DERMATOLOGY
Resident ROUNDUP

MARCH 2003

Official publication of the Resident & Fellows Committee, American Academy of Dermatology Association

Supported by an educational grant from 3M Pharmaceuticals

Message from the chair

By Joel Gelfand, M.D.

It has been an honor to serve you as Chair of the Resident & Fellows Committee (RFC) for this past year. The RFC is an important method by which issues important to residents are advocated for to the American Academy of Dermatology (AAD) and the AAD Association (AADA).

The RFC has played a vital role in making the dermatology match concurrent with other specialties and with moving up the board exam date from fall to summer, a change supported by an overwhelming majority of residents.

In the past year, we have successfully advocated for the organizational re-structuring of the RFC. The RFC now reports to the Council on Health Policy and Practice. As Chair of the RFC, I advocated resident views in monthly conference calls with this Council and in quarterly Board of Directors meetings. Other RFC activities included representing dermatology resident issues at the American Medical Association, coordinating the Resident Colloquium at the AAD Annual Meeting (a venue for residents to discuss career issues with leading dermatologists), and publication of a fellowship directory. In 2003, we added Mohs Fellowships to our directory.

The RFC has also been an active contributor to the AADA's *Dermatology Resident Roundup*. In 2002, we added a section highlighting important information for boards preparation, which has received positive feedback from many residents across the country.

By serving as Chair of the RFC, I have learned how critically important it is for us as dermatologists to be active in advocating for our patients and our profession. Our training is occurring at an incredible time period in medicine. We have the ability to diagnose and treat dermatologic diseases with increasing success.

Despite the dramatic advances in our ability to help patients suffering from skin disease, however, we are confronted with tremendous challenges. Access to dermatologists and the treatments we prescribe is still out of reach for far too many people. Even those who have insurance are becoming increasingly frustrated by the wait times to see dermatologists. Malpractice problems increasingly impact our ability to deliver care. Declining reimbursement for dermatologic services could exacerbate these issues, particularly for patients with complex skin diseases. In addition to these health care delivery issues, dermatologists also need to play a key role in public health issues, such as skin cancer education and prevention and the evolving issues relevant to bioterrorism.

As you become experts in diagnosing and treating skin disease, I encourage you to stay informed about these issues that impact our ability to take care of patients. The AAD is a great place to learn about the evolving issues that affect our patients and our profession. Now is the perfect time to get involved! RR

Third-year and fellows needed to participate in focus group during Annual Meeting

The American Academy of Dermatology Association will be sponsoring a one-hour focus group during the upcoming Annual Meeting in San Francisco on Friday, March 21 from 12 to 1 p.m. at the Marriott Hotel in the Nob Hill A room. The focus group will follow up and drill down issues that were identified by fellows and third-year residents who completed the Resident Workforce Issues Survey. This one-page survey was handed out at the Galderma Dermatology Boards Review Course that was held in Chicago this past summer.

Topics that will be explored in the focus group include:

- What factors contribute to a resident's decision when choosing a job post residency, and
- What area of specialty within dermatology will residents choose to pursue in the future and why.

Lunch will be provided to participants. Registration for the focus group will be taken on a first come first served basis. The first 15 third-year residents and fellows to apply will be accepted. To apply, send an e-mail to Jill Mlodoch at *jmlodoch@aad.org*, phone (847) 240-1805 or fax (847) 330-1120 by Friday, March 14. RR

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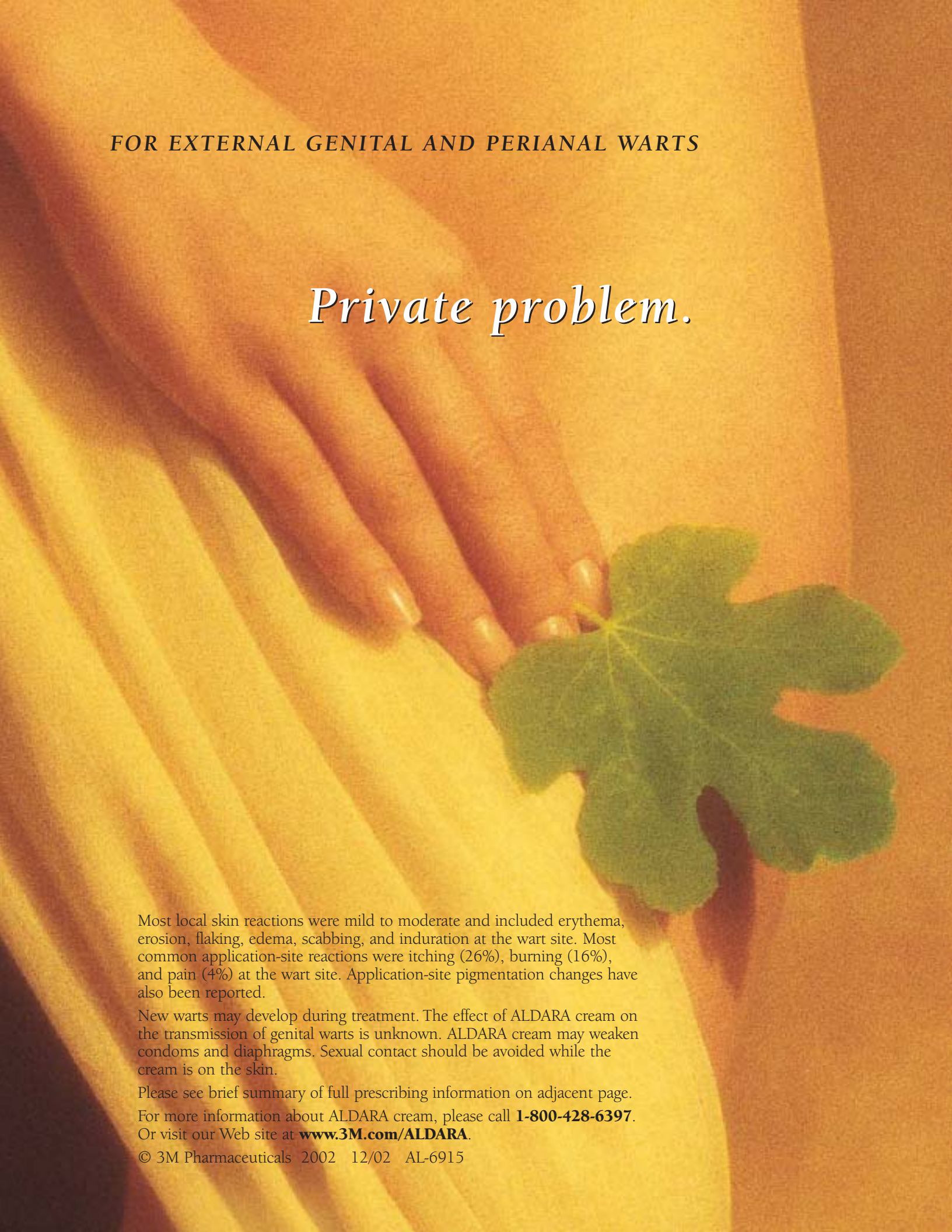

Most local skin reactions were mild to moderate and included erythema, erosion, flaking, edema, scabbing, and induration at the wart site. Most common application-site reactions were itching (26%), burning (16%), and pain (4%) at the wart site. Application-site pigmentation changes have also been reported.

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*Clinical relevance is unknown.

3M Pharmaceuticals

Disability Insurance: what you need to know before you buy

By Lawrence B. Keller, CLU, ChFC, RHU

You may have heard that the disability insurance policies available today are dramatically different from those available a few years ago. Although this may be true — especially for physicians who perform invasive procedures — quality coverage can still be found. It is important to understand how policies are offered and to know what provisions should be included in an individual disability policy.

Disability insurance can be purchased on an individual or group basis. Group insurance is usually provided by an employer or purchased individually from a sponsoring medical association, such as through the American Academy of Dermatology Group Insurance Plans, offered through JLT Services Corporation.

Although initially low in cost, group policies do have limitations. They can be canceled (by the association or insurance company), rates increase as you get older, and premiums are subject to adjustments based on the claims experience of the group. In addition, group and association contracts may contain restrictive definitions of disability as well as less-generous contract provisions.

Most insurance companies will issue disability insurance coverage equal to approximately 60 percent of earned income; however, interns, residents, fellows and physicians just entering practice are provided with "special limits." These special limits permit them to purchase benefits in excess of what their current earnings would normally allow.

COSTS

Premium rates are based on several factors including age, gender, monthly benefit amount, riders added to the policy and the occupational classification the insurance company assigns to your medical specialty. The younger you are when the purchase is made, the lower the cost of the insurance. Therefore, you should purchase a policy as early in your career as possible to lock in lower premium rates.

Although women are considered better risks for life insurance coverage, this is not the case with disability insurance. Rates for females are substantially higher and their policies can cost 50 to 75 percent more than men. The occupational classification assigned by the insurance company, to your medical specialty, will significantly impact the premium rates as well as the policy provisions offered to you. Generally, if you perform invasive procedures, you will be placed in the "surgical" category; where the definition of disability may be more restrictive and the premiums charged will be higher as compared to those of a non-invasive, non-surgical physician. Each insurance company has their own occupational classification guide and insurance companies may treat the same medical specialty differently.

Although it is an invasive specialty, dermatology is unique in that some companies do not place dermatologists in the "surgical" category. As a result, the definition of disability available is more liberal and the premium rates are lower than if had you been classified as a surgeon.

SEE "DISABILITY INSURANCE" PAGE 5

"DISABILITY INSURANCE" FROM PAGE 4

WHAT TO LOOK FOR

The renewability provision is one of the key features of an individual disability income insurance policy. This provision defines your rights when it comes to keeping your disability policy in force. If you purchase a policy that is *non-cancellable* and *guaranteed renewable*, you can remain in control of your financial security. The insurance company cannot cancel, increase your premiums, change any provisions or add restrictions to the policy — even if the issuing company no longer offers similar policies in the future.

DEFINITION OF TOTAL DISABILITY

Arguably, the definition of disability is the most important aspect of a disability policy. As a physician, you must pay careful attention to the definition of disability found in your policy as it will ultimately determine how any claim you make for benefits will be judged. There are three definitions of "disability" commonly found in the insurance industry, and each has significant differences.

Although difficult to find, **own-occupation** (also known as true or pure own-occupation) is usually the definition of choice for dermatologists as it is the most liberal definition of total disability available. This type of policy pays benefits if you are disabled and "not able to perform the material and substantial duties of your occupation." Therefore, you would collect full disability benefits if you could no longer practice dermatology and/or perform dermatologic surgery, even if you decided to work in another occupation or medical specialty, earning the same or more income than you did as a dermatologist.

More common is **modified own-occupation**. This type of disability policy has become the most prevalent in the industry today and typically pays benefits if you are "unable to perform the substantial and material duties of your occupation *and you are not working*." Although benefits are still contingent upon your ability to practice dermatology and/or perform dermatologic surgery, this definition will not allow you to continue receiving full disability benefits if you are working in another occupation or medical specialty.

The **any occupation** definition — the third and most restrictive of the three described here — is commonly found in group or association policies. Under this definition, you are eligible to receive benefits only if you are found to be "unable to work in any occupation which you are reasonably suited to by your education, training or experience." Unfortunately, it is the insurance company that makes this determination and physicians, being as educated and well-trained as they are, will find it extremely difficult to collect benefits on this type of policy. You should take every precaution to avoid purchasing a policy that contains this definition.

Many policies offered to physicians today might incorporate an own-occupation with a modified own-occupation" definition. Here, the policy would contain a true "Own-Occupation" definition for a limited time period (typically one, two or five years), and then convert to the more restrictive modified own-occupation definition described above. Until recently, in certain states such as California and Florida, and for certain medical specialties, this often was the best definition of disability made available.

OPTIONAL RIDERS

Unless your policy contains a residual disability rider, you may have to be totally disabled to collect any benefits. While an own-occupation policy protects your ability to practice dermatology and/or perform dermatologic surgery, it may not sufficiently protect your income level. There are many disabilities that might allow you to continue working in your occupation, on a limited basis, while suffering a loss of income. Adding a residual disability rider to your policy would allow you to continue receiving benefits, proportionate to your loss of income, if you returned to dermatology on a part-time basis.

Furthermore, with policies such as Modified "Own-Occupation" or "Any Occupation, this rider might allow you to continue receiving benefits if you decided to work in another occupation, or if the insurance company determined that you could work in another "reasonable" occupation with reduced earnings.

A Cost of Living Adjustment (COLA) Rider is designed to help your benefits keep pace with inflation after your disability has lasted for 12 months. This adjustment can be a flat percentage or tied to the Consumer Price Index. Ideally, you want a COLA that is adjusted annually on a compound interest basis with no "cap" on the monthly benefit. Although important, if cutting the cost of coverage is an issue, this might be the first optional rider to consider excluding from your policy.

A **future purchase option rider** is a must for young physicians. It provides you with the ability to increase your disability coverage, regardless of your future health, as your income rises. It is important to know when you can increase your coverage, as well as by what increments, on any given option date. Some companies may allow you to use your entire option in one year as long as your then current income warrants the increase; Others, however, may limit the amount that you can purchase.

Policies vary greatly in terms of the definition of disability made available, the contract provisions offered and the premiums charged. It is more important than ever that you take the time to compare each of the policies you are considering, and understand how and why they differ. The best approach is to employ the services of a professional insurance agent who specializes in working with physicians. He or she will not only be familiar with your occupation, but with which companies' policies are best suited to your particular specialty. Then you and the agent can decide which insurance company's policy best meets your individual insurance needs. RR

Lawrence B. Keller, CLU, ChFC, RHU is the founder of Physician Financial Services, an independent New York City-based firm, specializing in insurance, investments, and financial services for physicians. He can be reached for questions or comments toll-free at (866) 442-6262 x166, locally at (212) 867-9080 x166, or by e-mail to lkeller@sfnonline.com.

JLT Services Corporation, AAD Group Insurance Plans, may be reached at (888) 747-6866, or visit www.aad-insurance.com.

Boards' Fodder: bugs and their vectors

Benjamin A. Solky, M.D. and Jennifer L. Jones, M.D.

This is the third installment in an ongoing series designed to bring to light "askable factoids" for the dermatology boards and mock boards. This installment focuses on important (or frequently asked) infectious disease for which there are known vectors of transmission.

DISEASE	CAUSE	VECTOR
Acrodermatitis Chronica Atrophicans	*Borrelia afzelii*	*I. ricinus*
African Trypanosomiasis	*Trypanosoma gambiense* *Trypanosoma rhodesiense*	Tsetse fly (*Glossina morsitans*)
Bovine Farcy	*Nocardia Farcinica*	Cattle
Carrion's Disease	*Bartonella bacilliformis*	*Lutzomyia verrucarum* (sandfly)
Cercarial Dermatitis	Cercariae of *Schistosomes* (Non-human)	Snails
Chagas' Disease (American Trypanosomiasis)	*Trypanosoma cruzi*	Reduviid bug (assassin bug, kissing bug)
Chiclero Ulcer	*Leishmaniasis mexicana*	*Lutzomyia flaviscutellata*
Cutaneous Larva Migrans	*Ancylostoma braziliense*	Contact with animal feces
Cystercercosis Cutis	*Taenia solium*	Contaminated food
Dracunculiasis (Guinea Worm Disease, Medina Worm)	*Dracunculus medinensis*	*Cyclops* water flea in drinking water
Ehrlichiosis	*Ehrlichia chaffeensis*	Tick bites
Elephantiasis Tropica	*Wuchereria bancrofti* *Brugia malayi* *Brugia timori*	*Culex*, *Aedes*, and *Anopheles* mosquitos
Erysipeloid of Rosenbach	*Erysipelothrix rhusiopathiae*	Found on Pigs, Shellfish, & Turkeys
Glanders (Farcy)	*Pseudomonas mallei*	Horses, Mules, & Donkeys
Leishmaniasis, New World	*L. mexicana; L. braziliensis braziliensis* *L. braziliensis guyanensis; L. b. panamensis*	*Lutzomyia* (Sandfly)
Leishmaniasis, Old World	*L. tropica; L. major; L. aethiopia; L. infantum*	*Phlebotamus perniciosus* (Sandfly) RESEVOIR:Rodents (gerbils)
Loaiasis (Calabar, Tropical and Fugitive Swelling)	*Loa loa*	*Chrysops* species (Mango Fly or Deer Fly)
Lyme Disease	UNITED STATES *Borrelia burgdorferi* EUROPE *B. garinii* and *B. afzelli*	NE & MID-WEST U.S.*Ixodes scapularis* (*dammini*), WESTERN U.S.*I. pacificus,* EUROPE *I. ricinus*
Mediterranean Fever (Boutonneuse Fever, S. African Tick Bite Fever)	*Rickettsia conorii*	*Rhipicephalus sanguinous* (Dog Tick)
Melioidosis (Whitmore's Disease)	*Burkholderia pseudomallei*	Swamp Water
Myiasis	*Dermatobia hominis* (Botfly) & *Cordylobia* species	Mosquito
Onchocerciasis (River Blindness)	*Onchocerca volvulus*	*Simulium* species (Black Fly)
Plague	*Yersinia pestis*	*Xenopsylla cheopis* (Rat Fleas)
Rat-Bite Fever (Haverhill Fever, Sodoku)	*Spirillium minor* *Streptobacillus moniliformis*	Rat Bites
Relapsing Fever	*Borrelia duttonii* *B. recurrentis*	*Pediculosis humanus* (Louse) & *Ornithodorus tholozani* (Tick)
Rickettsialpox	*Rickettsia akari*	*Allodermanyssus sanguineus* & *Liponyssoides sanguineus* (House Mouse Mites) RESEVOIR: *Mus Musculus* (House Mouse)
Rocky Mountain Spotted Fever	*Rickettsia rickettsii*	*Ixodid* Ticks, *Dermacentor andersoni*, *D. variabilis*, & *Amblyomma americanum* (Lone Star Tick)
Schistosomiasis	*S. mansoni*, *S. haematobium,* & *S. japonicum*	Snails
Scrub Typhus (tsutsugamushi fever)	*Rickettsia tsutsugamushi*	*Trombiculid* red mite (Chigger)
Sparganosis	*Spirometra* (dog and cat tapeworm larvae)	Application or ingestion of infected flesh from frogs or snakes
Toxoplasmosis	*Toxoplasma gondii*	Cat feces & Undercooked meat
Trench Fever	*Bartonella quintana*	Pediculosis humanus (Louse)
Trichinosis	*Trichinella spiralis*	Pig, Bear, and Walrus Meat
Tularemia (Ohara's Disease, Deer Fly Fever)	*Francisella tularensis*	Wild rabbit handling*Dermacentor andersonii* (tick) *Amblyomma americanum* (Lone Star Tick) *Chrysops discalis* (deer fly)
Typhus, Endemic	*Rickettsia typhi*	*Xenopsylla cheopis* (Rat Flea)
Typhus, Epidemic	*Rickettsia prowazekii*	*Pediculus humanus* (body louse) RESEVOIR: *Glaucomys volans*(Flying Squirrel)
Weil's Disease	*Leptospira interrogans icterohaemorrhagiae*	Rat Urine
West Nile Fever	Arbovirus - RNA-virus	*Culex* (mosquito)

Resident fellows events at 2003 Annual Meeting

The following events may be of interest to residents at the AAD Annual Meeting:

OPEN SESSIONS - NO TICKET REQUIRED

Residents Colloquium, Saturday, March 22, 12:15 p.m. to 1:45 p.m., Room 301 of The Moscone Center.

Residents & Fellows Symposium, Sunday, March 23, 9:55 a.m. to 2:00 p.m., Room 301 of The Moscone Center.

OTHER SYMPOSIA - NO TICKET REQUIRED

SYM 301 Gross & Microscopic Dermatology Symposium, Friday & Saturday, March 21-22, 9:00 a.m. to 5:00 p.m. each day.

SYM 308 Fundamentals of Cutaneous Surgery, Friday, March 21, 9:00 a.m. to 5:00 p.m.

SYM 328 Basic Internal Medicine, Monday, March 24, 9:00 am. to 12 p.m.

SYM 335 Advanced Internal Medicine, Monday, March 24, 2 p.m. to 5 p.m.

SYM 338 Clinicopathological Conference, Monday, March 24, 2:00 p.m. to 5:00 p.m. (view slides prior to session, with presentation by faculty during session).

TICKETED SESSIONS

POSTER DISCUSSION

PDS 491-495 Poster Discussion Sessions - see Annual Meeting Program Book for details

COURSES

CRS 108 Basic Self-assessment of Dermatopathology, Saturday, March 22, 9:00 a.m. to 5:00 p.m. (hands on use of microscopes).

CRS 111 Fundamentals of Cosmetic Surgery, Saturday, March 22, 9:00 a.m. to 5:00 p.m.

CRS 202 Basic Dermatopathology, Friday & Saturday, March 21 & 22, 9:00 a.m. to 5:00 p.m.

CRS 203 Structure & Function of the Skin, Friday & Saturday, March 21 & 22, 9:00 a.m. to 5:00 p.m.

DISCUSSION GROUPS

DSG 425 Academic Dermatology: Problems & Solutions, Friday, March 21, 2:30 p.m to 4:00 p.m.

FORUMS

FRM 535 Workforce Issues & Dermatology Practice, Tuesday, March 25, 9:00 a.m. to 11:00 a.m.

FOCUS GROUPS

FOC 604 Starting a Practice in Dermatologic Surgery, Friday, March 21, 7:15 a.m. to 8:45 a.m.

FOC 642 Clinical Drug Development for Dermatology, Sunday, March 23, 7:00 a.m. to 8:30 a.m.

FOC 835 Dermatology on Three Continents, Saturday, March 22, 12:15 p.m. to 1:45 p.m.

FOC 849 Delivery of Dermatologic Health Care, Sunday, March 23, 12:15 p.m. to 1:45 p.m.

For details on any of these sessions, please see your Annual Meeting Program Book.

News from the AMA

OSHA says 'no' to 80-hour workweek petition by residents

The Occupational Safety and Health Administration (OSHA) in October denied a petition filed by three groups asking it to restrict medical resident work hours, in part, because "other knowledgeable groups are taking action to work on this problem," said OSHA Administrator John L. Henshaw.

The petition was filed April 30, 2001, by Public Citizen, the Committee of Interns and Residents and the American Medical Student Association. They asked for limits of an 80-hour workweek for residents, one day off a week, and work shifts no more than 24 hours long.

The petitioners claimed sleep-deprived residents were at increased risk of being in auto crashes, suffering from depression, and giving birth to premature infants. They are pushing for federal legislation to set restrictions on resident hours and vow to keep up the fight. "Our work will continue with federal legislation. That's the only way that real reform can come about," said Eric J. Hodgson, M.D., national president of the American Medical Student Association.

In June 2002, the Accreditation Council for Graduate Medical Education (ACGME), which accredits about 7,800 residency programs in the United States, set new standards on resident work hours. It plans to enforce those rules beginning July 1, 2003.

During its annual meeting last June, the American Medical Association (AMA) House of Delegates backed the ACGME and adopted recommendations to limit resident hours.

The ACGME and AMA said residents should work 80 hours per week on average and go on-call no more than every third night.

Henshaw cited the ACGME's guidelines in his Oct. 4 letter to Public Citizen rejecting the petition. "OSHA believes that the ACGME and other entities are well-suited to address work-duty restrictions of medical residents and fellows," he said. The petition also was denied, Henshaw added, because "the issues involved with medical resident hours go well beyond job safety and affect hospital patient safety."

Ruth Potee, M.D., president of the Committee of Interns and Residents, said more must be done to give residents a better training environment. "Residents don't want to work 100 to 110 hours a week. Nobody does," she said. "If they can't train us to be good physicians in 80 hours a week, then something's wrong." RR

Seeking new authors

The Self-Assessment/Recertification Task Force of the American Academy of Dermatology is seeking new authors to develop Self-Assessment Examinations. The self-assessment examinations are published bi-monthly in the *Journal of the American Academy of Dermatology* and consist of a brief case history and a series of multiple choice questions each with five possible responses. A description follows the questions highlighting the correct response and the correct answer is listed at the conclusion of the description. A bibliography is listed to provide additional references. At the conclusion of the self-assessment learning activity, physician participants should be able to assess their own diagnosis and patient management skills with respect to those of their colleagues in the field, use the results of the self-assessment to help determine personal learning needs that can be addressed through subsequent CME involvement, and enhance their ability to comply with the requirements for certification in the specialty of dermatology. Self-assessment examinations in *JAAD* are also cited in *Index Medicus*. Examples of previously published self-assessment examinations may be requested from the AAD Department of Education at (847)240-1696. Interested authors should contact Mary Spellman, M.D., Chair of the Self-Assessment/Recertification Task Force via e-mail at *mspellma@san.rr.com* or the AAD Department of Education at (847) 240-1696. RR

AAD resident, fellows mentor program available

The American Academy of Dermatology's Resident and Fellows Committee (RFC) has a mentorship program that is intended to serve as a resource for residents, young physicians, and all AAD members who have career or clinical questions in dermatology.

Mentors include:

- Michael J. Bernhardt, M.D., Jacksonville, FL
- Richard Clark, M.D., Stony Brook, NY
- Fran E. Cook-Bolden, M.D., New York, NY
- Ray Cornelison, M.D., Oklahoma City, OK
- Jaime Ferrer-Bernat, M.D., MEXICO*
- Philip Fleckman, M.D., Seattle, WA
- Carlos Guillen, M.D., Valencia, SPAIN
- Thomas J. Hogarty, M.D., Big Horn, WY*
- Sandy Johnson, M.D., Little Rock, AK
- Jason Lockridge, M.D., Gainesville, FL
- Markham C. Luke, M.D., Rockville, MD*
- Laertes Manuelidis, M.D., Charleston, SC
- Ricardo Mejia, M.D., Heathrow, FL
- Alessandra B. Alio Saenz, M.D., VENEZUELA
- Linda Spencer, M.D., Crawfordsville, IN
- Virginia P. Sybert, M.D., Seattle, WA
- LaKimerly Woods-Coates, M.D., Freeport, IL

**new mentors since last issue*

Members who would like to participate as a mentor may fill out the questionnaire online at the AAD's Web site, www.aad.org. Mentors will be posted on the AAD Web site. For more information about the program, contact Sandra Peters by phone (847) 240-1819, or e-mail *speters@aad.org*. RR

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