AAD 1938 American Academy of Dermatology

Directions in Residency

Spring 2007

Official Publication of the Residents & Fellows Committee, American Academy of Dermatology Association

Special report: Demystifying the boards

The American Board of Dermatology (ABD) presented an overview of the ABD and certification examination process to the Residents and Fellows Committee on Feb. 4 during the American Academy of Dermatology (AAD) Annual Meeting in Washington, D.C. The intent of the committee was to learn more about the ABD and the examination process, as well as help residents have a better understanding of the process and the reasoning behind it. The committee hoped the ABD could clarify some of the rumors and misinformation surrounding the ABD and the exam.

Prior to the event, the committee formed a work group that created questions for the ABD representatives to address. Topics of the questions included the purpose and history of the ABD, the process of developing and administering the examination, changes to the exam for 2007, and maintenance of certification. Antoinette Hood, M.D., the ABD's executive director, and Stephen Webster, M.D., the associate executive director, gave a presentation highlighting those questions to the committee.

Stephen Webster, M.D., and Antoinette Hood, M.D., were guest presenters at the Resident and Fellows Committee meeting, held during the Academy's Annual Meeting in February.

Overview of the ABD

The ABD is a voluntary, non-profit, private, autonomous organization formed for the primary purpose of protecting the public interest by establishing and maintaining high standards of training, education and qualifications of physicians rendering care in dermatology. The objective of all of its activities is to

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sound advice

Graduating this year? Don't leave your membership behind!

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If you're graduating this year, your benefits, including subscription to the *Journal of the American Academy of Dermatology (JAAD)* will end on June 30, 2007.

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During your residency training, you received a complimentary subscription to *JAAD*. This subscription will end with the July issue. If you do not apply for AAD membership prior to Sept. 1, 2007 and you wish to continue your subscription to *JAAD,* the price for individual subscribers is $264. Applicants for membership receive *JAAD* at no charge, effective July-December or within one month of receipt of your membership application. In addition, if you do not apply for membership prior to the deadline, and you plan on attending the 2008 Annual Meeting, you would need to register at the non-member rate (the non-member physician fee for the 2007 Annual Meeting was $1,400).

In order to continue your membership status without interruption, please make sure to submit your membership application no later than Sept. 1, 2007. Please note that if you are continuing your training in a fellowship program, your Graduate status will be retained through the period of the fellowship training program. The AAD will need a letter from the fellowship program director attesting

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History of the ABD

The history of the dermatology certifying examination began in 1933, when 27 candidates participated in the first exam consisting of written and oral sections. In 1949, the written exam changed from essay to true/false or multiple choice questions. In 1955, the Board changed its name from the American Board of Dermatology and Syphilology to The American Board of Dermatology. The ABD also established the Residency Review Committee, in cooperation with the American Medical Association. 1969 saw the In-Training Examination first administered. In 1974, the first examination for Special Competence in Dermatopathlogy was administered.

1976 saw many changes inside the ABD. The exam had evolved into a two-day examination. Part One continued to be written, while Part Two had the oral examination replaced with Kodachromes and glass slides on clinical, laboratory, surgery, therapy, and dermatopathology. Separate scores were issued for Part One and Part Two.

In 1991, time-limited certifications were first issued, coming from public demand for accountability in the medical field, with 1999 marking the first recertification examination being administered. All of the 24 members of the American Board of Medical Specialties, now issue time-limited certifications.

In 2006, one score would now be issued for the entire exam, rather than one for each part. In 2007, a one day examination will be instituted, with the hope of eventually moving to a computer-based examination administered at many testing centers throughout the US. D

provide assurance that a diplomate of the Board possesses and maintains the knowledge and skills essential for the provision of superior, specialized care to patients with cutaneous diseases.

Responsibilities and Mission

The ABD is a part of the American Board of Medical Specialties (ABMS), which is made up of 24 specialties, including allergy and immunology, anesthesiology, colon and rectal surgery, dermatology, emergency medicine, family practice, internal medicine, medical genetics, neurological surgery, nuclear medicine, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, preventative medicine, psychiatry and neurology, radiology, surgery, thoracic surgery, and urology. Roughly 85 percent of all practicing physicians are certified by one or more of the 24 ABMS Member Boards. What makes the ABMS unique from other, self-designated medical boards is that the ABMS boards work together, rather than independently, on setting and ensuring standards of the examination and maintenance of certification.

The current mission of the ABD is: to serve the public interest by promoting excellence in the practice of dermatology through lifelong certification.

Some of the responsibilities of the ABD include setting standards for residency and fellowship education (through the standards laid out by the Residents Review Committee for Dermatology by the Accreditation Council for Graduate Medical Education). The ABD also oversees residents/fellows while in training, through In-Training Examination, certification, and recertification/maintenance of certification. This also includes subspecialties.

Keeping Current

The ABD keeps abreast of changes in the dermatologic industry, along with updates on trends the ABD has observed, and by having contacts with dermatologic specialty societies. Currently the ABD also has liaisons on the Residency Review Committee (RRC) for Dermatology, thereby working with the Accreditation Council for Graduate Medical Education (ACGME). ABD also has liaisons to various educational committees of the AAD, as well as on other medical associations. In addition, the ABD endorses the ethical principles laid out in the Academy's *Manual on Ethics in Medical Practice*.

Developing the Exam

The process the ABD uses for developing the certification examination is highly thorough. The ABD forms test committees for each part of the examination. These test committees are made up of director and non-director volunteers selected by the ABD. New questions are reviewed by two directors, and then vetted through committee meetings. The National Board of Medical Examiners (NBME) then creates the first draft of the examination using a pool of questions available. Contarty to popular belief, of the questions vetted, there are no unscored questions used to "try out" for future examinations. Finally, the examination is edited by two directors.

Administering the Exam

Residents who have completed the training requirements are eligible to apply for the examination. For residents completing their residency training, application forms will be sent to program directors for distribution to each candidate. The completed application must be filed with the Board office before March 1 of the year in which the candidate plans to take the examination. Physicians who complete their residency training in dermatology by July 1, 2007 are eligible to apply to take the examination in August 2007.

A candidate is not considered an "active" candidate until his or her application has been received and approved by the Board. This approval includes a review of the application and annual evaluation reports from the candidate's training director. After the application is approved, the candidate is required to take the examination within two years.

New Format for Examination

Aug. 13, 2007 will see the introduction of a one day examination, a break from the previous two-day examination. The agenda for the

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one-day examination will be dermatopathology slides, written, lunch, and then images, all in the same room. Aside from the obvious removal of one day, the number of questions presented will be different. In 2006, there were 264 written questions, 320 image questions, and 48 dermatopathology slides. In 2007, there will be 150 written questions, 160 image questions, and 36 dermatopathology slides. This marks a 237 question difference between the two examinations.

Reviewing the Exam

Following the exam, a preliminary item analysis is performed by the NBME. A key validation conference call will happen, where directors will review all questions that did not perform well. A determination will be made whether to delete or retain *poorly performing* questions used in the examination. Standard setting exercises are content-based, em-ploying the Modified Angoff Content-based Standard Setting and the Hofstee Compromise Standard Setting. A minimum passing score is then set. This process is repeated for each examination, which means there are no fixed minimal performance line and no curve. Theoretically, there could be a 100 percent pass rate or 0 percent pass rate, depending on the candidate pool.

Pass Rate

The failure rates vary from year to year. In 2004, the failure rate was 8 percent. Compared to other boards in the ABMS, it was on the low end (the range was 8-46 percent).

In-Training Examination

The purpose of the In-Training Examination is to expose residents to the style and format of the certifying examination. It tests only one competency: medical knowledge. The test is intended to provide residents and program directors a sense of the level of knowledge achieved as residents progress through a program, offer a comparison to "classmates" (the composite group of individuals in each post-graduate year level) and programs in the U.S., give program directors an objective measure to determine strengths and weaknesses in their educational program, and identify strengths and weaknesses in a resident's knowledge bank.

Ask the ABD

Your boards questions answered by Antoinette Hood, M.D., the executive director of the American Board of Dermatology.

Q. When looking at failure rate (see chart below), what is the difference between the total row and the reference group row?

A. The reference group is first time U.S. and Canadian test takers. The total row represents everyone who took the examination.

Q. Will the dermpathology section of the upcoming board examination (Aug. 13, 2007) be on computer, or with microscopes?

A. With microscopes.

Q. I heard from previous residents that on the day of the examination, many of the photos are projected on small TV screens at the front of a very large room. Has there been any move to change this (ie bigger screens, smaller room, or putting the images on individual computer screens)?

A. The images are projected on the largest screens available that will fit in the hotel ballroom. There are 10 screens and no one is more than 6 rows from a screen. Some residents bring binoculars/opera glasses but they are rarely used. We have been giving the examination in the same room since the 1970s and it seems to work well.

The committee welcomes additional questions residents and fellows might have on the ABD or the examination process. If you have any questions, please direct questions to tanderson@aad.org, *or the editor of* Young Physician Focus *at* dmonti@aad.org.

Maintenance of Certification

Residents graduating in 2006 and after and diplomates who took the recertification examination in 2006 will enter the Dermatology Maintenance of Certification Program (D-MOC). It is a 10 year cycle resulting in voluntary renewal of certification by the physician. It is made up of four components:

- **Component 1** – Professional Standing.
- **Component 2** – Commitment to Lifelong Learning and Self-assessment.
- **Component 3** – Cognitive Expertise.
- **Component 4** – Evaluation of Practice Performance.

Embedded in the four components are the ACGME/ABMS six core competencies:

- patient care,
- medical knowledge,
- practice-based learning and improvement,
- interpersonal and communication skills,
- professionalism, and
- system-based practice.

Component 1 will be based essentially on maintaining a medical license.

Component 2 will be fulfilled with 40 hours of Continuing Medical

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Failure percentage rate from 1999 to 2006

	1999	2000	2001	2002	2003	2004	2005	2006
Total	10.1	8.5	4.6	7.1	5.9	5.1	3.6	10.1
Reference Group	6.3	5.3	2.5	4.1	3.4	1.7	0.0	9.3
							Total number of individuals taking exam	372.0

The reference group is composed of first-time examination takers completing residency in the US or Canada.

Hypertrichosis

Antoine Amado, M.D. & Sharon E. Jacob, M.D.

	Disorder	Inheritance	Gene Defect	Clinical Manifestations	Mechanism Hypertrichosis
congenital (circumscribed)	Congen. nevo-cellular nevus			Increased hair within the lesion	
	Smooth muscle hamartoma			Pigmented pebbly patch trunk, vellus hair hypertrichosis, pseudo-Darier sign	↑ hair size & pig-mentation
	Nevoid hypertrichosis			Usually solitary patch of terminal hair w/o other abn, anywhere body	↑ # normal hair follicles
	HT w neurofibroma			Periorbital cases	
	HT cubiti (hairy elbows)	Sporadic ?AD ?AR *somatic mosaicism		Symmetric pattern, appears during infancy, resolves part/compl. adolescence	High percentage of hair follicles in Anagen phase
	Hemihypertrophy		? spontaneous mutation	Terminal hair limited to hypertrophic side Assoc. Beckwith-Wiedemann synd, neurofibromatosis, Klippel-Trenaunay-Weber synd & Proteus synd, Wilms tumor, hepatoblastomas, brain tumors, adrenocortic neop, internal hemangiomas and GU malfor.	↑ hair shaft diameters & terminal hair follicles
	Hairy cutaneous malfor. palms & soles	AD		Patches of skin with hair follicles bilaterally on the palms &/or soles. Vellus in women and children, male's hair becomes terminal at puberty	androgen-sensitive N hair follicles
	Spinal hypertrichosis			Excess hair over the spine: discrete patch of sacral terminal hair ["faun-tail"] or midline vellus hair ["silky down"] Underlying spinal dysraphism [50% dermat find; 1/3 those hypertrichosis]: dermal cyst or sinus, myelomeningocele, diastematomyelia, vertebral abn, subdural or extradural lipoma. Cervical spinal hypertrichosis ~ kyphoscoliosis. MRI evaluation	Simulatenous abn. skin & nervous tissue → ectodermal origin
	Anterior cervical hypertrichosis	AD, AR, XLD		Small patch of terminal hair superior to laryngeal prominence solitary (AD, XLD) or with peripheral neuropathy (AR) and hallux valgus	
congenital (generalized 1°)	Congenital HT lanuginosa (Ambras Synd)	AD, sporadic	Cr8q22	Lanugo hair (may be vellus) remains over the entire body after birth, sparing palms, soles & mucous memb. Assoc dental & ear abn., glaucoma, pyloric stenosis, photophobia.	
	Congenital Gen. HT	XL	CrX24-q27.1	Terminal hair face, trunk & limbs; sparing palms, soles & mucosa. One family in Mexico reported	
	Gingival fibromatosis w HT	AD		Early childhood; hairiness face, trunk, eyebrows + progressive gingival hyperplasia. 50% mental retardation &/or seizures. ≠ Antiepileptics & cyclosporine	
	Osteochondro-dysplasia w HT (Cantú synd)	AR, AD	Unknown	Gen. HT, sparing glabrous skin & membranes. Also macrosomia & cardiomegaly	
	HT, pigmentary retinopathy & facial abn			Gen. HT, sparing ant. torso, palms, soles & mucous memb; hyperpigmentation face & extrem; facial abn, regional lipoatrophy, pigmentary retinopathy. ~ SMH	
congenital (generalized 2°)	Brachamann-de Lange synd (Cornelia de Lange synd)	AD XL	Cr5p13.1 NIPBL mutation Cr Xp11.22-p11.21 SMC1L1 mutation	Thick & convergent eyebrows (synophrys) & eyelashes; low hairline; vellus HT trunk, post. neck, sacrum, elbows; cutis marmorata; severe mental retard; upturned nostrils, depressed nasal bridge, low set ears, small & irregular teeth, micrognathia, high palate & bifid uvula; short arms & abn hands & feet	
	Teratogens			**Fetal hydantoin syndrome:** during first 9 weeks gestation have 10% risk; HT, nail hypoplasia, cleft lip, midfacial hypoplasia, long upper lip, low birth weight. After 9 weeks LBW w/o other congenital abn. **Fetal alcohol syndorme:** during any point in pregnancy. HT[inconstant]; prenatal growth deficiency, develop. delay, mental retardation, & facial abn [microcephaly, short upturned nose, short palpebral fissures, thin upper lip, & poorly developed philtrum]	

	Disorder	Inheritance	Gene Defect	Clinical Manifestations	Mechanism Hypertrichosis
congenital (generalized 2°)	Lipoatrophy	AR	- Type 1: Cr9q34 AGPAT2 mutation - Type 2: Cr11q13 Seipin gene (BSCL2) mutation	**Berardinelli-seip synd:** HT scalp, face, neck & extrem. ↑ age. Gen. lipoatrophy, acanthosis nigricans, hyperhidrosis, phlebomegaly, xanthomas, NIDDM , genital hypertrophy, mental retard, corneal opacities, cardiac, renal, & ovarian abn., hepatosplenomegaly	androgen-sensitive???
			Cr19p13.2 INSR mutation	**Donohue syndrome** (leprechaunism), more severe: HTface & trunk, acanthosis nigricans; loose & redundant skin. Lipoatrophy, genital hypertrophy, abdominal distension, slow growth, prominent eyes & lips, low-set ears, flattened nasal bridge. Hyperinsulinemia w insulin resistance	
	Mucopoly-saccharidoses			Short stature w typical facies, skeletal deformities, hepatosplenomegaly & cardiac abn. Lanugo HT back & extrem, bushy eyebrows, low frontal hairline, abundant & coarse scalp hair. Hurler syndrome (MPS-I), Hunter (MPS-II), and Sanfilippo syndrome (MPS-III) - hair-shaft dysmorphism	Animal std: ↑ glycosaminog-lycans skin
	Stiff-skin synd			Stony-hard skin, ↓ joint mobility, & mild HT; complic: restricted lung capacity	
	Winchester synd		Cr16q13 MMP2 mutation	Thickened & HTskin, short stature w severe osteolysis carpal/tarsal bones, corneal opacifications	
	Porphyrias			Congenital erythropoetic porphiria (Gunther disease) photosensitivity birth → vesicles & bulla, hyperpigmentation, scarring, & HT. PCT may present w HT (60%) face (temple areas) & upper torso [sole sympt]. HT later stages erythropoietic protoporphyria; Hereditary coproporphyria & Variegate porf.	
	Rubinstein-Taybi synd		Cr22q13, 16p13.3 CREBBP mutation EP300 gene mutations (genetic heterogeneity)	HT, bird-like face, keloids, broad thumbs/great toes, short stature, mental retardation. [cAMP-bind prot]	
	Schinzel-Giedion synd			HT face & limbs, depressed nasal bridge, high forehead, hypoplastic midface, club feet, abn. ribs, limbs & skull. Hypoplastic dermal ridges, seborreic rash, suscep. dermatophyte infect	
	Barber-Say synd	AD, XL		HT ↑ forehead, neck & back; atrophic skin, macrostomia, growth retardation & ectropion	
	Coffin-Siris synd	AR	?Cr7q32-34	Or **fifth digit syndrome**, Lumbosacral and eyebrow HT. Hypoplastic or absent fingernails & toenails (5th), mental & growth retard, sparse scalp hair, joint laxity; coarse face[microcephaly, prominent lips, low nasal bridge, wide nasal tip]	
	Hemimaxillo-facial dysplasia			unilateral enlarged maxilla, hypoplastic teeth, ipsilateral HT [inconstant]	
	Craniofacial dysostosis			PDA, hypoplasia labia majora, dental & eyes abn, ↑ terminal HTlimbs, back & low hair line	
	Hypomelanosis of Ito		Mosaicism Xp11 translocation?	Hypopigmented macular patches (Blaschko lines), neurological symp & HT	
	MELAS Syndrome		Mutation in several mitochondrial Transfer RNA genes	(Mitochondrial encephalomyopathy, lactic acidosis and stroke-like episodes) Pruritus, scaling erythema neck, terminal HT legs	
acquired (circumscribed)	Becker nevu	Sporadic, ? paradom-inant		Irregular hypermelanotic patch torso, ↑ hair at puberty. ↑ males, solitary, acquired & unilateral. Pigmentation before HT. Histology, hamartoma **Becker nevus synd:** Becker nevus, ipsilateral hypoplasia shoulder girdle, arm or breast; scoliosis or vertebral abn. ≠smooth muscle hamartoma	↑ # androgen receptors
	Hypertrichosis w local inflammation			Chemically induce dermatitis [iodine or psoralen], orthopedic casts & splints [vellous], friction [insect bites, sack bearers], thrombophlebitis, osteomyelitis, vaccination sites	Reg. effect healing Fx; Freq scratching; ↑ reg. blood flow

Hypertrichosis

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acquired (circumscribed)	HT of the pinna	AD		Older men. In AIDS, babies with XYY synd, babies with diabetic mothers, diabetics	
	Trichomegaly			Isolated HT eyelashes & in areas of linear scleroderma. HIV, SLE, Latanoprost	
	Cerebral disturbances			Gener. HT. Post viral encephalitis, posttraumatic head injury children, traumatic shock, transient diencephalic, pitituitary or hypothalamic disturbances	Hypothalamic factors
	Acrodynia			Reaction to chronic mercury exposure. Gen. HT, erythema fingers, toes & nose; perspiration & salivation, painful hands/feet	
	Infection			TB: transient HT children, face & limbs. AIDS: HT eyelashes, eyebrows & ears	
	Malnutrition			Gen. vellus HT (marasmus, celiac dz), bulimia 36% & 77% anorexia nervosa	
	Dermatomyositis			Juvenile DM ↑ hair growth face & limbs, ↑ male children & Mexican ancestry. PM adult also gen. HT	
acquired (generalize)	Thyroid abnormalities			**Hypothyroidism:** HTchildren >adult, resolves w replacement Tx. **Hyperthryroidism:** Localized HT over plaques of pretibial myxedema	
	Lawrence-Seip synd			Lipoatrophic diabetes ~ Berardinelli-Seip synd. HT after viral infection	
	Acquired porphyrias			↑ hair growth [PCT 2° hexachlobenzene exposure]	
	Acquired HT lanuginosa (Malignant Down)			Assoc. malignancies lung, colon, lymphomas, Ewing's sarcoma, rectum, pancreas, breast, ovary & uterus. Precede CA 1 to 2 years. New lanugo: workup	Tumor-secreted substance ↑ hair growth
	POEMS synd (Crow-Fukase Syndr)			(polyneuropathy, organomegaly, endocrinopathy, M protein, skin changes) assoc w plasma cell dyscrasias. Gen. HT 78-85% (lower extrem), hyperpigmentation, skin thickening,	digital clubbing, cutanous angiomas
	Pharmacologic hypertrichosis			***Phenytoin HT:** after 2-3 m; ↑ limbs, face & trunk, resolve after 1 year discont 75%. * glaucoma Tx, regional hypertrichosis: **Acetazolamide** [children, back & legs] & **latanoprost** topical (prostagalndine F2 analogue) eyelashes & eyelids 77 %. ***Streptomycin:** Diff. TB. ***Cyclosporine:** HTafter organ transp. 24-94%. * **Psoralen:** HT light-exposed areas. Diazoxide. Minoxidil ↑ terminal hair growth after 4 m.	Phenytoin: unknown Latanoprost: mitogenic pathw Diazoxide: ↑ follicles anagen Minoxidil: Vellus to Termimal hairs

Antoine Amado M.D., is a Contact Dermatitis Fellow at the Cleveland Clinic, Ohio.

Sharon E. Jacob, M.D., is an Assistant Professor of Clinical Dermatology, Director of the Contact Dermatitis Clinic and Medical Student Education, Department of Dermatology and Cutaneous Surgery, University of Miami, School of Medicine, Miami, Fla.

Abbreviations

AGPAT2: 1-acylglycerol-3-phosphate O-acyltransferase 2
CREBBP: Transcriptional coactivator CREB-binding protein
HT: hypertrichosis
INSR: Insulin receptor gene
MMP2: Matrix metalloproteinase-2
NIPBL: Nipped-B-like (Human homolog of Drosophila melanogaster Nipped-B)
SMC1L1: Structural maintenance of chromosomes 1-like 1

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Editor's note: Dr. Jacob has generously provided several Boards Fodder topics for this publication and the editors of Directions In Residency *appreciate her contributions. This is her final Boards Fodder.*

If you would like to contribute to this popular, widely-read feature, please contact the editor, Dean Monti at dmonti@aad.org.

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Education (CME) a year, in addition to three self-assessment exercises performed over a 10-year cycle.

Component 3, at the present time, is an Internet-administered examination taken in the diplomate's office. After 2009 this will be a proctored examination taken in testing centers across the country and will continue to be an examination that is clinically oriented, with practice-related questions. As currently envisioned, there would be 100 questions related to general clinical dermatology and 100 questions in either medical dermatology, surgical dermatology, pediatric dermatology, or dermatopathology. Questions would be made available to the diplomate prior to the examination for self-study. As technology progresses to authenticate an examinee electronically during a test, the ABD may be able to revert back to an Internet-administered examination as utilized in the years 1998-2009.

Component 4 requires diplomats to evaluate charts and survey patients and peers once during the 10-year cycle. The first part involves reviewing charts, measuring results, developing an improvement plan, and re-measuring. The second part involves surveying patients and peers. The results and feedback are presented to the diplomate.

The ABD and the AAD Residents/Fellows Committee

The AAD Residents and Fellows Committee is taking a number of steps to keep residents and fellows better informed about ABD Activities. A Q&A section has been added specifically on the ABD and the examination process, (see page 3). The committee will also be reaching out to the ABD in the future to update residents on any changes to the examination process or other pertinent changes at the ABD. The committee feels fostering a relationship with the ABD will build stronger communication channels that will help ensure correct information on the examination process and changes to the examination and MOC. These updates can then be distributed to residents and fellows.

The committee welcomes additional questions residents and fellows might have on the ABD or the examination process.

Preparing for D-MOC: The Academy is Here to Assist You

Keeping up with changes in maintaining certification can sometimes seem overwhelming for residents. The Maintenance of Certification (MOC) is a program of education and professional development designed to assess the competence of physicians on an ongoing basis. The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) has identified six general competencies: medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvements, and system-based practice.

For MOC, the six competencies are placed into four areas of assessment. The four components are:

1. Evidence of Professional Standing.
2. Evidence of Commitment to Lifelong Learning and Periodic Self-Assessment.
3. Evidence of Cognitive Expertise.
4. Evaluation of Performance in Practice.

The American Board of Dermatology (ABD) has established the Dermatology Maintenance of Certification (D-MOC) program, which includes each of these components, to take place over a 10-year cycle.

The American Academy of Dermatology is committed to assisting its members in the practice of dermatology. Included in this commitment is awareness of the issues that our members face in maintaining their certification. In response to changes in certification, the Academy's Council on Education is developing programs to assist members in fulfilling components of the ABD's D-MOC program. Specifically, the Academy's Self-Assessment Task Force has created the Maintenance of Certification Manual for Dermatology™ (MOCMD™) to fulfill Component 2: Evidence of Commitment to Lifelong Learning and Periodic Self-Assessment. The Academy's Quality Assurance/Quality Improvement Self-Assessment Task Force is currently developing a program to fulfill part of Component 4: Evaluation of Performance in Practice. This program will be pilot-tested in 2008 and ready in 2009. In effort to support our membership, the Academy will continue to develop tools to assist our members in maintaining their certification.

Sound Advice from p. 1

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Benefits of Membership

Some of the many benefits of membership, in the Academy include:

- FREE *JAAD* and *Dermatology World* subscription
- Reduced registration to attend the Annual Meeting in 2008
- Significant discounts and special pricing on products and services, offered exclusively to Academy members.

message from the chair

Jorge Garcia-Zuazaga, M.D.

Greetings from Cleveland!

The Resident and Fellows Committee (RFC) met formally on Feb. 4, 2007 in Washington, D.C. During this meeting we welcomed four new members and hosted resident representatives from Canada. This was a very productive meeting as we brainstormed our agenda for next year. I want to take a moment to thank a number of groups who have helped our committee to function efficiently this year. First, credit goes to your Regional Representatives and Academy staff that have provided support and worked for progress on resident and fellow issues. This year we all worked diligently to organize the very successful Resident Reception and Career Fair. We will continue these events in future meetings. Second, I want to acknowledge the Board of Directors and other Academy leadership for their continuing support of an active role for residents and fellows in the organization.

Boards explained

Our guest speakers for the RFC meeting were Dr. Hood and Dr. Webster from the American Board of Dermatology (ABD). They gave us a brief overview on the history of the Dermatology Board Examination and answered a few questions regarding the new one-day examination. We have included a summary of their talk starting on p. 1 of this issue. This information reported in this newsletter has been approved by the ABD and is considered accurate.

Improving resident courses

Other important highlights from our meeting included discussions of improving resident courses at the next Annual Meeting. We have submitted a proposal to the Scientific Assembly Committee (SAC) to have a Der-matopathology Self Assessment Course for residents only. In addition, next year we will integrate all resident educational sessions into one full day. During this day, we will coordinate with the ABD and invite them to the forum for another informative session.

Call for leaders!

In the year ahead, I encourage each of you to communicate with your RFC members. Their names and e-mail addresses can be found on the resident section of the AAD Web site, www.aad.org. The RFC is here to help work on issues facing dermatology residents, and I urge you to continue bringing suggestions and ideas to the attention of the committee. We are now in the process of identifying new members for next year. Feel free to e-mail me at Jorge.Garcia-Zuazaga@uhhospitals.org if you want to get involved.

Stay active

Finally, to the graduating class of 2007, I urge you to stay active and challenge you to take an active role in the various committees the Academy has to offer. Your ideas and leadership are always welcomed. Congratulations on finishing up residency. Fair winds and following seas!

Directions in Residency

Spring 2007

Questions or Comments?
Contact the AAD Member Resource Center (MRC) toll-free at (866) 503-SKIN (7546) or mrc@aad.org.

Mission Statement
Directions in Residency is published by the American Academy of Dermatology Association to provide a forum for information concerning resident dermatology physicians, and providing news, views and actions of the Academy, the Residents & Fellows Committee, and the American Board of Dermatology.

next issue

American Academy of Dermatology Association
P.O. Box 4014
Schaumburg, Illinois 60168-4014

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