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.

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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Discount offered on the first year’s dues

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By applying for membership today, you will be able to continue experiencing the many benefits that come with being a member of the AAD, including receiving a 70 percent savings off your first years’ dues. Yes, that’s right, you can join the Academy for $225!

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 See Sound Advice on p. 7

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4 MOC Assistance
8 Message from the Chair
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 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. Contary 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
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, employing 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, offering a comparison to “classmates” (the composite group of individuals in each post-graduate year level) and programs in the U.S., giving 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.

**Maintenance of Certification**

Residents graduating in 2006 and after and diplomats 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 Education.
## Hypertrichosis

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

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Inheritance</th>
<th>Gene Defect</th>
<th>Clinical Manifestations</th>
<th>Mechanism Hypertrichosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congen. nevocellular nevus</td>
<td></td>
<td></td>
<td>Increased hair within the lesion</td>
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<tr>
<td>Smooth muscle hamartoma</td>
<td></td>
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<td>Pigmented pebbly patch trunk, vellus hair hypertrichosis, pseudo-Darier sign</td>
<td>↑ hair size &amp; pigmentation</td>
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<tr>
<td>Neviod hypertrichosis</td>
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<td>Usually solitary patch of terminal hair w/o other abn, anywhere body</td>
<td>↑ normal hair follicles</td>
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<tr>
<td>HT w neurofibroma</td>
<td></td>
<td></td>
<td>Periorbital cases</td>
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<td>HT cubiti (hairy elbows)</td>
<td>Sporadic</td>
<td>?AD?AR&quot;somatic mosaicism&quot;</td>
<td>Symmetric pattern, appears during infancy, resolves part/compl. adolescence</td>
<td>High percentage of hair follicles in Anagen phase</td>
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<tr>
<td>Hemihypertrophy</td>
<td>? spontaneous mutation</td>
<td></td>
<td>Terminal hair limited to hypertrophic side</td>
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<tr>
<td>Hairy cutaneous mktor. palms &amp; soles</td>
<td>AD</td>
<td></td>
<td>Patches of skin with hair follicles bilaterally on the palms &amp;/or soles. Vellus in women and children, male's hair becomes terminal at puberty</td>
<td>androgen-sensitive N hair follicles</td>
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<tr>
<td>Spinal hypertrichosis</td>
<td></td>
<td></td>
<td>Excess hair over the spine: discrete patch of sacral terminal hair [&quot;taur-tail&quot;] or midline vellus hair [&quot;silky down&quot;]</td>
<td>Simultaneous abn. skin &amp; nervous tissue ➔ ectodermal origin</td>
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<tr>
<td>Anterior cervical hypertrichosis</td>
<td>AD, AR, XLD</td>
<td></td>
<td>Small patch of terminal hair superior to laryngeal prominence solitary (AD, XLD) or with peripheral neuropathy (AR) and hallux valgus</td>
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<tr>
<td>Congenital HT lanuginosa (Ambras Synd)</td>
<td>AD, sporadic</td>
<td>Cr8q22</td>
<td>Lanugo hair (may be vellus) remains over the entire body after birth, sparing palms, soles &amp; mucous membro. Assoc. dental &amp; ear abn., glaucoma, pyloric stenosis, photophobia.</td>
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<tr>
<td>Congenital Gen. HT</td>
<td>XL</td>
<td>Ctx24-q27.1</td>
<td>Terminal hair face, trunk &amp; limbs; sparing palms, soles &amp; mucosa. One family in Mexico reported</td>
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<tr>
<td>Gingival fibromatosis w HT</td>
<td>AD</td>
<td></td>
<td>Early childhood; hairiness face, trunk, eyebrows + progressive gingival hyperplasia. 50% mental retardation &amp;/or seizures. ≠ Antiepileptics &amp; cyclosporine</td>
<td></td>
</tr>
<tr>
<td>Osteochondrodysplasia w HT (Cantu synd)</td>
<td>AR, AD</td>
<td>Unknown</td>
<td>Gen. HT, sparing glabrous skin &amp; membranes. Also macrosomia &amp; cardiomegaly</td>
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<tr>
<td>HT, pigmentary retinopathy &amp; facial abn</td>
<td></td>
<td></td>
<td>Gen. HT, sparing ant. torso, palms, soles &amp; mucous membro; hyperpigmentation face &amp; extrem; facial abn, regional lipatrophy, pigmentary retinopathy. — SMH</td>
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</tr>
<tr>
<td>Brachamann-de Lange synd (Cornelia de Lange synd)</td>
<td>AD</td>
<td>Crisp13.1 NeRBL mutation</td>
<td>Thick &amp; convergent eyebrows (syndromes) &amp; eyelashes; low hairline; vellus HT trunk, post. neck, sacrum, elbows; cutsis marmorata; severe mental retard; upturned nostrils, depress-ed nasal bridge, low set ears, small &amp; irregular teeth, micrognathia, high palate &amp; bifold uvula; short arms &amp; abn hands &amp; feet</td>
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<tr>
<td>Teratogens</td>
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<td>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.</td>
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<td>Fetal alcohol syndrome: during any point in pregnancy, HT[inconstant], prenatal growth deficiency, develop. delay, mental retardation, &amp; facial abn [microcephaly, short upturned nose, short palpebral fissures, thin upper lip, &amp; poorly developed philtrum]</td>
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<tr>
<td>Disorder</td>
<td>Inheritance</td>
<td>Gene Defect</td>
<td>Clinical Manifestations</td>
<td>Mechanism</td>
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<tr>
<td>Lipoatrophy</td>
<td>AR</td>
<td></td>
<td><strong>Berardinelli-seip synd:</strong> HT scalp, face, neck &amp; extrem. + age. Gen. lipoatrophy, acanthosis nigricans, hyperhidrosis, phlebomegaly, xanthomas, NIDDM, genital hypertrophy, mental retard, corneal opacities, cardiac, renal, &amp; ovarian abns., hepatosplenomegaly</td>
<td>androgen-sensitive??</td>
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<td><strong>Donohue syndrome</strong> (leprechaunism), more severe: HT face &amp; trunk, acanthosis nigricans, loose &amp; redundant skin. Lipoatrophy, genital hypertrophy, abdominal distension, slow growth, prominent eyes &amp; lips, low-set ears, flattened nasal bridge.</td>
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<tr>
<td>Mucopolysaccharidoses</td>
<td></td>
<td><strong>AGPAT2 mutation</strong> - Type 1: Cr9q34</td>
<td>Short stature w typical facies, skeletal deformities, hepatosplenomegaly &amp; cardiac abn. Lanugo HT back &amp; extrem, bushy eyebrows, low frontal hairline, abundant &amp; coarse scalp hair. Hunter syndrome (MPS-II), Hunter (MPS-II), and Sanfilippo syndrome (MPS-III) - hair-shaft dysmorphism</td>
<td>Animal std: glycosaminoglycans skin</td>
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<td><strong>Seipin gene (BSCL2) mutation</strong> - Type 2: Cr11q13</td>
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<td><strong>INSR mutation</strong> Cr19p13.2</td>
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<td><strong>Hypertrichosis w local inflammation</strong></td>
<td>Chemically induce dermatitis [iodine or psoralen], orthopedic casts &amp; splints [vellous], friction [insect bites, sack bearers], thrombophlebitis, osteomyelitis, vaccination sites</td>
<td>Reg. effect healing Fx, Freq scratching; + reg. blood flow</td>
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<tr>
<td>Stiff-skin synd</td>
<td></td>
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<tr>
<td>Winchester syd</td>
<td>CR16q13</td>
<td><strong>MMP2 mutation</strong></td>
<td>Thickened &amp; HT skin, short stature w severe osteolysis carpal/tarsal bones, corneal opacifications</td>
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<td>Porphyras</td>
<td></td>
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<tr>
<td>Rubinstein-Taybi syd</td>
<td>CR22q13, 16p13.3</td>
<td><strong>CREBBP mutation EP300 gene mutations</strong> (genetic heterogeneity)</td>
<td>HT, bird-like face, keloids, broad thumbs/great toes, short stature, mental retardation. [cAMP-bind prot]</td>
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<td>Schinzel-Giedion syd</td>
<td></td>
<td></td>
<td>HT face &amp; limbs, depressed nasal bridge, high forehead, hypoplastic midface, club feet, abn. ribs, limbs &amp; skull. Hypoplastic dermal ridges, seborrheic rash, suscep. dermatophyte infect</td>
<td></td>
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<tr>
<td>Barber-Say syd</td>
<td>AD, XL</td>
<td></td>
<td>HT + forehead, neck &amp; back; atrophic skin, macrostomia, growth retardation &amp; ectropion</td>
<td></td>
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<tr>
<td>Coffin-Siris syd</td>
<td>AR</td>
<td>?Cr7q32-34</td>
<td>Of fifth digit syndrome. Lumbosacral and eyebrow HT. Hypoplastic or absent fingernails &amp; toenails (5th), mental &amp; growth retard, sparse scalp hair, joint laxity; coarse face[microcephaly, prominent lips, low nasal bridge, wide nasal tip]</td>
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<tr>
<td>Hemimandibulofacial dysplasia</td>
<td></td>
<td></td>
<td>unilateral enlarged maxilla, hypoplastic teeth, ipsilateral HT [inconstant]</td>
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<tr>
<td>Craniofacial dysostosis</td>
<td></td>
<td>Mosaicism Xp11 translocation?</td>
<td>Hypopigmented macular patches (Blaschko lines), neurological symp &amp; HT</td>
<td></td>
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<tr>
<td>Hypomelanosis of Ito</td>
<td></td>
<td><strong>Mutation in several mitochondrial Transfer RNA genes</strong></td>
<td>(Mitochondrial encephalomyopathy, lactic acidosis and stroke-like episodes)</td>
<td></td>
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<tr>
<td>MELAS Syndrome</td>
<td></td>
<td></td>
<td>Pruritus, scaling erythema neck, terminal HT legs</td>
<td></td>
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<tr>
<td>Becker nevus</td>
<td>Sporadic, i</td>
<td></td>
<td>Irregular hypermelanotic patch torso, + hair at puberty. + males, solitary, acquired &amp; unilateral. Pigmentation before HT. Histology, hamartoma</td>
<td>+ androgen receptors</td>
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<tr>
<td></td>
<td>paradominate</td>
<td></td>
<td></td>
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<tr>
<td>Hypertrichosis</td>
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</tbody>
</table>
Hypertichosis
Antoine Amado, M.D. & Sharon E. Jacob, M.D.

**Disorder** | **Inheritance** | **Gene Defect** | **Clinical Manifestations** | **Mechanism**
--- | --- | --- | --- | ---
HT of the pinna (acquired)(circumscribed) | AD | Older men. In AIDS, babies with XYY synd, babies with diabetic mothers, diabetics | | 
Cerebral disturbances | | Gener. HT. Post viral encephalitis, posttraumatic head injury children, traumatic shock, transient diemphatic, pitilatory 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 | | 
Mainspiration | | 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 | | 
Thyroid abnormalities | | Hypothyroidism: HT>children >adult, resolves w replacement Tx. Hyperthyroidism: 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 lanuginos (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, cutaneous angiomas | | 
Pharmacologic hypertichosis | | *Phenytoin HT: after 2-3 m. ♠ limbs, face & trunk, resolve after 1 year discout 75%. * glaucoma Tx, regional hypertichosis: Acetazolamid (children, back & legs) & latanoprost topical (prostaglandine F2 analogue) eyelashes & eyelids 77 %. *Stereomycin: Diff. TB. *Cyclospomin: HTSHT after organ transp. 24-84%. * Psoraleen: HT light-exposed areas. Diazoxide. Minoxidil ♠ terminal hair growth after 4 m. | Phenytoin: unknown Latanoprost: mitogenetic pathway Dioxide: ♠ follicles anagen Minoxidil: Vellus to Terminal hairs | 

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

**References**
db=OMIM

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
Boards from p. 3

Evidence of Professional Standing.

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 systems-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.

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

to your status and the term of your fellowship. Also, make sure you provide your forwarding address so that future correspondence and publications reach you promptly.

Don’t miss out on this great opportunity and ensure no interruption to your JAAD subscription. You can apply online at www.aad.org or contact us at (866) 503-SKIN (7546) or (847) 240-1280 (for persons outside the U.S.).

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.
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 Dermatopathology 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!