

## How would you diagnose your financial picture?

### 5 questions residents should ask themselves

Residency is consumed with clinical work, clinical learning, and sleep. Precious free time exists to spend with loved ones and on other activities that keep you sane. It doesn't leave a lot of time to think about finances and insurance. But, at some point, there are a few financial moves that you can't ignore. Directions in Residency asked two financial experts that specialize in working with physicians, Jim Dahle, MD, and Lawrence Keller, for a list of five key questions residents should ask themselves.

#### 1. Do you have an individual disability insurance policy?

Your greatest asset as a dermatologist is your ability to practice your specialty. Over your career, that asset is likely to be worth over \$10,000,000. You must protect it. You do this by purchasing a non-cancellable, guaranteed renewable disability insurance policy with a true "own-occupation" definition of total disability. This type of policy will provide you with income if you are disabled and cannot work as a dermatologist — even if you can earn the

same or more income in another occupation or medical specialty.

You will want a policy that provides benefits to the age of 65 or longer as well as a residual disability rider, a cost of living adjustment (COLA) rider, and a future purchase option rider. An individual policy is generally far superior to the group policy your hospital may provide to you as a house staff member. Not only are you more likely to actually get paid in the event of disability, but you can take the policy with you when you graduate.

You may need to eventually purchase policies from two separate companies in order to maximize your coverage, as any one company is unlikely to issue a policy with a monthly benefit of more than \$17,000.

You may save a lot of money by getting a policy that includes a "multi-life" or association discount. While this can provide male dermatologists with a savings of 10 to 15 percent off of their policies, female dermatologists can save as much as 60 percent if a gender-neutral



or "unisex" rate is available. There may already be existing multi-life discounts in your hospital that an insurance agent that specializes in working with physicians can help you obtain. Otherwise, you'll need 2 to 4 employees from the hospital, in addition to yourself, to pur-

See **FINANCIAL** on p. 3

## ethical considerations



*Karen Scully, MD, is a board-certified dermatologist in Canada and the United States, and has an MA in ethics from UNC, Charlotte.*

### Truth telling and the doctor-patient relationship

*What's a physician's obligation to absolute honesty?*

*By Karen Scully, MD*

As physicians, are we obligated to be truthful to patients? The answer to this question is not as straightforward as it seems. In this column, I will discuss our obligation of honesty to patients and the subtleties involved in telling the truth.

Honesty in the informed consent process has replaced a paternalistic approach in which physicians of the past told patients little or nothing about their diagnosis, particularly if it was cancer or a terminal illness. Physicians made decisions for patients, and they decided on treatment without patient involvement. The physician was not questioned. Frank dishonesty on the part of the physician was not unusual.

Today, conformed consent involves patients in their health care process. Autonomy is now one of the four important principles involved in ethical medical care.

There are three arguments which justify the ethical obligation of honesty to patients.<sup>1</sup> First of all, honesty is based on respect for others. Secondly, honesty has a close connection to fidelity and promise keeping. When we enter into a relationship with a patient, we implicitly promise not to deceive them. Lastly, doctor-patient relationships depend on trust, and being truthful is essential to trust.

Although deception in medi-

cine is wrong, the obligation of complete honesty to patients is not absolute. Put another way, physicians

See **ETHICS** on p. 2

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## AAD.org adds Dermatology World section, enhances online features, functionality

Continuing enhancements to both its website and *Dermatology World*, the Academy recently launched two new features on AAD.org that make both resources more valuable to members. A new *Dermatology World* section of the website, located at [www.aad.org/dermatology-world](http://www.aad.org/dermatology-world), gives readers access to the current and past issues of the magazine, with online-only bonus sidebars, audio, and image slide-shows; and the continued availability of the magazine as a digital edition or PDF.

Also, in addition to being able to search for *Dermatology World* con-

tent through the AAD.org search function, users can search for articles with a dedicated magazine search function. Meanwhile, visitors to AAD.org will notice the site's overall search function has been dramatically enhanced. It returns results quickly and allows users to preview pages by hovering over a result before clicking. These updates will make the site easier to navigate not only for members, but also for the public as it visits to learn more about its skin, hair, and nail conditions. Try a search for your topic of interest at [www.aad.org/search/](http://www.aad.org/search/). 



## The resident's crystal ball — or something like it — awaits you online with Derm CareerLink

Unfortunately there's no actual crystal ball to predict your future as a dermatology resident. However, you can prepare for your future by being well informed about your profession, its trends, and employment opportunities via the Derm CareerLink Occupational Outlook 2012. This outstanding online publication includes information about

how technology can enhance your career, insights into sub-specialization, tips for resumes and CVs, a listing of the employment opportunities offered by the 2012 AAD Career Development Fair, exhibitors/potential employers, and more. View it online today at [www.nxtbook.com/nxtbooks/elsevier/dermcareerlink2012/](http://www.nxtbook.com/nxtbooks/elsevier/dermcareerlink2012/). 



### ETHICS from p. 1

are not obligated to tell the whole truth. An example of not telling the whole truth is treating a very sick patient who asks his/her physician not to reveal to him/her the diagnosis. The physician should respect this patient's autonomy. As physician/ethicist Edmund Pellegrino states, "To thrust the truth ... on a patient who expects to be buffered against news of impending death is a gratuitous and harmful misinterpretation of the moral foundations for respect for autonomy."<sup>2</sup>

In the case of the patient with a terminal illness, by respecting the patient's autonomy, the physician would not immediately disclose the patient's fatal illness as soon as it was diagnosed. Since the patient asked the physician not to disclose the diagnosis, he/she presumably would not be ready for the cold, hard facts. The physician would help the patient come to terms with the reality of his/her impending death over time. This process attempts to achieve truthfulness gradually, respecting the principles of beneficence and non-maleficence within the time constraints of the patient's

terminal illness.

In this example, beneficence would indicate that telling the whole truth is not always in the patient's best interests. This has been referred to as "benevolent deception."<sup>3</sup> The obligation to tell the truth may be outweighed by other moral considerations, such as the obligation to do no harm. There are, however, arguments against this line of reasoning. Shielding a patient from bad news to prevent anxiety, for example, may be inadvisable; not telling the patient the whole truth may result in causing more anxiety. Furthermore, it may threaten the doctor-patient relationship by causing the patient to mistrust the doctor. As opposed to the practice of benevolent deception, it may be inferred from this latter argument that being completely honest and disclosing all findings with all patients may be the best action in our care of patients.

Generally in North America, there is direct, frank honesty in sharing information with patients about diagnosis and treatment options, but a less direct approach in sharing prognosis.<sup>4</sup> Most physicians agree that compassion and sensitivity for

patients would lead to disclosure of a poor prognosis over time. In this way the physician attempts to let the patient know that his/her prognosis may be guarded but at the same time optimistic, and appeal, for example, to statistics of patients with the same disease. The process of sharing bad news with the patient depends on the individual doctor-patient relationship, the patients' understanding of his/her medical problem, and all the particular nuances of that patient's medical problem.

As physicians we are ethically obligated to be honest with our patients. Some of us may decide to be "benevolently deceptive" in our compassion for certain patients at certain times. Others will decide to be strictly honest with all patients at all times. It is up to each of us to determine how to fulfill this ethical obligation. 

### References

1. Beauchamp TL and Childress JF. Principles of Biomedical Ethics. Fifth Ed. Oxford University Press 2001 New York. P. 284.
2. Pellegrino E in Beauchamp and Childress p. 289.
3. Beauchamp and Childress p. 288.
4. Beauchamp and Childress p. 286.

To enable you to stay on top of your ethical and professional responsibilities and ensure delivery of the highest quality and ethical patient care, the Ethics Committee has updated the Academy's Ethics in Medical Practice booklet. You may access it on our website at [www.aad.org/ethics](http://www.aad.org/ethics).

chase policies from the same insurance company in order to establish a multi-life discount.

## 2. Do you have a level premium term life insurance policy?

If there is anyone besides you who relies on your future income, you absolutely must purchase a 20-30-year level premium term life insurance policy. If you are concerned you may become uninsurable in the future, you may want to purchase a policy to protect a future spouse or child. Term insurance is extremely cheap, and it would be wise to get a policy of at least a \$1,000,000 as a resident, and double or triple it shortly after residency graduation.

Term life insurance is for the most part a commodity, so the pricing is very competitive and comparison shopping is easy. Websites such as [www.term4sale.com](http://www.term4sale.com) can compare the premium rates for several insurance companies as well as the pricing for various death benefit amounts and guarantee periods. You'll see that a \$1,000,000 20-Year Level Premium Term Life Insurance policy, for a 29-year-old male dermatology resident in the best underwriting classification can cost as little as \$425 annually. You should employ the services of an experienced insurance agent who represents several companies to help you get the best rates, especially if your health is less-than-perfect. The agent will know which carriers are likely to provide you with a better underwriting classification based on your height and weight, family history, and/or other medical issues to allow you to secure a lower premium rate.

Additionally, we advise against permanent life insurance while you are in training (whole life, variable life, universal life, equity indexed universal life, etc). In fact, some physicians believe that they will never have a need for a permanent life insurance policy.

## 3. Do you have an umbrella in addition to your other insurance policies?

It's not just getting sued at work that you need to worry about. Even though you don't have any assets yet, many people view you as their lottery ticket. You should have high liability limits on your auto and renters/homeowners insurance policies. In addition, you should purchase an umbrella insurance policy of at least

\$1,000,000. Umbrella policies are inexpensive, generally in the \$200-300 per year range.

A personal umbrella liability policy supplements the basic liability protection you already have by insuring you against large losses or losses not covered under your other personal liability policies. Although an umbrella policy is often added to an existing homeowners or automobile policy, it can also be purchased as a stand-alone policy from a different insurer. In either case, your insurer will ordinarily require you to carry basic liability insurance with certain minimum limits. If all of your policies are with the same company, substantial discounts may be available. Please note that an umbrella policy does not protect you in the event of a malpractice claim.

## 4. Have you "maxed out" your contributions to a Roth IRA?

A Roth IRA is an Individual Retirement Arrangement named after the late Senator William V. Roth, Jr., (R-Delaware) that allows you and your spouse to save for retirement. You can just think of it as Uncle Sam's gift to residents. Unlike a traditional IRA (and most other retirement accounts), you don't get an upfront tax break for contributing. But as a resident, that isn't worth much. What is worth a lot, however, is the fact that the money in this account will never be taxed again.

You can contribute up to \$5,000 per year into your own Roth IRA, and another \$5,000 into a spousal Roth IRA. Even with a working spouse, residents generally have income low enough to qualify to contribute. (Your ability to contribute begins phasing out at \$110,000 if you're single, \$173,000 if you're married.) Even as an attending, however, you can still contribute via the "Backdoor Roth IRA" through a loophole that allows anyone to convert a non-deductible IRA. Learn more at <http://whitecoatinvestor.com/retirement-accounts/backdoor-roth-ira/>.

A withdrawal from a Roth IRA (including both contributions and investment earnings) is completely income tax and penalty-free if (1) made at least five years after you first establish any Roth IRA, and (2) one of the following also applies:

- You have reached age 59½ by the time of the withdrawal.
- The withdrawal is made due to qualifying disability.
- The withdrawal is made for

first-time homebuyer expenses (\$10,000 lifetime limit).

- The withdrawal is made by your beneficiary or your estate after your death.

Withdrawals that meet these conditions are referred to as "qualified distributions." If the above conditions aren't met, any portion of a withdrawal that represents investment earnings will be subject to federal income tax and may also be subject to a 10 percent premature distribution tax if you are under age 59½.

## 5. Have you considered using other retirement plans?

Your hospital may offer other retirement plans, such as a 401(k) or a 403(b).

As of 2012, you can contribute up to \$17,000 per year to these plans to reduce your taxable income. This is likely the biggest tax break available to you as a resident. In addition, some plans provide a "match." This is basically free money to you. It's really part of your salary, but to get it you must contribute some money into the retirement account. A typical arrangement is for your employer to provide a 50 percent match up to 6 percent of your pay. So if you make \$45,000 per year, and if you put \$2,700 into the 403(b), the hospital will put \$1,350 into the 403(b), in addition to the tax deduction (probably worth around \$400) and possibly even a retirement tax credit of up to \$100. All in all, that \$2,700 contribution may be instantly worth \$4,550.

Yes, you'll have to pay taxes on that money when you pull it out later, but deferring taxes can make you a lot of money in the meantime. However, since residents are probably in a lower tax bracket than they will be throughout their careers and probably even in retirement, you should give preference to a Roth IRA over a 403(b), at least after you collect the free money from the employer matching. IRAs often have much lower investment expenses and better investment choices as well. Many 401(k)s and 403(b)s also offer a Roth option, which you should probably take advantage of while in residency. Even if your residency doesn't offer a Roth option, you should consider converting the account to a Roth IRA the year you graduate when you're still in a relatively low tax bracket.

Taking these steps as a resident will put you in good standing to begin your career on the right financial foot. 



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*Articles in Directions in Residency represent the perspective of the individual author(s) and should not necessarily be construed as advice from the American Academy of Dermatology or the Resident/Fellows Committee.*

## Oral Disease, Part 1

by Helena Pasiaka, MD

	CLINICAL	PATHOLOGY	TREATMENT	ASSOCIATIONS
<b>DEVELOPMENTAL CONDITIONS</b>				
Fordyce Granules	1-2mm yellowish papules on buccal mucosa and vermillion. Asymptomatic.	"Free" sebaceous glands.	None indicated.	
Geographic Tongue	Well-defined red patches on lateral & dorsal tongue with a serpiginous white border.	Psoriasiform mucositis.	If symptoms, potent topical steroids.	
Fissured Tongue	Multiple grooves on dorsum of tongue. ("Scrotal tongue") Asymptomatic.	Numerous grooves on dorsum of tongue.	None indicated.	Melkerson-Rosenthal & Down syndrome. Occasionally in Cowden, pachyonychia congenita & acromegaly (in setting of macroglossia).
Hairy Tongue	Hair-like elongation of lengthening of papillae on dorsum of tongue, especially in central area.	Pronounced accumulation of parakeratosis at tips of otherwise normal filiform papillae.	Identification & cessation of cause and if symptoms, scraping or brushing tongue.	Smoking, poor hygiene, oxidizing mouthwashes, and hot beverages.
Median Rhomboid Glossitis	Well-demarcated, diamond-shaped eroded area in midline of posterior dorsal tongue.	Loss of filiform papillae. Consistently associated with candidiasis.	Anticandidal treatment, such as clotrimazole troches or PO fluconazole.	
<b>PERIODONTAL AND GINGIVAL DISEASE</b>				
Necrotizing Ulcerative Gingivitis	Necrosis and/or ulceration of the interdental papillae "punched-out papillae". Painful and hemorrhagic.	Non-specific, as disease etiology is bacteria from normal oral flora.	Debridement of necrotic areas, oral hygiene instruction, and control of pain.	
Desquamative Gingivitis	Diffuse painful gingival erythema. Epithelium readily mechanically sloughs leaving behind a smooth appearance.	Depends on the vesiculoerosive disease it represents. Biopsy for H&E + DIF should be performed.	Treatment directed at underlying dx. Meticulous dental prophylaxis & hygiene can decrease severity of lesions.	Erosive lichen planus, cicatricial pemphigoid, pemphigus vulgaris, lichenoid mucositis, linear IgA bullous dermatitis, SLE, EBA, or chronic ulcerative stomatitis
Intraoral Dental Sinus Tract	Soft, non-tender, erythematous papule on alveolar process +/- diffuse, tender swelling of facial soft tissues.	Necrosis surrounding a non-vital tooth.	Elimination of the focus of infection (extraction).	
<b>PHYSICAL &amp; CHEMICAL INJURIES</b>				
Fibroma	Firm, smooth, nodule in the mouth; usually the same color as surrounding tissue. Most commonly on buccal mucosa.	Unencapsulated mass of hyperplastic fibrous connective tissue with minimal inflammation. Overlying epithelium may show atrophy or hyperkeratosis from friction/biting.	Excision is curative.	
Chemical Burn	Initially, erythema. In time, a wrinkled white membrane representing superficial necrosis appears.	Coagulative necrosis, extending from surface either partially or fully into the epithelium.	Should self resolve after prevention of exposure to the offending agent.	
Morsicatio Buccarum	Bilateral shaggy white or shredded lesions of the anterior buccal mucosa that approximate the occlusal plane.	Marked hyperparakeratosis of the surface epithelium with ragged morphology +/- spongiosis in the superficial portion of the epithelium. Colonization by bacteria can also be seen.	Benign condition, requires no treatment.	
Traumatic Ulcer	Mild erythema surrounding a central ulcer covered by a yellow fibrinopurulent membrane. Can have a white border of hyperkeratosis adjacent to the ulcer. Most commonly on the tongue, lips and buccal mucosa.	Normal histology with mixed inflammation.	As traumatic ulcers clinically mimic oral SCCs, biopsy is indicated if the ulcer does not resolve within 2 weeks.	
Drug-Related Gingival Hyperplasia	Gingival enlargement of the interdental papillae of the anterior teeth. Edentulous areas usually spared, but can involve areas under poorly maintained dentures.	Redundant tissue of normal composition or an increased amount of collagen with a normal density of fibroblasts. Often with a plasmocytic infiltrate.	Discontinuation of the offending drug or substitution with another drug of the same class may result in cessation/regression. Extirpation of the excess gingival tissue is the treatment of choice.	
<b>ALLERGIC AND CONTACT DISEASE</b>				
Contact Stomatitis	Variable; cinnamon and dental amalgam most common. Cinnamon causes shaggy, white hyperkeratotic areas on the lateral tongue & buccal mucosa. Amalgam causes superficial erosions w/radiating white striae localized to the buccal mucosa adjacent to a restoration.	Lichenoid mucositis, epithelium may show hyperkeratosis, basilar crowding and atypia, atrophy of the spinous layer, lymphocytic exocytosis +/- ulceration.	Discontinuation of the offending product. Polishing or replacing the dental work with inoffensive material.	
Recurrent Aphthous Stomatitis	Painful, <5 mm diameter, round or oval creamy-colored "cookie-cutter" ulcers with an intense erythematous halo.	Non-specific. Early lesions show spongiosis, usually show prominent fibrinous neutrophilic membrane.	Mostly supportive. Potent topical steroids may shorten duration of ulcer. Complex aphthosis may require therapy with oral colchicine, dapsone or thalidomide.	



Helena Pasiaka, MD, is a second year resident in the department of dermatology at Johns Hopkins University.

## Oral Disease, Part 1 (continued)

by Helena Pasieka, MD

	CLINICAL	PATHOLOGY	TREATMENT	ASSOCIATIONS
<b>ALLERGIC AND CONTACT DISEASE (continued)</b>				
Behçet's Disease	Aphthae usually multiple, <6 mm diameter, lasting approximately 1-3 weeks. Ocular involvement is the clue.	Perivascular lymphocytic and monocyte cellular infiltration +/- fibrin deposition in the vessel wall and surrounding tissue necrosis.	Topical anesthetics, NSAIDs for symptoms of arthritis and inflammatory skin lesions. Colchicine, dapsone or thalidomide for mucocutaneous lesions. Ocular involvement is organ-threatening and requires systemic steroids +/- immunosuppressives.	
Eosinophilic Ulcer of the Oral Mucosa	Rapidly enlarging, firm nodule(s) that develop a central ulceration with elevated borders and indurated base. Becomes 1-2cm in size. +/- pain. Typically covered with a fibrinous exudate. Usually tongue, but the buccal, labial, alveolar and palatal mucosa can also be affected.	Ulcer w/dense infiltrate of eosinophils and pleomorphic mononuclear cells extending deep into the submucosal tissue and underlying striated muscle. Large atypical cells are CD30+ T lymphocytes. Base of ulcer is composed of poorly formed granulation tissue +/- increased capillaries with prominent endothelial cells.	Most resolve spontaneously within a few months, no treatment necessary.	
Orofacial Granulomatosis	Initially intermittent, then persistent non-tender swelling of the lip and/or face.	Non-necrotizing granulomatous inflammation.	Intralesional corticosteroids, sometimes repeatedly. Dapsone, clofazimine, hydroxychloroquine, thalidomide, TNF inhibitors, or systemic corticosteroids have also been used.	Often with undiagnosed GI disease. Referral to GI for scopes to rule out enteric involvement.
Wegener's Granulomatosis	Pathognomonic friable 'strawberry gums'. Necrotizing granulomatous vasculitis of the upper and lower respiratory tract. Destructive ulcerated lesions of the oral and nasal cavity.	Skin biopsy can demonstrate leukocytoclastic vasculitis and/or granulomatous inflammation. Such classic features are infrequently observed in oral biopsy specimens.	Systemic corticosteroids and cyclophosphamide.	
<b>EPITHELIAL PATHOLOGY</b>				
Oral Leukoplakia	Sharply demarcated, homogeneous or speckled white plaque, often on floor of mouth, lateral & ventral surfaces of the tongue, and the soft palate.	Simple hyperkeratosis seen most frequently. +/- epithelial dysplasia (mild to severe). Carcinoma in situ or even invasive SCC possible.	Cessation of smoking. Biopsy mandatory, as considered premalignant. If no or mild dysplasia evident, site of the lesion dictates treatment. Low-risk sites (buccal mucosa, labial mucosa, hard palate) warrant periodic clinical follow-up. Moderate or severely dysplastic lesions require complete removal.	
Oral Erythroplakia	Flat or slightly elevated, velvety, sharply circumscribed plaque. The lesions are often asymptomatic.	Advanced epithelial dysplasia w/90% of lesions demonstrating carcinoma in situ or invasive carcinoma at the time of biopsy.	Prompt surgical removal and careful follow-up. Cessation of smoking.	
Nicotine Stomatitis	Posterior hard palate & anterior soft palate w/grayish-white mucosa. Sometimes, umbilicated papules w/red central puncta are found, representing inflamed palatal mucous salivary gland orifices.	Hyperkeratosis and parakeratosis, acanthosis, and mild chronic sialodochitis.	Cessation of smoking typically results in complete resolution within 1-2 weeks.	
Actinic Keratosis/ Cheilitis	Loss of normal dermatoglyphics, atrophy, and blurring of vermilion border. The development of hyperkeratotic scaling suggests evolution to precancerous actinic cheilitis.	Thickening of epithelium and hyperkeratosis. Different degrees of epithelial dysplasia possible in the same lesion so multiple sections of biopsy should be reviewed to find areas of severe dysplasia, carcinoma in situ, or invasive SCC.	Cryosurgery, topical agents such as 5-FU or imiquimod, and Blu-U. CO2 laser ablation has also been used, but only after the presence of invasive SCC has been excluded.	
Oral Squamous Cell Carcinoma	May present as ulcer, exophytic mass, or endophytic process w/varying degrees of induration. The surface is typically irregular, rough or granular. Most commonly on lateral and ventral surfaces of the tongue and floor of the mouth.	Histologically similar to those occurring elsewhere.	Surgery, radiation therapy, or both; chemotherapy + radiation therapy may decrease the risk of mets. 90% of recurrences occur w/in 2 years of initial treatment.	
Verrucous Carcinoma	White exophytic papillomatous or warty proliferations w/well-defined borders, most commonly on palate, buccal mucosa, & alveolar processes. Slow growing. Uncommonly ulcerated.	Epithelium with hyperkeratosis & acanthosis w/a papillary or verrucous surface. Well differentiated epithelium and few mitotic figures. A dense infiltrate of chronic inflammatory cells can be present. Evaluate multiple sections, as 25% show foci of typical SCC.	Wide surgical excision. Adjunctive therapy with imiquimod and/or oral retinoids has been reported. Radiation of no utility.	

### Sources:

1. Bologna JL, Jorizzo JL, Rapini RP eds. Dermatology. 2nd ed. Mosby; 2007.
2. Rapini R. Practical Dermatopathology. Mosby; 2005.

Special thanks to Dr. Gary Warnock.

*Do you have an interesting Boards' Fodder? We're expanding our Boards' Fodder archives and you can be a part of it. Contact Dean Monti, managing editor, special publications, at [dmonti@aad.org](mailto:dmonti@aad.org).*

*Watch for Oral Disease, Part 2 in the next Boards' Fodder.*

*Need more Boards' Fodder? Visit the Directions in Residency archive listed under "Publications" at [www.aad.org](http://www.aad.org).*

## Race for the Case

By Markus Boos, MD, and Karolyn Wanat, MD

### Making a case

We're hoping to ramp up our archives of Race for the Case. Perhaps you have a clever quiz and a trio of photos you feel would fit in nicely on this page? If you would like to contribute, contact Allison Evans, [aevans@aad.org](mailto:aevans@aad.org) for details on submission.



Photos by Markus Boos, MD

A 57-year-old Caucasian man with history of hypertension controlled with medication presents with abrupt onset of a new pruritic dermatitis. It began on his upper back and progressed to involve his chest and upper extremities. He has tried topical steroids without relief. Physical examination is notable for erythematous annular plaques with

scale as noted in the above images.

- 1) What is the diagnosis and what would you expect to see on pathology?
- 2) What is the most common medication associated with this eruption?
- 3) What is the HLA most commonly associated with this condition?

- 4) In the majority of cases, what is the auto-antibody most commonly associated with this?

Respond today with the correct diagnosis to Allison Evans, staff editor at the AAD, at [aevans@aad.org](mailto:aevans@aad.org), and be a part of our drawing for a Starbucks gift card and your photo in *Directions*!



## Earth to Michaels: You've just won RFTC

Jason Michaels, MD, is a first year dermatology resident at Mayo Clinic in Scottsdale, Arizona. Prior to pursuing medicine, he earned a master's degree in biotechnology and briefly entertained the idea of becoming an astrobiologist with the ultimate goal of being a crew-member on the first manned mission to Mars. Realizing there was very little cutaneous disease on Mars, he ultimately abandoned his interstellar intentions. In addition to dermatology, his earthly pursuits



Jason Michaels, MD

include playing indoor soccer, hiking, listening to music, and writing. Congratulations! 

## Skin Deep



Illustration by Dean Monti

"A tiny patch of dermatitis? Doc, isn't that a little rash?"

### Release your hidden artist

Do you have drawing aptitude? Certainly you can draw better than the editor of *Directions* (see cartoon on right). If so, prove it by sending your best original medical drawing to Dean Monti, [dmonti@aad.org](mailto:dmonti@aad.org). If we're impressed, we may publish it in an upcoming issue of *Directions*.



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# 70th ANNUAL MEETING

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## Residents in jeopardy!

*Georgia Health Sciences prevails to take trophy*



Another thrilling bout of Resident Jeopardy took place during the 70th Annual Meeting in San Diego. Loma Linda (above left), proved a powerful challenger, but in the end it was Georgia

Health Sciences holding the trophy. Pictured, above right, are Shalini Reddy, MD, BS, Christine Dewitt, MD, and April Armstrong, MD, MPH, (panel members); 2012 Resident Jeopardy champions

Keith Leblanc, MD, PGY4, and Justin Sigmon, PGY3, from Georgia Health Sciences University; Roopal Vashi-Kundu, MD (panel member); and Amit Garg, MD, director of the session. 

**Want to see more? You can view additional photos of Resident Jeopardy, plus Resident Transitions and the Resident Reception by going to the *Directions in Residency* website at [www.aad.org/DIR](http://www.aad.org/DIR).**

## 2012 Fox Award celebrates best of research

The Resident and Fellows Symposium, which presents the latest laboratory-based and clinical-based research findings, was held on March 18 during the AAD's 70th Annual Meeting in San Diego. Three winners were selected from each category based on their abstracts and have been awarded the prestigious Everett C. Fox Award.

Back row: starting from left, the clinical-based research awardees were Sofia Chaudhry, MD (3rd); Anokhi Jambusaria, MD (2nd), MS; and Elena B. Hawryluk, MD, PhD (1st); and the laboratory-based awards went to Rubeta Martin, PhD, MBBS, MRCP (DERM) (1st); Cynthia M. C. DeKlotz, MD, MAsT (3rd); and Bryan Gammon, MD (2nd). Front row: from left, session directors Sewon Kang, MD, Yolanda Helfrich, MD, and David Rubenstein, MD, PhD. 



*Check out the new Summer Academy Meeting promo films featuring Academy President Dan Siegel, MD, on YouTube: [www.youtube.com/watch?v=DwwlbvXdVgQ](http://www.youtube.com/watch?v=DwwlbvXdVgQ). There's also an alternate version of the video here: [www.youtube.com/watch?v=WvPK\\_BebE08](http://www.youtube.com/watch?v=WvPK_BebE08). We're sure that you will recognize the man with the lobster.*

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AMERICAN ACADEMY OF DERMATOLOGY



## Boston has everything you could possibly need!

Registration is now open for the American Academy of Dermatology's Summer Academy Meeting 2012, Aug 15 – 19, in Boston. Meeting news and information will be available via the AAD's home page, [www.aad.org](http://www.aad.org). Additional news and information about the meeting can also be found at: [www.aadmeetingnews.org](http://www.aadmeetingnews.org). 

## Message from the Chair



Jeremy Brauer, MD

Greetings from New York! I'd like to dedicate this issue's message to welcoming all of the new dermatology residents who are receiving *Directions in Residency* for the first time and to let you know about the function of the Residents/Fellows committee (RFC).

The RFC is the voice of dermatology residents and fellows within the AAD and is charged with the mission of representing their interests and concerns during their postgraduate education. The committee promotes effective communication and action toward these ends between individuals, training programs, graduate medical education societies, and the Academy.

The RFC has several standing workgroups dedicated to tasks such as the development of study materials for the Board Certification exam, a leadership curriculum for residents, and mentoring and volunteer opportunities. The RFC also has a workgroup that contributes to the resident section of the

AAD website. In addition, the RFC designs the content for the very popular Residents Transitions session at Annual Meeting. If you have ideas for any of these workgroups, please send us an email at [residents@aad.org](mailto:residents@aad.org).

*Directions in Residency* is published quarterly and is full of important information for residents at all levels. If you enjoy writing and would like to contribute, I strongly encourage you to consider submitting an article or feature for an upcoming issue. Contact Dean Monti, managing editor of special publications, at [dmonti@aad.org](mailto:dmonti@aad.org) for more information.

We also strongly encourage you to take the *Directions in Residency* readership survey, scheduled for later this summer. Your input can make a difference! Watch your email for details.

And finally, congratulations to all of the residents and fellows who have completed training this academic year! 

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

## Your Resident/Fellows Committee, live in San Diego!



Representatives of the AAD's RFC met March 15 during the Academy's 70th Annual Meeting in San Diego to discuss recent successes and plans for the future. Back row, from left: Tom Rohrer, MD, (Board of Directors liaison); Brian Hinds, MD; Karolyn Wanat, MD; Jeremy Brauer, MD (chair of the RFC); Ern Loh, MD, PhD; and Jennifer Ahdout, MD (AMA Resident Representative). Front row, from left: Sara Lohser, MD; Nazanin Saedi, MD; Ahou Meydani, MD; Erica Dommasch, MD (AMA Resident Representative); Lindsay Wilson, MD; Gopal Patel, MD; and Kalpana Reddy, MD.



Summer 2012

### Residents / Fellows Committee

Jeremy Brauer, MD, <i>chair</i>	2013
Karolyn Wanat, MD, <i>physician reviewer</i>	2013
Christina Han, MD	2013
Brian R. Hinds, MD	2015
Jeannette R. Jakus, MD	2014
Ern Loh, MD, PhD	2013
Sara Lohser, MD	2013
Gopal Patel, MD	2014
Sara Samimi, MD	2014
Rahul Shukla, MD	2013
Lindsay H. Wilson	2014
Amit Garg, MD, <i>ex-officio</i>	2013

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**Staff Editor:** Allison Evans

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