

Principlism: ethical considerations for residents

by Karen Scully, M.D., M.A., Ethics, FAAD

Ethics is an important, vital area of your medical training, but some areas of professional medical ethics seem confounding and more gray than ever. Directions in Residency will begin to address these issues with a series of articles specifically for dermatology residents, beginning with this overview, explaining the method of principlism.

As physicians, most of us would consider ourselves to be ethical in everything we do. Until I looked deeper into medical ethics, I would have said that I was ethical. As it turns out, I am not as ethical as I thought I was. In this first article on ethics, I will introduce and expand on a framework for considering ethical issues in medicine, known as principlism. The most commonly cited method of principlism is the one crafted by Beauchamp and Childress.¹ They espouse the following principles: autonomy, beneficence, non-maleficence, and justice in the care of patients. I will address each of these principles — and how they may relate to you in your medical career.

Autonomy and decision making

Respect for autonomy involves respecting the decision-making capacities of autonomous persons, such that the patient has control over his/her person regarding medical decisions. Autonomy is the foundation of informed consent. Previously, informed consent



was physician-driven. Now it is patient-centered. Informed consent should not be limited to the patient's signature on a long, confusing, written form presented by a nurse. Informed consent should be a process involving a dialogue between the physician and patient, to enable the patient to come to a decision regarding a medical

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AMA Update



Sara Brooks, M.D., is a medicine-dermatology resident at Washington Hospital Center and Georgetown University Hospital.

Residents represented in Chicago 2010 meeting

by Sara Brooks, M.D.

I'm writing this fresh in the wake of the 34th Annual Meeting of the AMA Resident and Fellow Section. We gathered in beautiful Chicago in mid-June to discuss the present and future of our chosen field. I am sure you would be proud to know that there were many resident and attending dermatologists representing our interests within the broader context of medicine.

Within the AMA-RFS there were nine resolutions and five reports considered. Of these, eight resolutions and all five reports were adopted. Each resolution or report was interesting and notable in its own way and generated significant discussion. I will highlight a few of the most relevant and interesting ones here.

One resolution that was passed which definitely has implications for

the many breastfeeding mothers/residents is the "Support of Access and Flexibility to Breast Feeding During Required National Board of Medical Exams" resolution. Board exams are long, allow limited break time and almost never have locations available with dedicated pumping or nursing facilities. Taking these facts into consideration, this resolution encourages individual boards to allow for pumping or nursing in a secured private and sanitary location separate from the lavatory. It will also clearly state at the time of exam registration exactly which test locations have these facilities.

The next relevant resolution is the "Scope of Practice of Mid-Level Providers." Because of an overlap with a prior AMA policy, this was passed as internal policy and not

forwarded on to the General AMA House of Delegates. Increasingly, "mid-level" providers such as nurse midwives and nurse practitioners are practicing independently and

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intervention. All the necessary information the patient needs to make a decision about an intervention should be provided by the physician. This should include, but not be limited to, risks and benefits of the proposed intervention, other treatment options, the physician's experience with the intervention, any financial conflicts of interest the physician may have, and so on. Keeping the autonomy of the patient one of the prime principles in problem-solving ensures that the patient is playing an important role in the process. This empowers the patient to participate in his/her care to the appropriate extent, and keeps the physician mindful of the patient's role in the decision-making process.

Autonomy should be respected, unless the physician feels that it would not be in the best interests of a patient. For example, consider the case of a dermatology resident who sees a patient with Kaposi's sarcoma and determines that the patient is HIV positive, a condition which the patient was previously unaware of. The patient begs the resident not to tell his wife. The resident would like to respect the patient's wishes, but he or she feels that it is in the best interest of the patient and his wife not to follow his patient's wishes in this case. His wife is at risk of being HIV positive, if she isn't positive already. She needs to be aware of her husband's HIV positivity for her health. The resident offers to facilitate telling the patient's wife and schedules a meeting with his patient and his patient's wife. In this case, the dermatology resident felt that it was in the patient's best interests to tell his wife of his HIV status rather than honoring the patient's autonomy.

Cosmetic dermatology procedures have some unique features to consider regarding informed consent. The patient needs to understand that a cosmetic procedure may be state-of-the-art one year, such as radio frequency skin tighteners or CO₂ laser resurfacing for wrinkles, but it may become obsolete the next year as technology improves and physician experience expands. It is the cosmetic dermatologist's duty to discuss these concerns, particularly that new cosmetic procedures may have poorly known results and may have some unknown consequences. In particular, many laser systems come to

market without being extensively tested, so that the long term effects and side effects may not be known. The patient needs to be made aware of this possibility.

Beneficence and non-maleficence

Autonomy must be supplemented with other principles, including beneficence. The principle of beneficence involves a group of norms for providing benefits to the patient and balancing benefits against risks and costs. Doing what is in the best interests of patients is the guiding norm of the medical profession. The principle of non-maleficence embodies the assertion, "do no harm." This principle is of considerable importance in the practice of cosmetic dermatology. Since the cosmetic patient may be perfectly healthy, and cosmetic procedures are entirely elective, harming a cosmetic patient may be considered to be of more concern than harming a sick patient. On one hand, possible harms to a sick patient may be acceptable if the intervention helps the patient's overall health problem. On the other hand, harming a cosmetic patient may make that person worse off than before the cosmetic intervention.

Justice and ethics

The fourth principle, justice, involves fairness in the distribution of care, as well as fairness in costs, risks and benefits. Major healthcare disparities are evident in the United States related to race, ethnicity, and socio-economic status. Minorities do not always receive the same quality of healthcare, nor do they have the same access to healthcare, and they have poorer overall health than non-minorities.² We as physicians should strive to eliminate these disparities.

These four principles, autonomy, beneficence, non-maleficence, and justice are intended to function as an analytical framework to consider moral issues and guide the process of problem-solving rather than serving as fixed, moral laws.³ As a framework, principles may be somewhat abstract. Because they are intended to be applied to individual medical cases, the principles need to be balanced and specified according to the unique moral issues in any given case or issue.⁴

We need to look at ethical questions with a more critical lens, and over the next few issues I will focus

on some ethical concerns which are most relevant to the dermatology resident in greater depth. These will include the following:

- **Managing the dermatopharma interface.** I will discuss relationships between dermatology residents and drug reps, whether prescription writing is influenced by pharma gift-giving, and the issue of sampling.
- **Research ethics.** I will look at conflicts of interest, disclosure of relationships with industry, and intellectual property.
- **Professional integrity.** What does it mean to be a member of a profession? I will examine the moral obligations of the dermatology resident to the patient, to society, to the dermatology profession, and to him/herself.
- **Ethics of cosmetic dermatology.** I will highlight some of the ethical questions which arise in the practice of cosmetic dermatology including, but not limited to the ethics of selling cosmetic products, and ethical advertising, among others.

References

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2. American College of Physicians Position Paper. Racial and Ethnic Disparities in Health Care. *Annals of Internal Medicine* (2004) | Volume 141 Issue 3 | Pages 226-232
3. Beauchamp and Childress, p. 15
4. Ibid



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We encourage your feedback! Respond to this article, present your own resident-related ethical questions or pose a new one. Send them to Dean Monti, editor of Directions in Residency, at dmonti@aad.org.

Opinions expressed are those of the author and may not reflect those of the American Academy of Dermatology. R

Dermoscopy buzz-words and phrases

Sheila M. Valentín Nogueras M.D., and Elena Nogales M.D.

Skin tumor or disorder	Dermoscopic findings
Melanocytic lesions	
Melanoma	Irregular granularity in association with red or white colors; linear, irregular, polymorphous atypical vessels; milky-red globules; blue-whitish veil; depigmented areas and pseudopods (invasive melanoma)
Acral melanoma	Parallel ridge and bizarre pattern
Congenital melanocytic nevus	Terminal hairs; cobblestone/globular or homogenous pattern or multi-component pattern; milium-like cysts; crypts and fissures
Spitz/Reed nevus	Starburst pattern
Dermal nevus	Cobblestone pattern; comma vessels
Acral nevus	Parallel furrow, lattice-like, and fibrillar patterns
Blue nevus	Homogenous blue-metallic areas
Vulvar melanosis	Ring-like pattern
Non-melanocytic lesions	
Basal cell carcinoma	Arborizing vessels; leaf-like structures; blue-gray nests and globules (pigmented BCC); spoke-wheel areas; ulceration
Seborrheic keratosis	Milia-like cysts; comedo-like openings; fingerprint-like structures; cerebriform pattern; hairpin vessels
Solar lentigo	Fingerprint-like structures
Keratoacanthoma	Central brownish structureless area and hairpin vessels on a whitish background
Sebaceous hyperplasia	Aggregated white-yellow nodules and crown vessels (radial wreath-like)
Hemangioma	Red-bluish "lakes" (lacunar or saccular pattern)
Dermatofibroma	Pigment network; central white patch
Lichen planus-like keratosis	Granular pattern (early); regression (late)
Clear-cell acanthoma	Dotted vessels arranged in a serpiginous (string of pearls) pattern surrounded by a whitish halo; translucent collarette scaling
Bowen's disease	Glomerular vessels; scaly surface; small brown globules and/or homogeneous pigmentation (pigmented BD)
Actinic keratoses	Rosette sign; "strawberry pattern"
Squamous cell carcinoma	Rosette sign; glomerular vessels; radial streaks, globules, and homogeneous blue pigmentation (pigmented SCC)
Eccrine poroma	White to pink halo; pink-white structureless areas; glomerular vessels
Pyogenic granuloma	Reddish homogenous area; white collarette
Other skin disorders	
Lichen planus	Polymorphic pearly whitish structure (Wickham striae); radial capillaries
Psoriasis	Multiple uniformly sized and distributed dotted vessels; central surface scale
Scabies	"Triangle sign" (mite's head); curved-white line(scale)
Lichen aureus	Coppery-red background; round to oval red dots, globules, and patches; gray dots; partial network of interconnected pigmented lines
Disseminated superficial actinic porokeratosis	Single or double "white track" structure
Supernumerary nipple	Central white scar-like area; cleft-like appearance in the central region; fine pigment network in the periphery
Alopecias	
Alopecia areata	Numerous yellow dots, black dots; broken hairs, and clustered short vellus hairs; exclamation mark hairs (indicate disease activity)
Androgenetic alopecia	Variability in hair shaft diameter >20%; early: peripilar brown depressions, advanced: yellow dots



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Dermoscopy buzz-words and phrases (cont'd)

Sheila M. Valentin Nogueras M.D., and Elena Nogales M.D.

Skin tumor or disorder	Dermoscopic findings
Alopecias (continued)	
Telogen effluvium	Empty follicles, short regrowing hairs and less than 20% hair diameter diversity
Trichotillomania	Black dots; broken hairs, hair shafts of different lengths, coiled hairs; few yellow dots in some cases
Lichen planus-pilaris	Absence of follicular openings; perifollicular scales (peripilar casts); perifollicular erythema
Discoid lupus erythematosus	Mottled dyschromia; follicular plugs; telangectasias; white central plaque; blue-grey dots in a "speckled" pattern; follicular red dots

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being reimbursed by Medicare at 100 percent of what physicians are paid. This resolution asks that the AMA oppose the independent practice of mid-level providers in the interest of patient safety and provider competency.

Another resolution which may be of interest to those residents who participate in extracurricular activities having to do with health care advocacy is the "ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities" resolution. The rationale for this was that GME programs usually allow almost unlimited time for presentation at state/national meetings. However, a reciprocal respect for organized medical activities is not always there. This resolution asks that the AMA encourage all programs to support their residents and fellows in their involvement and pursuit of leadership in organized medicine.

Lastly, there were two emergency resolutions of interest that were passed. The first one addresses fellow duty hours and quality of training. In December 2008 the Institute of Medicine released a report entitled Resident Duty Hours: Enhancing Sleep, Supervision and Safety with a focus on developing strategies for implementing optimal work schedules to improve safety in health care. Their recommendations were to reduce the maximum number of hours residents can work without sleep to 16, allow overnight call with a five-hour sleep period, and increase the number of days residents must have off. Although this may sound good in the short term, this will create an undue hardship on training programs to find coverage, and possibly even extend residency training. Additionally, studies performed recently to validate the 80-hour work week have shown that it actually has not increased patient safety. Therefore, this resolution states that the AMA should encourage the ACGME not to adopt the IOM report recommendations and realize that different disciplines and training levels need flexibility.

The second emergency resolution dealt with AMA advocacy regarding FICA taxation of house staff. Currently, students employed by a school, college or university are exempt from FICA tax (supplemental security income or SSI, and

Race for the case *by Andrew Krakowski, M.D.*



This 68-year-old retired U.S. Marine presents to the Veterans Administration Hospital in San Diego with a chief complaint of "zits all over me" and has experienced them for "the last 30 or so years." He reports having only mild acne as a teenager, and there is no family history of severe acne. He is "fed-up because nothing seems to make any difference." On general physical exam, the patient is afebrile, in no apparent distress, and otherwise appears in good health. On skin exam, you note hundreds of diffusely scattered, fairly monomorphic, 2-6mm open and closed com-

edones along with diffuse, pitted scarring and several cysts over the chest and back; there are no frank pustules. The face is almost completely spared. He has no tenderness on palpation of the affected areas and no arthralgias or bony tenderness.

Submit your diagnosis to dmonti@aad.org for a chance to win something stimulating.

You're such a smart group of readers that we've added a tie-breaker question this time: What was the most likely cause? Need a hint? Consider his age and occupation (if you haven't already). 

Case Buster revealed!

Billions and billions of dermatology residents supplied the correct answer to last issue's Race for the Case. Well, not *billions*. But at least enough to crowd our inbox for a few days. But this time the winner (and frequent *RFTC* contestant) with the correct answer **coccidiomycosis**, was **Kesha Buster, M.D.**, who is currently doing a combined residency and research fellowship (the so-called 2 + 2) and is in her fourth and final year at University of Alabama. So let's see ... 2 + 2, fourth and final, plus the right answer, that adds up to a \$15

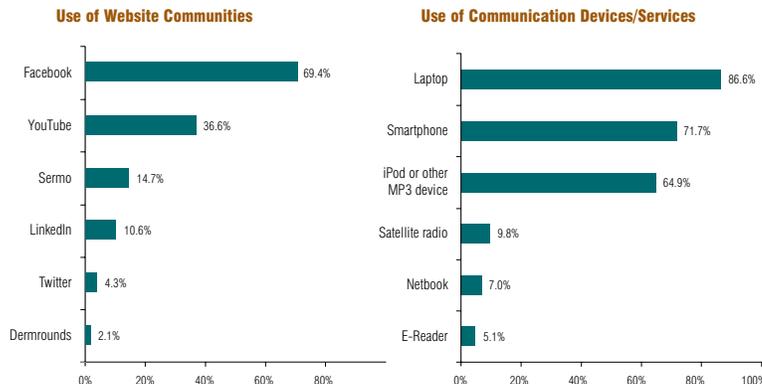


Starbucks gift certificate, the way we figure it. When not correctly identifying coccidiomycosis, Dr. Buster enjoys spending time with her husband and two girls. Congratulations! 

Medicare taxes which equal 15.3 percent of wages). There is currently a split between the circuit courts over whether medical residents qualify for the FICA student exemption. On June 1, 2010, the U.S. Supreme Court agreed to resolve the issue. There are advantages and disadvantages for residents on each side. The advantage of not paying FICA is obviously higher after tax income and take-home pay. The disadvantage, however, is that exemption from FICA can lower average earn-

ings on which SSI benefits are based and reduce the amount of retirement benefits available. Also, being exempt from FICA may prevent qualification for disability benefits. In addition, there is the possibility that reclassification of residents as students and not employees would remove the protections and benefits that one gets as an employee such as disability and health insurance. The future of this issue remains to be seen and will be one that residents will want to keep an eye on. 

Use of website communities & communication devices/services



A recent AAD survey of dermatology residents reveals a rapid trend toward technology-based information gathering. As we look to the future of *Directions in Residency* we'll be looking at how we can bring this publication to the Web.

What do you value in a website? What features — that are not currently available in print — would you like to see in a Web publication of *Directions*? Send your comments and ideas to Dean Monti, editor, at dmonti@aad.org.

International meeting travel grant available to residents

Through mutual arrangements with several international dermatological societies, a number of travel grants are available for U.S. and Canadian residents, fellows or young dermatologists (within five years of completing residency) to attend the 2011 annual meetings of the societies.

This is a wonderful opportunity for the successful applicants to meet foreign colleagues and possibly establish long-lasting professional relationships. Participating societies

include the British Association of Dermatology, the Chilean Academy of Dermatology, and the EADV. Applications are due online **Sept. 30, 2010**.

Learn more online

For more information on these and other AAD scholarship opportunities, including application information and deadlines, visit www.aad.org/scholarshipopportunities/, and start making a difference in the world.

Review Boards' Fodder online

Boards' Fodder is frequently cited as one of the most popular and useful tools in *Directions in Residency*. You can view past Boards' Fodder topics, as well as past issues of *Directions*, online at the Residents section of the Academy's website, www.aad.org.

Boards' Fodder topics currently online (in PDF format) include:

- Syphilology
- Genes
- Bones, Eyes, and Nails
- Bugs and their Vectors
- Contact Allergens
- Histologic Bodies
- Viruses
- Inherited Palmar Plantar Keratodermas
- Porphyrias

These additional Boards' Fodder topics (and more) can be found within issues of *Directions in Residency*, also online at www.aad.org.

- Paraproteins and paraneoplastic syndromes
- Most common tumor locations
- Dermatologic manifestations of underlying endocrinopathy
- Hypertrichosis
- Autoimmune bullous disorder
- Review of retinoid biology
- Review of surgical anatomy
- Immunodeficiency disorders
- Medical mycology

Skin Deep *by Krakowski/Monti*



"Do you want me to cut the sutures 'too long' or 'too short' this time?"

Interested in Leadership Development?



Visit www.aad.org/leadership to view opportunities as well as a listing of Leadership sessions available at the 69th Annual Meeting in New Orleans, Louisiana.

message from the chair



Angela Kyei, M.D.

As you settle into a new year in your graduate education, I want to encourage you to get involved with the Academy. There are opportunities to do skin cancer screenings, apply for grants, or present at the Annual and Summer Academy Meetings. If you are politically inclined, consider joining DAN, the Dermatology Advocacy Network. Your membership in DAN will keep you up to date on important legislative and regulatory issues that affect our specialty. There are many opportunities to match your interests to activities, but above all else get involved!

The Resident/Fellows Committee (RFC) has provided input to the Academy to help formulate their meeting programs to meet the educational needs of residents.

There are many exciting upcoming sessions that I would like to let you know about scheduled for the Academy's 2011 Annual Meeting in New Orleans:

- **Boards Blitz** – This is a new session at the Annual Meeting! This interactive session will provide key points and tips for identifying and making diagnoses for the digital image portion of the certification or recertification exam. Attendees will have the opportunity to view numerous digital images in rapid fire progression preparing them for the digital image portion of the exam.
- **High Yield Power Hour for Residents** - Four high-yield topics will be covered in this new session: mechanisms of action and side effects of systemic derma-

tologic therapies; basic concepts of laser and surgical dermatology; allergens associated with contact dermatitis; and genetic and autoimmune disorders of the epidermal basement membrane. Multiple choice questions will highlight take-home pearls.

- **Resident Transitions Session** – This session will provide information on the structure, format, and process for the American Board of Dermatology Examination from a representative from the ABD. A panel of recent test takers will also share information about their experience and helpful tips about preparing for and taking the exam. In addition, successful career dermatologists will share some of the challenges they faced when launching a career in academic and private practice. You won't want to miss this session!
- **Resident Jeopardy** – Join your colleagues for self-assessment through a familiar, engaging game show format. Find out which institution will be awarded the coveted Jeopardy trophy! Audience members are invited to play along.

Directions in Residency is your publication! If you have suggestions for articles or if you would like to submit an article on a topic you are interested in, send me an e-mail at residents@aad.org, or contact the editor at dmonti@aad.org. We also welcome your feedback on the articles we publish. The RFC wants to hear from you. Have a great year! 

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Fall 2010

Residents / Fellows Committee

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Julie Fenner, MD	2012
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Sara Lohser, MD	2013
Ahou Meydani, MD	2013
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Don't forget to attend the Practice Management Symposium for residents while at the Annual Meeting.

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