What I wish I’d known in residency

By Lisette Hilton

Filled with long days and nights spent studying and treating patients at sometimes far-away clinics, residencies are an opportunity for hands-on learning, collaboration, and developing long-term relationships. Dermatologists say, however, residents need more than they typically learn during residencies to launch successful careers in dermatology. Reflecting on their residency experiences, dermatologists share what future and current residents need to know in order to get the most from the experience.

Lessons learned outside books

Residencies go a long way in preparing residents to care for patients. Nicole F. Velez, MD, who is finishing her residency in dermatology at Harvard in June 2013, says the hands-on care teaches much more than books.

“I think that in getting to know patients and following them through with their skin conditions — whether it be a rash or a skin cancer — I’ve learned so much about the diseases and how to care for and manage patients,” Dr. Velez says. “I’ve also learned from my co-residents, who have helped me with difficult cases and have shared their own experiences.”

Lisa Chipps, MD, MS, director of dermatologic surgery at Harbor-UCLA Medical Center and a practicing dermatologist in Beverly Hills, Calif., says she learned to appreciate the different environments in which dermatologists see patients and different patient populations. “To this day, I see patients in various clinics. I enjoy interacting with different kinds of people,” Dr. Chipps says.

Residency also is a great opportunity for collaborating and building relationships, according to Dr. Velez. “I have fortunately formed a great network of advisors and mentors, where if I see something difficult or challenging, I know who to ask,” Dr. Velez says. “[Mentors] have really helped me grow as a person and as a physician. They’ve helped me achieve my goals, one of which was getting a Mohs fellowship for next year.”

Kristina Collins, MD, a Mohs surgeon at the New England Dermatology and Laser Center, encourages new residents to seek mentors and start projects early on, so that they may “try on” numerous interests and career paths before the end of residency. “I think, oftentimes, residents see their mentors as people that will be part of their career during residency, but, the truth is the very best mentors are mentors for life,” Dr. Collins says.

Time flies when you’re a resident

Less than a year since completing her training, including a fellowship at the Lahey Clinic, Dr. Collins says what surprised her most about her residency was how quickly time flew by.

“Prior to residency, I think the tendency is to view the process as … long and arduous, but once you are actually working as a resident, it is incredible how short the time feels,” she says. “I remember about three months into dermatology residency, as we (first years) were stumbling over some questions in lecture, one of our professors said … you know more dermatology than just about anyone else in the hospital. And you know what, he was right!”

While fast paced, residency is actually the calm before the storm of real-life practice, says Dr. Collins.

“Looking back, residency is an amazing amount of protected time, where you aren’t focusing on business, financial, or staffing issues and are only expected to learn about dermatology and focus on your own career choices,” Dr. Collins says.

Still, residency is quite a change from medical school and internship, according to Elizabeth Grossman, MD, MBA, who practices in Chicago and is an instructor of clinical medicine, Northwestern University Feinberg School of Medicine.

“During residency, there is a lot of outside learning, reading, and research preparation that goes on,” Dr. Grossman says. “I was surprised at the amount of outside work … that I needed to complete in order to stay prepared and succeed with my research and education. This was hard, as I already had a four-month-old baby and a husband in surgical residency. I learned quickly to be as efficient as possible.”

See RESIDENCY on p. 3

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Amgen proudly supports the American Academy of Dermatology’s Directions In Residency publication.
**RESIDENCY from p. 1**

Had she known the extent of the demands, Dr. Grossman says she would have better prepared her husband, as well as focused on accepting that, even though she was at home, there was work that needed doing.

Dermatologists say residencies don’t prepare them for the interactions they’ll face with insurance companies, pharmaceutical companies, and government and health care delivery systems. Dr. Chipp adds that residency training on coding is in short supply.

**Speaking of finances...**

Residency training can be a tricky time, financially. Dr. Grossman recommends residents open a Roth IRA during residency.

“I don’t care if you put in $1000. Do it. You are only eligible to contribute to a Roth IRA if you earn under a certain income. Typically, attending salaries are over this limit, so you should contribute during residency, when you are able to,” Dr. Grossman says.

Those completing their residencies should budget for upcoming bills, including licensing and boards. Some residencies or first employers, Dr. Grossman notes, pay for boards.

**Business, as usual**

Residencies tend to fall short in preparing dermatologists for business and other challenges that come with running a practice.

Elizabeth Grossman, MD, MBA, who completed her dermatology residency at Northwestern University McGaw Medical Center in 2011, says residency prepared her for the transition to an attending. “However, as an attending, the hardest part of my job is often managing the patient-physician dynamic. How do you manage a patient who refuses a biopsy? [Or] who wants you to write them for Retin-A and code it as acne, when it is for photoaging?” says Dr. Grossman, who practices in Chicago and is an instructor of clinical medicine, Northwestern University Feinberg School of Medicine. “When you have a difficult patient-physician dynamic as a resident, it is easy to report back to the attending and, then, defer to the attending to manage the situation. I wish I had participated in the conversation with the attending more, and asked them specifically how to manage these dynamics.”

**Remember to live**

It’s important to study and work hard during residency; it’s also important to strike a balance by paying attention to health, happiness, and pursuits outside of medicine. Dr. Chipp went from her residency at University of Colorado Health Sciences Center in Denver to a two-year dermatology fellowship. The transition from residency to fellowship was smooth, Chipp says. But residency did not prepare her well for the job hunting and contract negotiations to follow. She recommends residents attend practice management and job hunting-type sessions at American Academy of Dermatology and American Society for Dermatologic Surgery (ASDS) meetings.

“I also encourage residents to talk to people who are doing what they think they’d like to do and get ideas from them on how to get to that place. A lot of practicing dermatologists have made a few mistakes before ending up where they’ve wanted to be. So, you can learn from others’ experiences,” Dr. Chipp says.

**Take a chance**

Suzanne M. Olbricht, MD, chair of the department of dermatology, Lahey Clinic, associate professor of dermatology, Harvard Medical School, and secretary treasurer of the AAD, shares her residency wisdom.

**Directions:** What mistakes or difficulties do you see among residents, and how can they avoid those mistakes?

**Dr. Olbricht:** Residents often rigidly define their objectives either for what they want to learn or the path they want their career to take. They make a list of things to study and don’t wander from the agenda, or they pick a career path and only participate in activities that are tightly aligned with advancement on that path. What the resident then misses are the side messages — some of which might be so interesting that they can swing an entire career in a new and fascinating direction. Be open to experiences that aren’t in your master plan. Trust the process. Believe in serendipity.

**Directions:** Do you have a favorite memory from your own residency?

**Dr. Olbricht:** When I was a third-year resident, I ran the Harvard Thursday afternoon patient rounds. After rounds one evening, a dermatologist from Portland, Maine asked me if I knew of anyone who would practice per diem once a month in Presque Isle, Maine. So I was thinking: island, Maine, sounds sweet! Turns out it was inland, frozen north potato land, 450 miles from Boston. But I decided to do it anyway, saw great patients, learned a lot about dermatology, made friends with the primary care providers, had lovely babysitters for my kids, explored a unique part of the US, and traveled to the Gaspe Peninsula four times for long weekends (one of my most favorite places on earth).

I ended up going to Maine for eight years, at least once a month for three days of patient care. The patients were so appreciative. I believe it was formative in my career, as I was the only dermatologist and needed to also function as an intermediary administrator in the hospital system. The lesson I learned: Say yes and serendipity will take over and lead to great adventures. It has been my mantra ever since.

**Directions:** What tips can you offer residents to help them survive residency?

**Dr. Olbricht:** Love what you do at work, and you will be more successful at home. Love what you do and who you are with in your non-work space and you will be more successful at work. This does not relate to hours spent at work, but rather the power of full engagement (hint: a good book to read) in all spheres of your life.
Inheritance
K5 & 14
Widespread blisters as early as
Acral blisters at birth
Onychogryphosis
EBS, local
Laminin 332
Intertriginous blisters; milia; scar
Generalized blisters at birth; milia;
Laminin 332,
AD
Generalized erosions at birth;
AR
AR
Laminin 332
Plectin
Widespread blisters at birth;
Unknown
α
Lethal
Widespread or anogenital blis
Superficial erosions as early as
Migratory circinate
Widespread blisters since birth
Plectin,
K5 & 14
Generalized erosions at birth;
K14, BPAG1e
Desmoplakin
Blisters since young adulthood;
Generalized blisters at birth;
Palmoplantar bullae, erosions
K5
Plectin
Herpetiform blisters since birth;
Laminin 332
Key Findings
JEB,
Type XVII
Widespread bullae since birth;
Laminin 332

EPIDERMOLYSIS BULLOSA
Suprabasal
LETHAL
ACANTHOLYTIC EBS
AR
Desmoplakin
Generalized erosions at birth;
GI, GU, RT involvement; lethal in neonatal period
Neonatal teeth Complete nail shedding
Universal alopecia

Plakophilin deficiency
AR
Plakophilin-1
Generalized erosions at birth;
focal PPK; blepharitis;
astigmatism
Hypotrichosis
Anhidrosis
Perioral & tongue fissures

EBS, other
generalized
AD
K5 & 14
Superficial erosions as early as birth; milia;
sparing of palms & soles

Basal
EBS, localized (Weber-
Cookayne)*
AD
K5 & 14
Superficial erosions as early as birth; milia;
sparing of palms & soles

EBS with muscular
dystrophy
AR
Plectin
Widespread erosions &/or painful calluses as early as infancy (may present during early adulthood)

EBS with pyloric atresia
AR
Plectin, α6β4 integrin
Widespread erosions as early as birth; milia;
sparing of palms & soles

EBS, Ogna
AD
Plectin
Acral blisters at birth

EBS with mottled
pigmentation
AD
K5
Widespread erosions as early as birth;
sparing of palms & soles

EBS, migratory
circinate
AD
K5
Widespread erosions as early as birth;
sparing of palms & soles

EBS, autosomal
dominant
AR
K14, BPAG1e
Widespread erosions as early as birth;
sparing of palms & soles

JUNCTIONAL
EPIDERMOLYSIS
BULLOSA (JEB)
Intralaminar Lucida
Herlitz
AR
Laminin 332
Generalized erosions at birth;
GI, GU, RT involvement
Perioral granulation tissue
Dental pitting/caries
Delayed puberty

Other
JEB, non-Herlitz
 generalized
AR
Laminin 332, Type XVII collagen
Generalized erosions at birth that improve with age; milia; scarring; dystrophic nails; focal PPK; mild SI

JEB, non-Herlitz
localized
AR
Type XVII collagen
Localized erosions at birth; milia; dystrophic nails; no SI

JEB with pyloric atresia
AR
α6β4 integrin
Generalized erosions at birth; dystrophic nails; pyloric atresia
Aplasia cutis
Rudimentary ears
Dental pitting
GU malformations

JEB, inversa
AR
Laminin 332
Intertriginous erosions; milia; scarring; dystrophic nails; no SI
Dental pitting/caries

JEB, late onset
AR
Laminin 332
Blistering since young adulthood; dystrophic nails
Absence of dermatoglyphs
Hyperhidrosis
Dental pitting

Laryngo-onycho-
cutaneous syndrome
(Shwachman syndrome)*
AR
Laminin 332 (α3 subunit)
Blistering since birth on face & neck; scarring; dystrophic nails; granulation tissue
Prominent laryngitis & conjunctival involvement

Malignant neoplasm
other
AR
α6β4 integrin
Generalized erosions at birth; milia;
sparing of palms & soles

Other
JEB, non-Herlitz
generalized
AR
Laminin 332, Type XVII collagen
Generalized erosions at birth that improve with age; milia; scarring; dystrophic nails; focal PPK; mild SI

JEB, non-Herlitz
localized
AR
Type XVII collagen
Localized erosions at birth; milia; dystrophic nails; no SI

JEB with pyloric atresia
AR
α6β4 integrin
Generalized erosions at birth; dystrophic nails; pyloric atresia
Aplasia cutis
Rudimentary ears
Dental pitting
GU malformations

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Intertriginous erosions; milia; scarring; dystrophic nails; no SI
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Malignant neoplasm
other
AR
α6β4 integrin
Generalized erosions at birth; milia;
sparing of palms & soles

Other
JEB, non-Herlitz
generalized
AR
Laminin 332, Type XVII collagen
Generalized erosions at birth that improve with age; milia; scarring; dystrophic nails; focal PPK; mild SI

JEB, non-Herlitz
localized
AR
Type XVII collagen
Localized erosions at birth; milia; dystrophic nails; no SI

JEB with pyloric atresia
AR
α6β4 integrin
Generalized erosions at birth; dystrophic nails; pyloric atresia
Aplasia cutis
Rudimentary ears
Dental pitting
GU malformations

JEB, inversa
AR
Laminin 332
Intertriginous erosions; milia; scarring; dystrophic nails; no SI
Dental pitting/caries

JEB, late onset
AR
Laminin 332
Blistering since young adulthood; dystrophic nails
Absence of dermatoglyphs
Hyperhidrosis
Dental pitting

Laryngo-onycho-
cutaneous syndrome
(Shwachman syndrome)*
AR
Laminin 332 (α3 subunit)
Blistering since birth on face & neck; scarring; dystrophic nails; granulation tissue
Prominent laryngitis & conjunctival involvement
EPIDERMOLYSIS BULLOSA (continued)

Rachelle E. Seijo-Montes, MD, and Elena M. Montalván-Miró, MD

<table>
<thead>
<tr>
<th>Type &amp; Level of Cleavage</th>
<th>Major Subtype</th>
<th>Subtype</th>
<th>Inheritance</th>
<th>Defective Protein</th>
<th>Clinical Manifestations</th>
<th>Key Findings</th>
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<tbody>
<tr>
<td>Dystrophic Epidermolysis Bullosa (DEB)</td>
<td>Dominant</td>
<td>DDEB, Generalized (Cockayne-Touraine)*</td>
<td>AD</td>
<td>Type VII collagen</td>
<td>Generalized blisters at birth; milia; scarring; absent or dystrophic nails</td>
<td>+/- albopapuloid lesions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DDEB, acral</td>
<td></td>
<td></td>
<td>Acral blisters &amp; erosions since birth; milia; scarring; nail dystrophy</td>
<td>Symptoms may cease in childhood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DDEB, pretibial</td>
<td></td>
<td></td>
<td>Pruritic lichenoid papules; +/-milia; scarring; nail dystrophy; may involve dorsum of hands &amp; feet</td>
<td>Pretibial involvement; Later onset; Lichen planus-like scarring</td>
</tr>
<tr>
<td></td>
<td>Recessive</td>
<td>RDEB, severe generalized (Hallopeau-Siemens)*</td>
<td>AR</td>
<td></td>
<td>Generalized blisters at birth; milia; scarring; absent or dystrophic nails; anemia; growth retardation; excessive caries; GI, renal &amp; cardiac involvement; osteoporosis</td>
<td>Pseudosyndactaly; SCC; +/- Melanoma; Delayed puberty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RDEB, generalized other</td>
<td></td>
<td></td>
<td>Generalized blisters at birth; milia; scarring; absent or dystrophic nails</td>
<td>+/- pseudosyndactaly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RDEB, inversa</td>
<td></td>
<td></td>
<td>Intertriginous &amp; lumbosacral blisters at birth; milia; scarring; absent or dystrophic nails; GU involvement</td>
<td>External auditory canal stenosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RDEB, centripetalis</td>
<td></td>
<td></td>
<td>Widespread blisters at birth; acral involvement in adulthood; milia; scarring; absent or dystrophic nails</td>
<td>Centripetal spread</td>
</tr>
</tbody>
</table>

Kindler Syndrome

Mixed (Intraepidermal, junctional or sublamina densa)

AR Kindlin-1

Generalized blistering at birth; scarring; PPK; +/- MR & bone abnormalities
Pikoloderma
Photosensitivity
SCC
Bladder CA

+/- may have; * formerly called; GI= gastrointestinal; GU= genitourinary; RT= respiratory tract; PIH= post inflammatory hyperpigmentation; PPK=palmoplantar keratoderma; EM= electron microscopy; MR = mental retardation; SI= systemic involvement

References:


Intong L & Murrell DF. Inherited epidermolysis bullosa: New diagnostic criteria and classification; Clinics in Dermatology (2012) 30, 70–77


RESIDENCY from p. 3

ness, and the occasional opportunity outside your training.

“In residency, just as in the rest of your career, remember that today is your only guarantee,” Dr. Collins says. “I know this sounds crazy, but you won’t have more time after residency. In fact, you will probably have less. So, there may never be that perfect time to take that once-in-a-lifetime trip, or attend that friend’s wedding in another state, or have that awesome costume party, or learn to play the piano, or organize a monthly poker night. There may never even be a perfect time to fall in love and have kids. But you know what, do it anyway.”

And don’t forget to enjoy the experience of being a resident. “It can be competitive, but keep in mind the perspective that you’re learning how to take care of patients and cherish the opportunities you have with great mentors and faculty. It goes by so fast. I can’t believe I’m almost done,” Dr. Velez says.
Race for the Case

By Chinmoy Bhate, MD

A 27-year-old man of Indian lineage is seen for scaly skin which he reports is worse in the winter time, and very dry skin since early childhood. The most prominent areas involved are the legs, where he often notes painful fissuring between the plate-like scales. His palms demonstrate prominent skin markings. He has no systemic symptoms and is otherwise well. Topical keratolytics have been modestly helpful; however, he is noncompliant because he states they sting when applied to the affected skin.

1) What is the causative mutation?
2) What is the most common mode of inheritance?
3) What are the most commonly associated cancers with the acquired form of this condition?
4) What is the enzyme defect in the x-linked form of this type of skin disorder?

Respond today with the correct diagnosis to Allison Evans, staff editor at aevens@aad.org, and will be part of our drawing for a Starbucks gift card and your photo in Directions!

The amazing Race ... for the Case winner!

The first Race for the Case winner of the year is Nita Kohli, MD, a 2nd-year dermatology resident at University Hospitals Case Western Reserve University in Cleveland, Ohio. Some of her hobbies are volleyball, tennis, salsa and ballroom dancing, hiking, and traveling to exotic places. From her extensive travels, her favorite trips include hiking in Machu Picchu (Peru), visiting Angkor Wat (the largest Hindu temple complex in the world located in Cambodia), snorkeling with the honu (green sea turtles) in Maui, white water rafting in Chiang Mai, Thailand, and having tea with a Japanese gaka (artist) in Kyoto.

The amazing Race ... for the Case winner!

Nita Kohli, MD

Happy trails!

We would be remiss if we did not thank Kari Wanat, MD, for serving as physician editor of Directions for the past two years. We first met Kari when she and her colleagues at University of Pennsylvania won the Race for the Case in our winter 2010 issue. By good fortune we ran into Kari at the Annual Meeting in New Orleans in 2012, and soon after she became physician editor of our publication during 2012-2013. Thanks, Kari, for keeping Race for the Case alive and providing guidance and good cheer!

Do you have a good Race for the Case photo feature? We are seeking new contributors. Contact Dean at dmonti@aad.org for submission details.

Answers to last Race for the Case, Winter 2012

The authors of our last Race for the Case were incorrectly identified in our Winter 2012 issue. The case was submitted by Lindsay Wilson, MD, and Anneli Bowen, MD. Our apologies for the error. Their original question and the answers are included here.

A 37-year-old male presents with three weeks of numbness in his left index finger and great toe. He complains of purple discoloration. He also has new onset calf claudication. He has no systemic symptoms. He reports a remote history of IV drug use, alcohol abuse, and a 25-pack year smoking history.

1) What is the diagnosis?
   - Buerger’s Disease or Thromboangiitis obliterans
2) What feature of his history is most associated with this disease?
   - Smoking history
3) What demographic is most commonly affected with this disease?
   - Men who smoke in their 30s-40s with periodontal disease.
4) What is the treatment?
   - Smoking cessation (even second hand smoke), aspirin, wound care and amputation for necrotic digits.
Stress Busters: How residents manage stress

The Physical Blockers
by Weilan Johnson, MD.

At Stanford, we stress bust as a team! Stanford faculty and residents joined together to form an intramural flag football team, appropriately named “the Physical Blockers.” Donning our zinc oxide football masks, we hit the field sprinting, blocking, and rushing against our undergraduate opponents. You wouldn’t believe how therapeutic it can be to watch your uber-accomplished attending dive to strip an opponent of their flags. The physicality of this supposed-to-be-non-contact-but-in-reality-it’s- football-without-pads game alone served as an outlet for stress. But beyond that, each successful play yields intense joy and celebration, melting our stresses away. Our defense kept the opponents guessing with our cheer, “the Grenz zone, we keep them out of the end zone!” Our inside joke had us chuckling every time. Laughter really is the best medicine.

Each game taught us the value of team work, communication, and the importance of supporting each other. The bonds that we fostered on the field have proven therapeutic off the field, as we built a sense of camaraderie that permeated into our professional lives. So whether it’s flag football, soccer, basketball, or any other team sport, I highly encourage other residents and faculty to stress bust with team sports. Simply chanting “Go Physical Blockers” helps us relieve stress. Go Physical Blockers! Pictured left to right are the stalwart Stanford team: Erik Cabral, Michael Krathen, Britt DeClerck, Betsy Bailey, Michelle Longmire, Weilan Johnson, Nicole Seminara, Ashley Wysong, and Teresa Fu.

Message from the Outgoing Chair

It’s incredible to think that I have had the privilege of serving on this committee for four years now — encompassing nearly the entire period of my training in dermatology, Mohs, and laser surgery. The last two years have been particularly rewarding as chair of the RFC. I would therefore like to begin my final message by thanking all of those residents, fellows, and the AAD Board and staff members that I have had the pleasure of working with and from whom I have had the opportunity to learn and grow as a physician and person.

As newly minted residents and fellows, we represent the future of our profession. These are interesting times to be a trainee in medicine and in dermatology, and while our predecessors have had their share of challenges, it appears as though we will deal with our fair share as well. Therefore, it is as important as ever to stay active and involved in shaping the direction taken by medicine, dermatology, and the AAD. Involvement can mean contributing to Directions in Residency, organizing and participating in local events raising awareness of skin disease, serving on various Academy task forces, workgroups, and subcommittees, or attending legislative events in Washington, D.C., to affect national policy. The possibilities are endless — all that is needed is to take that first step.

On behalf of the RFC and staff, I would like to introduce our new Chair and Resident/Fellows Board Observer, Brian Hinds, MD. Brian has gone far beyond that first step, joining and instantly becoming an active committee member, in particular volunteering to spearhead our latest mentorship initiatives. He possesses the drive and skills necessary to continue our efforts in making the training experience as meaningful and fulfilling as possible.

Our future is a bright one, and I look forward to working alongside all of you for many years to come.
Message from the Chair

Hello fellow residents and greetings from Louisville.

It is with great pleasure that I assume the role of RFC chair. I would like to thank our outgoing chair, Dr. Jeremy Brauer, for his phenomenal leadership and steadfast devotion to this committee. We have had tremendous success with Dr. Brauer at the helm, and the RFC would not be where it is today without his guidance.

In this opening message, I would like to review the RFC Mission and outline how it personally relates to you. The RFC is peer-run and serves a higher purpose of enriching educational opportunities beyond the clinic. The RFC voice arises unfiltered from the trainee’s perspective; thus, we depend on your active input. We are fortunate to have a talented team of residents [listed at bottom right], who strive to expand on resident interests in education, leadership, mentoring, and philanthropy. For clarity, these individuals lead workgroups that are unrestricted and open to any and all residents. I pledge that the experience will be rewarding, full of camaraderie, and a definite reprieve from inefficient EMRs or swarming board minutia. Time in residency is fleeting and transitory, so I encourage you to become involved and make your voice heard. Please consider contributing to the print editions or, at minimum, review Directions resources online to discover ways to maximize life in residency. Again, it is an honor to serve the RFC and the Academy, and I look forward to providing updates from our committee as we progress through 2013.

Opportunity awaits via resident grants!

Resident International grant
The Education and Volunteers Abroad Committee provides funding for U.S. or Canadian senior dermatology residents to participate in a four- to six-week elective in 2014 in Gaborone, Botswana. The grant allows dermatology residents an opportunity to learn about the care of tropical and HIV-related dermatologic conditions as well as how to practice routine dermatology with finite resources. Deadline to apply for 2014 rotations: April 30, 2013.

Native American health service resident rotation
Funding opportunity is available for U.S. dermatology residents currently in their second or third year of residency to provide dermatologic care to the Navajo Nation population at a one- to two-week rural health elective in Chinle, Ariz. Rotations will take place in March, May, August, and November 2014. Deadline to apply for 2014 rotations: April 30, 2013.

International Society meeting travel grant
The Academy offers scholarships to US and Canadian dermatologists to attend the 2014 meetings of select international dermatological societies. Terms of the scholarship and dates of each meeting vary with each society. Information about 2014 meetings will be available in May. Deadline to apply for the 2014 meetings: Sept. 30, 2013.

To learn more about all resident grants, go to www.aad.org/awards.

Amgen Pfizer proudly supports the American Academy of Dermatology and the Directions in Residency newsletter.