a compressed timeline, dozens of small but crucial tasks may surface. There are resources—such as the Medical Group Management Association's practice start-up checklist—that can provide a roadmap, ensuring no detail is overlooked as you transform a vision into a functioning clinic.²

Site Selection—First, determine whether you are opening a new standalone clinic, extending an existing practice, or creating a part-time satellite. Referral mapping with local primary care providers is essential, as is a scan

of payer mix and dermatologist density in the region to ensure sustainability.

Employment and Licensing—Confirm state licensure and Drug Enforcement Administration registration and initiate hospital privileges early. These processes can stretch across the entire 90-day window, so starting immediately is critical.

Credentialing and Contracting—Applications with commercial and federal payers, along with Council for Affordable Quality Healthcare updates, often consume weeks if not months. If you plan to perform office microscopy or establish a dermatopathology laboratory, begin the Clinical Laboratory Improvement Amendments certification process in parallel.

Operations—Once the regulatory wheels are in motion, shift to building your practice infrastructure. Secure space, weigh lease vs purchase, and consider partnerships with local hospitals for shared clinic facilities. Recruit staff with dermatology-specific skills such as clinical photography and biopsy assistance. Implement an electronic health record, set up payroll and malpractice insurance, and establish supply chains for everything from liquid nitrogen to surgical trays. Decide whether revenue cycle management will be in-house or outsourced and finalize dermatopathology workflows including courier and transport agreements.

Compensation and Career Sustainability

Compensation in rural dermatology mirrors that of other clinical settings: base salary with productivity bonuses, revenue pooling, or relative value unit structures. Financial planning is crucial. Develop a pro forma that models patient volume, expenses, and realistic growth. Risks exist, including payer mix, staffing, and competition, but the demand for care in underserved areas often offsets these, and communities may support practices with reduced overhead and strong loyalty. Hospital systems may add stipends for supervising advanced practitioners or outreach travel. Loan repayment programs, tax credits, and grants can further enhance packages. Consider checking with the state's Office of Rural Health.

Career sustainability ultimately depends on more than finances. Geography, amenities, schedule flexibility, autonomy in medical decision-making, work-life balance, the value of being part of and serving a community, and other personal values will shape your "best-fit" practice model. Ask whether you can envision yourself thriving in the community you would be serving.

Broader Efforts and Community

No one builds a rural dermatology practice alone. That is why one of the authors (M.E.L.) created the Rural Access to Dermatology Society (<https://www.radsociety.org/>), a

nonprofit organization connecting dermatologists, residents, and medical students with a shared mission. The organization supports residents through scholarships, mentorship, and telementoring. Faculty can contribute through advocacy, residency track development, and outreach to uniquely underserved rural populations such as Native American reservations where access to dermatology care remains severely limited. Joining can be as simple as attending a webinar, finding a mentor, or volunteering at a free clinic. You do not need to launch your own clinic to get involved; you can begin by connecting with a network already laying the foundation.

Teledermatology and Academic Tracks

Teledermatology and academic initiatives enhance rural care but do not replace in-person practice. Store-and-forward consultations extend reach but cannot match the continuity and trust of long-term patient relationships. Academic rural tracks prepare residents for unique challenges, but someone must staff the clinics. Private and hybrid models remain the backbone of rural access, where dermatologists take on the responsibility and the joy of being the local expert.

Final Thoughts

At its heart, rural dermatology is about trust and presence. Patients will share stories of delayed care, of driving hours for an appointment, of feeling invisible in the health care system. When you choose this path, you are not just filling a workforce gap, you are changing trajectories of lives, families, and communities. The rewards are not easily measured in relative value units or contracts; they show up in the loyalty of patients who return year after year, in the gratitude of families who no longer have to travel to "the big city," and in the satisfaction of building something bigger than yourself. As Dr. Shaffer noted, he views success primarily in relational terms, reflected in long-term patient trust and continuity of care, particularly when individuals with serious conditions return over many years and entrust him with their ongoing management (email communication, September 5, 2025).

So here's the invitation: bring one question to your mentor about rural practice and identify one rural site you could visit. The road less traveled in dermatology is closer than you think—and it might just be your path.

REFERENCES

1. Association of American Medical Colleges. ERAS Directory: Dermatology. Accessed December 11, 2025. https://systems.aamc.org/eras/erasstats/par/display.cfm?NAV_ROW=PAR&SPEC_CD=080
2. Medical Group Management Association. Large group or organization practice startup checklist. Accessed December 11, 2025. <https://www.mgma.com/member-tools/large-group-or-organization-practice-startup-checklist>