AAD 1938 American Academy of Dermatology

Directions in Residency

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Movin' on up: Easing post-residency fears

By Allison Evans, AAD staff editor

Residency is a critical time in a physician's education when there are endless opportunities for learning. And while dermatology residency programs present a host of challenges and learning experiences, one major concern for residents is what happens afterwards.

Directions in Residency spoke with Clarence Brown Jr., M.D., a past young physician observer to the AAD Board of Directors, about his experience transitioning out of residency. Dr. Brown completed his residency training in 1999 and fellowship in 2000. He shared his tips for turning what could easily be an overwhelming transition into a manageable plan.

Embrace the newness

When it comes to figuring out how a dermatologist's professional life will unfold, one piece of advice offered by Dr. Brown is to jump into each experience fully. "By never doing anything less than my best, I was always rewarded with the next opportunity to both learn and contribute … Never shy away, but always step forward with a pleasant voice and a smile, and opportunity will greet you."

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ethical considerations

Karen Scully, M.D., is a board-certified dermatologist in Canada and the United States, and has an M.A. in ethics from UNC, Charlotte.

Ethical considerations in research, part 2

Academic medicine/industry relationship, conflict of interest, academic freedom, and human research safety

By Karen Scully, M.D.

In the last ethics column, I discussed the academic medicine/industry relationship. One concern, in particular, is that industry may set the research agenda because of its huge financial clout, leaving the academic institution out of the process. This threatens the safety of trial subjects and the integrity of the research process, to which we, as physicians, have an obligation.

The author/industry dilemma

Another conflict of interest, in addition to the conflict between academic medical centers and industry, is the conflict of interest of the author who has a financial interest in a company sponsoring the research. The researcher's bias may be subtle and not even apparent to the researcher him or herself. Financial relationships such as consultancy, stock ownership, honoraria, and others have the potential of weakening the credibility of scientific articles, authors, journals, editors, and science in general.[1] In spite of this awareness, disclosure of authors' corporate ties remains variable and variably enforced.[2]

University researchers should not sign contracts with industry that inhibit their academic freedom. Responsible reporting of risks identified during clinical trials should be unrestricted to trial subjects, institutional review boards, and other parties. Trials should be allowed to continue, only if, in the judgment of the researcher, the risk to trial participants is minimal, and as long as participants are fully informed of any new concerns during the trial.

Missions must remain

Universities doing medical research need to remain true to their mission, that of the open and unbiased pursuit of knowledge in research; teaching and protection of students and training physicians; and safety in patient care. Blurring or incorporating this mission with that of industry will not maintain academic integrity. The mission of the pharmaceutical industry is to be profitable and ensure return on investment and also to protect their technology. According to Zach Hall, former vice chancellor at the University of California at San Francisco (UCSF) and later president of EnVivo Pharmaceuticals, the key to successful university/industry associations is for each to maintain its distinct mission.[3] When the unique

See ***ETHICS*** on p. 3

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As physicians move through the various stages of residency, it's important that they devote themselves fully to each task they undertake, said Dr. Brown. "Every time I devoted myself and my efforts to the endeavor at hand, a new and equally if not more, interesting opportunity would come my way," he said.

Be a trailblazer

Instead of passively sailing down whatever path residency brings, physicians should create their own path by taking charge of their education, recommended Dr. Brown.

"Residency is short, and it is the most wonderful period of life … you are fully immersed in learning. If your residency program is not able to offer you exposure to a specific aspect of dermatology, then for your own benefit seek it out! You are in control of your own learning."

Dermatologists who dictate their own paths in residency have a much easier time with the transition, Dr. Brown said, because once residency ends, physicians must embark on their own journey.

"After residency all of your education will be self directed, so don't miss an opportunity during residency to learn and be exposed to as much as possible," said Dr. Brown.

Listen and learn

One way for dermatologists to take control of their education is to take full advantage of all the resources available.

"Just prior to the Annual Meeting each year, the American Academy of Dermatology holds a full day of learning targeting dermatology residents (Practice Management Symposium). This, along with the AAD's Resident Transitions session (see page 8) and the AAD's online resources (see bottom of this page) is extremely valuable in helping to navigate this transition," said Dr. Brown.

Many residents seek mentors and established practitioners to try to help them avoid the known pitfalls before they occur. Those who have been down the slippery slopes before can often speak to both the positive and negative experiences.

Looking to instructors and members of the private dermatology community who attend regional and local conferences are typically excellent sources of information, Dr. Brown mentioned.

"Gather the opinions of many, not just a few when formulating career and life decisions. Know that all things are possible and do not allow others to impose limitations on your path or potential and always find a way around any road block that confronts you along the way," Dr. Brown said.

The time is now

One key to a successful transition, Dr. Brown said, is to avoid waiting until the last year of residency to start developing a plan, and to let your interests guide your path.

"I believe that each and every day of residency one should give some thought to what dermatology practice beyond residency will entail. The day to day variety of clinical case presentation and complexity should be the foundation upon which career contemplation is based. What have you seen that has interested you? Where can you see yourself devoting your passion and your daily efforts?" said Dr. Brown, responding to how early he started preparing for his post-residency life.

When Dr. Brown was asked what he wished he had known then about transitioning out of residency that he knows now, he said: "Focus less on income and more on practice harmony. Finding the best fit in a practice is far more important than a small increase in promised salary. Never chase money; chase happiness and allow money to chase after you." DR

Clarence W. Brown, M.D., is the chief executive officer at University Dermatology in Chicago.

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mission and core values of each is not recognized by the other, the ethical issues I have discussed develop.

Beneficial partnership is possible

University/industry contracts and agreements must recognize that researchers must have academic freedom and control with respect to all aspects of research: trial design, data collection and analysis, and publication in peer-reviewed journals. Universities must also recognize patenting needs of industry, which may delay publication, but should do so only for a short, defined period. Although many committees have looked into strengthening the rules and regulations of university/academic associations, still they remain vague. I would argue that this may be purposeful because universities do not want to turn down pharmaceutical funding so that they can retain good researchers and continue cutting-edge research. UCSF has insisted that their researchers retain the right to publish their data. In every case, the industry partner has agreed.[4] Partnerships that are scientifically and economically beneficial to all parties — researchers, trial subjects, universities, industry, and society — are feasable. Society's trust and the future of academic institutions depend on it. DR

References

1. Davidoff F, DeAngelis CD, Drazen JM et al. Sponsorship, Authorship, and Accountability. Editorial. New Engl J Med 2001;345(11):825-827
2. Rampton, Sheldon and Stauber, John. The Best Science Money Can Buy, in Trust Us, We're Experts: How Industry Manipulates Science and Gambles with your Future. 2002. Tarcher
3. Hall, Zach W. The Academy and Industry, A View Across the Divide, in Stein, Donald, Buying in or Selling Out, 2004. Rutgers University Press, Piscataway, NJ. p. 157
4. Ibid

Resources for residents just a click away!

Did you know that you can access even more educational and professional resources in the residents and fellows section on the AAD website? Some of the great resources available to you at the site include: past issues of *Directions in Residency*, including Boards' Fodder; Board Blitz Review – tips to help you master the board exam; *Derm Clips* – evidence-based summaries of clinical content from various medical journals; and *Dialogues in Dermatology*. Visit www.aad.org/member-tools-and-benefits/residents-and-fellows for all this and more! DR

Diagnosis and associations

Amy Reinstadler, M.D. and Nazanin Saedi, M.D.

Cutaneous finding	Associated disease	Gene	Other findings
Acanthosis nigricans	Diabetes	PPARG	Hypertension, diabetic dermopathy, diabetic ulcers
	HAIR-AN		Hyperandrogenism, insulin resistance, obesity
	PCOS		Irregular menses, infertility. hyperandrogenism, metabolic syndrome
	SLE		Associated with high titers of insulin receptor antibodies
	Paraneoplastic		Gastric CA. Less commonly of the uterus, lung, prostate, breast, or ovary
Basal cell carcinomas	Bazex		Follicular atrophoderma, hypotrichosis, hypohidrosis
	Rombo		Atrophoderma vermiculatum, hypotrichosis, milia, acral cyanosis
	Gorlin	PTCH	Jaw cysts, BCCs, calcification of the falx, ovarian fibromas, medulloblastoma, bifid ribs, palmar pits, frontal bossing, hypertelorism
Café au lait macules	Neurofibromatosis	NF1	Neurofibromas, axillary and inguinal freckling, Lisch nodules, sphenoid dysplasia, optic glioma, juvenile posterior lenticular opacity, meningiomas, pheochromocytomas
	McCune-Albright	GNAS1	Precocious puberty, polyostotic fibrous dysplasia
	Tuberous sclerosis	TSC1, TSC2	Cortical tubers, subependymal nodules, astrocytomas, ash-leaf spots, adenoma sebaceum, forehead plaques, shagreen patches, Koenen's tumors, cardiac rhabdomyomas, renal angiomyolipomas, retinal hamartomas, dental pits, gingival fibromas, confetti macules
	Fanconi anemia	FANCA, B, C, D1, D2, E, F, G, I, J, L, M, and N	Radial ray anomalies, poor growth, genitourinary problems, acute myelogenous leukemia, and 90 percent develop bone marrow failure
	Watson	NF1	Lisch nodules, axillary/inguinal freckling, pulmonary valve stenosis
Clear cell syringoma	Diabetes		Diabetic dermopathy, diabetic ulcers
Cylindroma	Brooke-Spiegler	CYLD	Trichoepitheliomas, spiradenomas, trichoblastomas, BCCs, follicular cysts, organoid nevi
	Familial cylindromatosis	CYLD	Eccrine spiradenomas
	Rasmussen		Milia, trichoepitheliomas
Depigmented patches	Vitiligo		Autoimmune diseases, APECED
	Piebaldism	c-kit	Rare case reports of Hirschsprung, mental retardation, deafness, cerebellar ataxia
	Waardenburg	Type 1: PAX3	Type 1: Dystopia canthorum
		Type 2: MITF, SLUG	Type 2: Deafness
		Type 3: PAX3	Type 3: Axial limb defects
		Type4: SOX10, EDN3	Type 4: Hirschprung disease
Dermatofibromas (multiple)	SLE		Photosensitivity, oral ulcers, malar rash, arthritis, serositis, renal, neurologic and heme abnormalities
	HIV		Recurrent VZV, numerous hyperkeratotic warts, treatment-resistant seborrheic dermatitis, oral hairy leukoplakia, chronic HSV, mucocutaneous candidiasis, and CMV, mycobacterial infections, condylomata acuminata, condylomalike molluscum contagiosum
Erythema gyratum repens	Paraneoplastic		Lung or breast CA
Erythema marginatum	Rheumatic fever		Migratory polyarthritis, carditis, Sydenham's chorea, fever, subcutaneous nodules, arthralgia, heart block
Erythema chronicum migrans	Lyme disese		Flu-like symptoms, facial nerve palsy, meningeal symptoms, migrating pain in muscles, joint, and tendons, heart palpitations, polyneuropathy, acrodermatitis chronica atrophicans
Fibrofollicuomas	Birt-Hogg-Dube	FLCN	Trichodiscomas, lipomas, oral fibromas, renal cell CA, medullary thyroid CA, colon CA

Amy Reinstadler, M.D., is dermatology resident at University of California, Irvine.

Nazanin Saedi, M.D., is a laser and cosmetics fellow at SkinCare Physicians, Chestnut Hill, Mass.

Diagnosis and associations (continued)

Amy Reinstadler, M.D. and Nazanin Saedi, M.D.

Cutaneous finding	Associated disease	Gene	Other findings
Fissured tongue	Down syndrome	Trisomy 21	Epicanthic skin folds, hypotonia, flat nasal bridge, single palmar fold, short neck, Brushfield spots, mental retardation, AML, ALL, atrioventricular septal defect, hypothyroid, Hirschprung's disease, dueodenal atresia, Celiac disease
	Melkersson-Rosenthal		Lip or facial swelling, Bell's palsy
Follicular spicules on the nose	Multiple myeloma		Bone pain, pathologic fractures, weakness, anemia, infection, hypercalcemia, spinal cord compression, or renal failure
Hair collar sign	Encephalocele, meningioma		Ectopic brain tissue
Hidrocytomas	Schopf-Schulz-Passarge		Hypotrichosis, hypodontia, nail abnormalities, multiple palmoplantar eccrine syringofibroadenomas
Hypertrichosis lanuginosa acquisita	Paraneoplastic		Lung or colon CA
Juvenile xanthogranuloma	NF1	NF1	Juvenile myelomonocytic leukemia (JMML)
Keratoacanthomas (eruptive)	Grzybowski		Generalized eruptive form in middle aged adults
	Ferguson Smith		Familial, large ulcerated lesions
	Muir Torre	MSH2, MLH1	Colon cancer, sebaceous neoplasms
	Immunosuppression		
	SLE		Photosensitivity, oral ulcers, malar rash, arthritis, serositis, renal, neurologic and heme abnormalities
Lichen amyloidosis	MEN 2A (Sipple)	RET	Medullary thyroid carcinoma, pheochromocytoma, and hyperparathyroidism
Lip swelling	Melkersson-Rosenthal		Bell's palsy, fissured tongue
	Crohn's disease		Fissures/fistulas, oral Crohn's, metastatic Crohn's, polyarteritis nodosa
	Sarcoid		Erythema nodosum, lupus pernio, granulomaous uveitis, cough, SOB, hilar lymphadenopathy, polyarthralgias, alopecia
	Cheilitis glandularis		Predisposing factor for the development of actinic cheilitis and SCC
	Angioedema		Urticaria, stridor, GI symptoms, eyelid swelling
Necrobiotic xanthogranuloma	Paraproteinaemia		IgGκ
Necrolytic migratory erythema	Glucagonoma		Weight loss, diabetes mellitus, diarrhea, DVTs, and stomatitis
Nevus sebaceous	Schimmelpenning		Deafness, mental retardation, seizures, colobomas, lipodermoids. Trichoblastomas, syringocystadenoma papilliferum may develop within lesions later
Pachydermyperiostosis	Paraneoplastic		Bronchogenic carcinoma
Pigmented macules/ lentigines	Peutz-Jeghers	STK11/ LKB1	GI hamartomatous polyps, GI adenocarcinoma, ovarian sex cord tumor, breast, pancreating, and endometrial CA
	Cronkhite-Canada		GI polyposis, nail atrophy, apopecia
	Bannayan-Riley-Ruvalcaba	PTEN	Macrocephaly, hamartomas, lipomas, hemangiomas, mental retardation
	LEOPARD	PTPN11	Café noir spots, ECG abnormalities, pulmonic stenosis, ocular hypertelorism, triangular faces, deafness, broad nasal root, growth retardation, abnormal genitalia
	Carney complex	PRKAR1A	Blue nevi, melanocytic nevi, atrial myoma, psammomatous melanotic schwannomas, testicular tumors, pigmented nodular adrenocortical diseases, pituitary adenoma with acromegaly
Pilomatricoma	Rubinstein-Taybi	CREBP	Broad thumbs, beaked nose, downward slanting palpebral fissures, mental retardation
	Gardner	APC	Colonic polyposis, congenital hypertrophy of the retinal epithelium, facial/skull osteomas, extranumerary teeth, desmoids tumors

Do you have an interesting Boards' Fodder? Contact Dean Monti, managing editor, special publications at the AAD, dmonti@aad.org.

*Watch for **histiocytosis** in the next Boards' Fodder.*

Diagnosis and associations (continued)

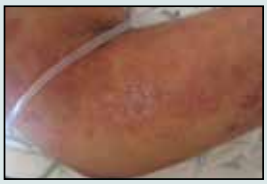
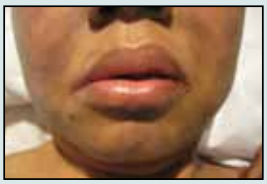
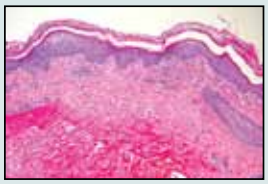
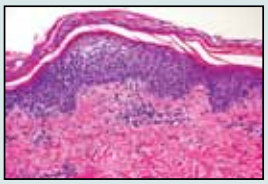
Amy Reinstadler, M.D. and Nazanin Saedi, M.D.

Cutaneous finding	Associated disease	Gene	Other findings
Pitted teeth	Junctional EB (Herlitz)	Laminin 5	Generalized bullae, perioral granulation tissue, nail dystrophy, anemia, growth retardation, tracheobronchial infections
	Tuberous sclerosis	TSC1, TSC2	Cortical tubers, subependymal nodules, astrocytomas, ash-leaf spots, adenoma sebaceum, forehead plaques, shagreen patches, Koenen's tumors, cardiac rhabdomyomas, renal angiomyolipomas, retinal hamartomas, dental pits, gingival fibromas, confetti macules
	Gorlin	PTCH	Jaw cysts, BCCs, calcification of the falx, ovarian fibromas, medulloblastoma, bifid ribs, palmar pits, frontal bossing, hypertelorism
Pyoderma gangrenosum	Ulcerative colitis		Erythema nodosum, aphthous ulcers, pyostomatitis vegetans
	Paraneoplastic		AML, Multiple myeloma
Sebaceous adenoma/ carcinoma	Muir-Torre	MSH2, MLH1	Colon cancer, keratoacanthomas
Seborrheic keratoses (eruptive)	Lesser-Trelat		Proceeds stomach CA, osteogenic sarcoma
Steatocystoma	Jackson-Lawler	K6b, K17	Natal teeth, epidermoid cysts, hair abnormalities
Syringomas	Down syndrome	Trisomy 21	Epicanthic skin folds, hypotonia, flat nasal bridge, single palmar fold, short neck, Brushfield spots, mental retardation, AML, ALL, atrioventricular septal defect, hypothyroid, Hirschprung's disease, dueodenal atresia, Celiac disease
	Nicolau-Balus		Milia, atrophoderma vermiculatum
Trichodiscomas	Birt-Hogg-Dube	FLCN	Renal CA, colonic polyps
Trichoepithelioma	Brooke-Spiegler	CYLD	Cylindromas, spiradenomas, trichoblastomas, basal-cell carcinomas, follicular cysts, organoid nevi
	Rasmussen		Milia, cylindromas
Trichilemmoma	Cowden	PTEN	Oral papillomas, sclerotic fibromas, breast fibroadenomas and adenocarcinomas, thyroid adenomas, GI polyps
	Bannayan-Riley-Ruvalcaba	PTEN	Venous/lymph malformations, macrocephaly, penile lentigines, intestinal polyps, lipoangiomatosis
Tripe palms	Paraneoplastic		Stomach or lung CA

Note: Portions of this article have been adapted from the resident rounds section that appeared in the June 2011 edition of The Journal of Drugs in Dermatology (JDD)*, and are being used with the permission of the* JDD.

Race for the Case

By Inbal Braunstein, M.D.

A 32-year-old African American female with history of systemic lupus erythematosus on oral prednisone was admitted to the medical intensive care unit for repair of a gastroenteric fistula that had developed three months prior as a complication of small bowel resection for ischemic bowel. Asymptomatic scaly red plaques started developing on her arms and leg two months prior to admission, and a dermatologist was consulted for the psoriatic rash on her body (photo 1) and face (photo 2). There was no prior history of psoriasis and no family history of psoriasis. A punch biopsy was performed (photo 3-4).

1) What is your leading diagnosis?
2) What are the histologic findings of this dermatosis?
3) Similar pathology can be seen in what other disorders?

Respond today with the correct diagnosis to Allison Evans, staff editor at the AAD, at aevans@aad.org, and be a part of our drawing for a Starbuck's gift card and your photo in *Directions*!

If you have an idea for a new case, contact aevans@aad.org. DR

AMA addresses resident issues in nation's capitol

By Ahou Meydani, M.D.

When I served as the American Academy of Dermatology's delegate to AMA Residents/Fellows Section (AMA-RFS), I had the privilege of participating in the 2011 AMA Annual Meeting June 18-22, 2011 in Chicago.

Several interesting resolutions that are relevant to dermatologists were discussed and passed among the approximately 125 RFS delegates present. I have highlighted a few below:

- **Individual mandate:** The RFS agreed to support policies that include personal/individual responsibility for citizens to buy health insurance, including financial disincentives for people who choose to forgo coverage. This turned out to be a very contentious issue in the larger House of Delegates (HOD), but ultimately the AMA HOD reaffirmed policy supporting individual responsibility for citizens to buy health insurance, with assistance for those who cannot afford it.
- **Scope of practice and reimbursement models for mid-level practitioners:** The RFS resolved that the AMA work at the local, state, and federal levels, through both legislation and regulation, to prevent the independent practice of medicine by mid-level health care providers, arguing that medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice. Also, the RFS resolved to work toward regulation and legislation that create reimbursement models that do not reimburse mid-level providers at the same rates as physicians, arguing that the difference in expertise, credentialing, and liability that physicians hold should be acknowledged.
- **Identification of non-physician providers:** The RFS resolved that the AMA should support state medical boards and medical societies in advancing legislation requiring providers to clearly identify their credentials to patients. This will improve transparency and patient understanding of the care they are receiving.

There were many other issues discussed and debated, ranging from autopsy education in residency to awareness of ionizing radiation exposure from medical imaging devices. It was exciting to see so many physicians actively engaged in debate, willing to apply their real world experience at home to influence the health care of all Americans.

In light of all of the uncertainties that lie ahead for health care in the United States, it is essential that dermatologists and dermatology residents have a voice at the table. This past year, serving as the AAD delegate to the AMA-RFS and interacting with the Dermatology Section Council has been an incredible learning opportunity for which I am deeply grateful. I plan to stay involved through the AMA, as well as through opportunities provided by the AAD, like the annual legislative conference in Washington, D.C. I hope that by sharing a bit about what we did this year, some of you budding dermatologists will be inspired to get your feet wet and come help us frame the debate in Washington! DR

Ahou Meydani, M.D., is a member of the AAD Resident/ Fellows Committee, and was a recent delegate to the AMA Resident/ Fellows section. This month, she will start as an instructor in the department of dermatology at New York University.

Holy cow! Marshfield Derm tips it in

We received many responses to the last Race for the Case, but the correct answers were:

1. Molluscum Contagiosum
2. From beetles in the order of Coleoptera and the family of Meloidae - commonly known as the blister beetle or Spanish fly. MOA: cantharidin is absorbed by the lipid layers of epidermal cell membranes, which leads to the activation or release of neutral serine proteases that cause degeneration of the desmosomal plaque, leading to detachment of tonofilaments from desmosomes. This process leads to acantholysis and intraepidermal blistering, and nonspecific lysis of skin.
3. Buzzwords: molluscum bodies, Henderson-Patterson bodies (intracytoplasmic inclusions

The first residents to milk the correct answers from the fatted cow of scientific query were the magnificent seven of Marshfield Dermatology in Wisconsin. Pictured left to right are David Nelsen, M.D., PGY3, Rachel Ade, M.D., PGY2, Alexandra Cameli, M.D., PGY3, Susan Walgrave, M.D., PGY4, Bruce Bauer, M.D., PGY2, Kristina Britton, M.D., PGY3, and Thomas McIntee, M.D., PGY4. Congrats to all! DR

New AMA resident representative appointed

Erica Dommasch, M.D., accepted the appointment as the Academy's AMA Resident Representative. Dr. Dommasch is a first-year dermatology resident (PGY-2) at Boston University in Boston. DR

Message from the Chair

Jeremy Brauer, M.D.

The AAD's Summer Academy Meeting 2011 in New York City turned out to be one of the best-attended summer meetings to date. This was certainly reflected by a great resident and fellow showing at the Friday night Resident's Reception.

The Summer Academy Meeting is one of the occasions during which the Board of Directors of the American Academy of Dermatology convenes. In addition to elected officers, several committee chairs, including the Resident/Fellows Committee (RFC), sit on the Board as Observers. In the role of Resident Board Observer, I attend the Board of Directors meetings as a non-voting member, and present a progress report and provide input on resident and fellowship related issues.

Having now participated in two board meetings, I can honestly say that my experience in this role has far exceeded my expectations. I have learned that the leadership of our organization is a dedicated group of individuals who is passionate about dermatology and the Academy. I am impressed at how issues are presented, discussed and debated, and ultimately resolved. The Academy continues to evolve and has developed a strategic framework that supports the Academy's vision of Excellence in Dermatology.

At the Board of Directors meeting, I also had the opportunity to talk with Academy President, Ron Moy, M.D., who is very interested in reaching out to the younger membership of the Academy. He is dedicated to addressing the needs and concerns of the residents and fellows, specifically related to the strategic framework and vision of excellence. I, and the rest of the members on your RFC, have taken his interest to heart and will be touching base with all of you in the near future regarding your own expectations for the RFC, the Board of Directors, and the American Academy of Dermatology.

As I mentioned in my last message, I want to encourage all of you to get involved in shaping your own training and dermatology experience. You do not have to be an appointed member of the RFC in order to serve on one of our workgroups. If you are interested in learning more about the RFC, please don't hesitate to contact us!

You can contact me at residents@aad.org. For information on workgroups and resident-related issues, contact Linda Ayers, staff liaison to the RFC at layers@aad.org. If you have ideas for (or comments about) this publication, contact Allison Evans, AAD staff editor at aevans@aad.org. We want to hear from you! DR

70th ANNUAL MEETING

San Diego, Calif. • March 16-20, 2012

The American Academy of Dermatology is holding its 70th Annual Meeting in San Diego, March 16-20, 2012. Early registration opens: **Tuesday, Nov. 22**. In addition to the many wonderful sessions and educational opportunities for residents, put these must-attend events on your calendar!

SAVE THE DATE(S)!

Sharing Mentoring Experiences Breakfast
Date: Friday, March 16, 2012
Time: 7:30 to 9 a.m.

Resident Transitions Forum
Date: Friday, March 16, 2012
Time: 9 to 11 a.m.

Reception Row: Residents' Reception, Career Fair and other networking opportunities
Date: Friday, March 16, 2012
Time: 5 to 6:30 p.m.

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AAD Directions in Residency

Fall 2011

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Christina Han, MD	2013
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