

Don't panic! Do more with the time you have!

13 time management tips for harried residents

By *Bethanee Schlosser, M.D., Ph.D.*

Bethanee Schlosser, M.D., Ph.D. leads a busy life. She is an assistant professor and director of women's skin health program in the department of dermatology at Northwestern University. She's an active member of AAD committees and a noted lecturer at AAD meetings. She is all these things, plus ... she can recall a time not so long ago when she was a dermatology resident herself. She completed her residency at Emory in 2007.

"Make no mistake about it," she says, "time management is work. It's also learned behavior, which means that anyone can acquire the necessary skills to maximize their time and productivity." Dr. Schlosser also has found time in her busy schedule to write articles for AAD publications like this one. Clearly, she must know something about managing her time well. *Directions in Residency* picked her brain for her best

See **TIME** on p. 3



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.

Reporting misconduct in a colleague

By *Karen Scully, M.D.*

One of the most difficult obligations as a physician is the duty to report misconduct in a medical colleague. This difficulty may relate to fear of ruining a physician's career and reputation, or there may be fear of legal retaliation. However, the welfare of patients, which would be compromised by medical misconduct, should be first and foremost.

The ethical basis for this professional obligation is related to the privilege of self-regulation as part of our social contract. Society honors this privilege of self-regulation as long as the medical profession safeguards the public interest. Reporting misconduct in a colleague is one such measure intended to protect the public from unprofessional, even dangerous, conduct on the part of physicians.

AMA's position on ethics

The Council on Ethical and Judicial Affairs of the AMA states: "Incompetence, corruption, or dis-

honest or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession."¹

There are three broad categories of misconduct: impairment, incompetence and unethical behavior. Impairment is most often secondary to drug and/or alcohol abuse, but may be secondary to severe emotional distress or extreme fatigue. In the case of alcohol/drug abuse, early rehabilitation is usually successful. All 50 states have impaired physician programs as do many hospitals and state licensing bodies. The focus is on rehabilitation rather than discipline and punishment.

Incompetence may be defined as the "inability to provide sound

medical care because of deficient knowledge, poor judgment, or sub-standard clinical skills."² The goal of reporting a physician's incompetence is to identify and deal with deficiencies that could threaten patient care.

Lastly, unethical conduct includes

See **ETHICS** on p. 7

Inside this issue

4-5 Boards' Fodder

6 Race for the Case

6 Skin Deep

7 2012 Annual Meeting highlights

8 Message from the Chair

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time management tips.

Dr. Schlosser adds, "I can't remember a time when I wasn't busy, but things certainly started to snowball during my residency, especially after having my first daughter, and the pace has only sped up since then. I still don't consider myself an expert in the realm of time management, but I've continually worked to improve my efficiency and productivity — trying to get all the "must do's" out of the way — at home and at work — in order to spend time doing the things I love with the people that I love. Here's what I've learned along the way to try to be my work's master and not its slave."

At the end of each calendar year, we all inevitably think: Where did the time go? It seems as though there will never be enough time to get everything done ... and this is probably true. The key to success in any realm of life is knowing which tasks must and should be done. The following tips will help you have more to show for the time you spend.

1. Give yourself 90 days.

You need to be motivated to change, otherwise failure is inevitable. Give yourself 60 to 90 days to solidify changes in your habits. If you fall off the wagon after 30 days, jump up and get right back on without beating yourself up. Time management is hard work and requires both energy and time.

2. Don't confuse productivity with activity.

Simply being busy isn't enough. Productivity depends on identifying and doing the most important tasks to move your goals forward. One can be very active but have very little to show for it at the end of the day. How many minutes or hours did you spend on social networking today? Every day, your most crucial decision is deciding what is most important to achieving your goals at that moment.

3. Get your priorities straight.

Formulating goals requires that you know what you expect of yourself and what others expect of you. You can't get what you want if you don't know what you want or where you want to be heading. Take the time to identify your goals for

today, this week, this month, your career. Review all of your projects and deadlines once a week. This will keep you focused, on track, and will hopefully eliminate those "Oh no, I forgot" moments.

4. Eat your "frogs."

Mark Twain once advised that if you eat a live frog first thing in the morning, you'll have the satisfaction of knowing it's probably the worst thing that will happen to you all day. In his popular book on



Seek out your "frogs," and eat them.

overcoming procrastination, author Brian Tracy uses "eating your frogs" as a metaphor for addressing your biggest, most important tasks of the day — those tasks that can have the greatest positive impact on your life at that moment.

Unfortunately, all too often, these are the tasks you are likely to procrastinate on if you don't "eat them" right away.

5. Know when you are at your best.

There are early risers and night owls. It is essential that you identify when you are at your best. Don't struggle against your natural energy current. If you study best at 5 a.m., then consciously plan to shut down early at night so that you will have all cylinders firing when you wake early the next morning.

6. Proper planning prevents poor performance.

Plan ahead and have everything that you will need for a given task on hand. Stopping to find necessary

materials is a bump in the road that can thwart your productivity efforts. You must literally and figuratively remove all distractions. Clear your study space or desk of all unrelated materials. Make a conscious decision to focus intently and solely on the task at hand. Leave the last 30 minutes of each day unscheduled; use this time to clean up your work space and make your next day's to-do list.

7. Just do it!

The most successful people are those that take action. Once you have singled out your most important and highest yield task, launch right in. Starting a task is often the most ominous part because it requires overcoming inertia. Avoid this time suck and get started.

8. Be a finisher.

Once you have initiated a project or task, discipline yourself to work in a steady and focused manner until that task is complete. Mind games work; make a deal with yourself that you will allow yourself a small reward after you have met a certain benchmark. Being productive is the runner's high of both the work and resident world, and productivity perpetuates itself.

9. Purge your mental inbox.

Every unfinished task is retained in your brain somewhere. These "open loops" clog your short-term memory and are a source of distraction. When an unfinished task comes to mind, immediately purge it by adding it to a running list. Regularly review the list to remove completed tasks and to reorganize or redistribute. It may be useful to have multiple organized lists: "at home," "at the computer," "in the clinic," etc. Purging your mental inbox will allow you to focus fully on your most important tasks.

10. The two-minute rule.

If you can delete, do, or delegate a task in a period of two minutes or less, then just do it. Performing the task removes it from your mental to-do list and allows you to focus on other more important tasks at hand.

Histiocytosis

Amy Reinstadler, M.D.

Histiocytosis	Age group	Most common mucocutaneous sites	Other findings	Histology
Langerhans cell histiocytoses				
Letterer-Siwe	Young infants (<2 years)	Scalp, face trunk, buttocks (resembles seborrheic dermatitis)	<ul style="list-style-type: none"> • Visceral and bone lesions • More fulminant course • Fever, anemia, lymphadenopathy • Hemorrhagic component may resemble blueberry muffin baby 	<p>Langerhans cells (reniform nuclei; may be foamy or resemble Touton histiocytes)</p> <p>Birbeck granules on electron microscopy</p>
Hand-Schüller-Christian	Children beyond infancy	May resemble Letterer-Siwe or may be papulonodular or granulomatous ulceration in intertriginous areas	<ul style="list-style-type: none"> • Diabetes insipidus • Bone lesions (skull) • Exophthalmos. 	<p>Less epidermotropism, more foamy cells, more giant cells</p>
Eosinophilic granuloma	Older children and young adults	Skin lesions rare. Nodulo-ulcerative lesions in mouth, perineal, perivulval, or retroauricular	Bone lesions primarily; more benign course	<p>Less epidermotropism, fewer foamy cells, more diffuse infiltrate with eosinophils, histiocytes, and giant cells</p> <p>S100+ CD1a+ CD68-</p>
Congenital self-healing reticulohistiocytosis (Hashimoto-Pritzker disease)	Congenital	Widespread, localized, or single lesion	Spontaneous resolution in several months; usually no systemic disease	<p>+/- Birbeck granules on electron microscopy</p>
Non-Langerhans cell histiocytoses				
Cutaneous, self-resolving				
Juvenile xanthogranuloma	Young infants (~75% occur in 1 st year of life)	<ul style="list-style-type: none"> - Head and neck > upper trunk > extremities - Small nodular form: multiple 2-5 mm papules - Large nodular form: one or few 1-2 cm nodules 	<ul style="list-style-type: none"> • Rare eye and visceral lesions; can lead to blindness • Oral XJG is rare; usually on lateral tongue or midline of the hard palate • When associated with NF1, 20x increased risk of developing juvenile myelomonocytic leukemia 	<p>• Nodular or diffuse infiltrate of histiocytes, lymphocytes, and eosinophils (early)</p> <p>• Foamy histiocytes and Touton giant cells (late)</p> <p><i>Dendritic cell marker:</i> Factor XIIIa+</p> <p><i>Macrophage markers:</i> CD68+ HAM56+/- Mac387 +/-</p>
Benign cephalic histiocytosis	Young infants	Face and neck	Usually none, spontaneous resolution	<p>Diffuse dermal non-foamy histiocytes with sparse lymphocytes and eosinophils</p> <p><i>Langerhans cell markers:</i> CD1a- S100- CD34-</p>
Reticulohistiocytoma	Adults	Head (solitary lesion)	None	<p>Circumscribed dermal nodule with oncocyctic mononuclear histiocytes, multinucleate giant cells with ground glass cytoplasm</p>
Generalized eruptive histiocytosis	<4 and adults	Widespread (axial); occasional mucosal involvement in adults	Spontaneous resolution	<p>Superficial and mid dermis with a uniform infiltrate of histiocytes and a few lymphocytes</p>
Indeterminate cell histiocytosis	Adults and children	Widespread > face and neck	<ul style="list-style-type: none"> • Uncommon visceral and bone lesions. • Ocular involvement has been described. • Usually self limited 	<p>Immunophenotypic profile—antigenic markers of both LCH (S100⁺, CD1a⁺) and non-LCH (CD68⁺, Factor XIIIa⁺, HAM56⁺)</p> <p>No Birbeck granules</p>



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

Histiocytosis (continued)

Amy Reinstadler, M.D.

Histiocytosis	Age group	Most common mucocutaneous sites	Other findings	Histology
Cutaneous, persistent/progressive				
Papular xanthoma	Any	Generalized; occasionally on mucous membranes	None. Affected individuals are usually normolipidemic	Factor XIIIa+ CD68+ HAM56+ Foamy macrophages and Touton giant cells. No chronic inflammatory cells
Progressive nodular histiocytoma	Any	Nodules on trunk and papules widespread (including genitals)	Normolipidemic	Histiocytes, foam cells, spindled cells
Cutaneous with frequent systemic involvement				
Necrobiotic xanthogranuloma	Teens to adults	Periorbital > trunk, extremities	Paraproteinemia, hepatosplenomegaly, lymphoproliferative disease	<ul style="list-style-type: none"> Broad zones of hyaline necrobiosis and granulomatous foci composed of histiocytes, foam cells, and multinucleate giant cells (Touton and foreign body type). Cholesterol clefts may be present
Multicentric reticulohistiocytosis	Adults (usually >30)	Head, hands, fingers ('coral bead' appearance periungually), ears, and articular regions of the limbs; mucosa (oral, nasopharyngeal)	<ul style="list-style-type: none"> Arthritis (often destructive) Up to 30% with internal malignancy Assoc with hyperlipidemia, + PPD, systemic vasculitis, and autoimmune disease 	<ul style="list-style-type: none"> Nodular infiltrate of histiocytes with ground glass cytoplasm. Bizarre multinucleated giant cells Mixed infiltrate CD68+, S100-
Rosai-Dorfman disease	Kids and young adults	Eyelids and malar area	Massive lymphadenopathy in a subset of patients, fever, hyper-gammaglobulinemia	<ul style="list-style-type: none"> Affected lymph nodes with dilated sinuses containing neutrophils, lymphocytes, plasma cells, and histiocytes with large vesicular nuclei and abundant cytoplasm Cutaneous lesions with dense dermal infiltrate of histiocytes with scattered lymphocytes, plasma cells and neutrophils Emperipolesis S100+, CD68+, CD1a-
Xanthoma disseminatum	Young adults, children	Flexural areas to widespread > mucosa (oral, nasopharyngeal)	Diabetes insipidus, osteolytic bone lesions. Normolipemic	<ul style="list-style-type: none"> Histiocytes, foam cells, spindle cells, Touton cells, and a moderate number of chronic inflammatory cells CD68+, factor XIIIa +, S100-, CD1a-
Systemic with rare cutaneous involvement				
Erdheim-Chester disease	Usually adults but can be any age	Dermal and subQ nodules, xanthelasma, intertrigo-like lesions, pretibial dermopathy, pigmented patches on the lips and mucosa	Primarily a disease of long bones producing patchy medullary sclerosis with sparing of the epiphyses	<ul style="list-style-type: none"> Lipidized histiocytes involve the dermis, often with extension into the subcutis CD68+, factor XIIIa+, CD1a-, and S100- +/- Touton giant cells
Hemophagocytic lymphohistiocytosis	Usually in infancy/ early childhood but can be any age	Jaundice and non-specific morbilliform rash	Fever, splenomegaly, liver dysfunction, cytopenia, hypofibrinogenemia, and tissue hemophagocytosis	<ul style="list-style-type: none"> Non-specific spongiosis and a mild perivascular infiltrate of lymphocytes and histiocytes S100-, CD68+

Do you have an interesting Boards' Fodder?

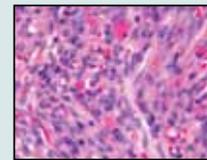
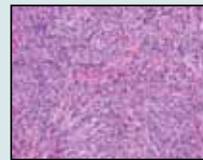
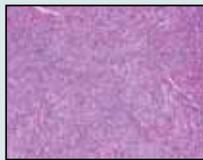
Contact Dean Monti, managing editor, special publications at the AAD, dmonti@aad.org.

Watch for Parasites in the next Boards' Fodder.

Need more Boards' Fodder? Visit the Directions in Residency archive listed under "Publications" at www.aad.org.

Race for the Case

By Karolyn Wanat, M.D.



A 43-year-old man in Botswana, Africa, presents with new lesions on his skin that first started three months prior and are getting progressively worse. He had never been seen by a physician before. A biopsy was performed to establish the diagnosis.

- 1) What is your leading diagnosis?
- 2) What laboratory test would you order?
- 3) What immunostains can be done to confirm the diagnosis if it is not classic in appearance on histopathology?
- 4) What are the most frequent sites of visceral involvement?

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 Starbucks gift card and your photo in *Directions*! Submit your ideas for the next Race for the Case to aevans@aad.org. 

Race for the case winner

In our last issue, we presented a patient with a history of systemic lupus erythematosus, admitted for repair of a gastroenteric fistula that had developed as a complication of small bowel resection for ischemic bowel. The questions and correct answers are:

- 1) What is your leading diagnosis?
 - a. Nutritional dermatosis
- 2) What are the histologic findings of this dermatosis?
 - a. Vacuolization and pallor of the keratinocytes of the upper stratum malpighii with overlying confluent parakeratosis and psoriasiform hyperplasia.
- 3) Similar pathology can be seen in what other disorders?
 - a. Necrolytic migratory erythema/

- b. Acrodermatitis enteropathica due to a mutation in Zinc transporter coded by SLC39A4 gene.
- c. Pellagra (acquired B3 deficiency)
- d. Hartnup's disease (congenital vitamin B3 deficiency)

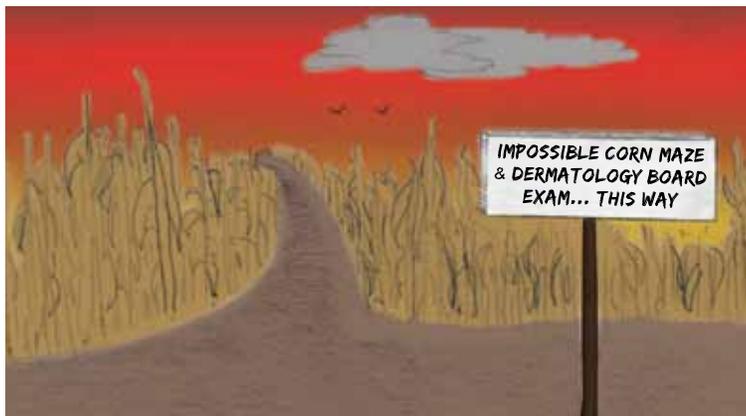
Congratulations to Cindy Bae, M.D., the winner of the fall 2011 Race for the Case! Dr. Bae is a 2nd year dermatology resident at Boston University. One of her proudest extracurricular moments was when she and her husband hiked the Kalalau trail in Kauai, Hawaii during their honeymoon. The trek is known to be one of America's top 10 most dangerous trails, and they hiked the 22 miles of narrow, rugged, but beautiful



Cindy Bae, M.D.

terrain in one day to experience the magnificent Napali coast. Perhaps her trekking experience prepared her for other arduous and rewarding experiences, like Racing for the Case ahead of everyone else this time around. 

Skin Deep By Dean Monti



Resident Evil

Transition into Practice: A Toolkit for Dermatologists Entering into the Workforce



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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 opened for residents **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)!

Below are some recommendations for those attending the 70th Annual Meeting. Bolded entries are highly recommended for residents!

Friday, March 16

- **Resident Transitions**, 9 to 11 a.m., Room 32AB.
- C03A-D Basic Self-Assessment of Dermatopathology, offered four times on Friday; 7 to 9 a.m., 9:30 to 11:30 a.m., 12:30 to 2:30 p.m., and 3 to 5 p.m.
- C001 LD: Head & Neck Anatomy: Cadaver Prosection, 9 a.m. to 12 p.m.
- S002 Hot Topics, 9 a.m. to 12 p.m.
- S008 Late-Breaking Research, 2 to 5 p.m.
- U026: New Health Care Policies: Incentives and Penalties, 2:30 to 4 p.m.
- **F016: Resident Jeopardy**, 3 to 5 p.m.
- S007: Gross & Microscopic Dermatology, 3 to 5 p.m.
- **Resident Reception**, San Diego Marriott, Ballroom B, 5 to 6:30 p.m.
- **Career Fair**, San Diego Marriott, Marriott Hall 4-6, 5 to 7 p.m.

Saturday, March 17

- **U037: High-Yield "Power Hour" for Residents**, 7:15 to 8:45 a.m.
- **F024: Boards Blitz**, 9 to 11 a.m., Room 11AB
- S007: Gross & Microscopic Dermatology, 3 to 5 p.m.

Sunday, March 18

- U071: Social Media and Dermatology: How Twitter and Facebook Will Help You and Your Practice, 7 to 8 a.m.
- **S024: Residents & Fellows Symposium**, 11 a.m. to 2 p.m.
- **C020: Volunteers Abroad Course: Beginner**, 2 to 5 p.m.

Monday, March 19

- U105: Emerging Laser and Aesthetic Technology, 7:15 to 8:45 a.m.
- C024: Basic Contact Dermatitis, 9 a.m. to 12 p.m.
- S041: Innovative Uses of Technology to Modernize Delivery of Dermatologic Care and Education, 2 to 5 p.m.
- U133: Smartphone and Cloud Computing in Dermatology and Dermatopathology, 2:30 to 4 p.m.

Tuesday, March 20

- U145: 50 Adverse Drug Reactions to the Skin, 7:15 to 8:45 a.m.
- F084: Medical Dermatology Challenge: Complex Cases from the Collection of Dr. Samuel Moschella, 9 a.m. to 12 p.m.
- S046: Key Surgical Principles we Should all Know, 9 a.m. to 12 p.m.
- F092: Surgical Cases we Wish we Could do Over, 12 to 2 p.m.

ETHICAL CONSIDERATIONS from p. 1

fraudulent billing, exploitation of patients, and violations of professional ethics, among others.³ Physicians in many states are obligated by law to report physician misconduct to the appropriate licensing board. If the physician does not report misconduct, he or she may be disciplined.

It is our duty to protect patients when their safety and welfare are at stake. Although unpleasant and delicate, reporting fellow physicians should be done with the intent of dealing with the misconduct and getting the physician back to normal functioning if at all possible.

What to do if you suspect misconduct

The AMA has guidelines to assist the reporting physicians through the reporting process. The guidelines vary depending on whether the misconduct is impairment, incompetence or unethical behavior.

If you suspect misconduct in a physician, consult the AMA guidelines first at www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/frequently-asked-questions.page. Subsequently you may need to contact your state licensing board, your hospital (if the physician is hospital-based), or your state medical society for more specific guidelines. 

References

1. Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, 1992. Section 9.04
2. CEJA Report A – I-91 Annual meeting of the House of Delegates, Report C of the Council on Ethical and Judicial Affairs, Reporting Impaired, Incompetent or Unethical Colleagues
3. CEJA Report A

TIME from p. 3

11. Touch it once and only once.

Ideally, you should handle each task once and only once. The more times you handle an item, the more time and mental energy you are wasting. Completing a task (i.e., finishing charts, sending an important email) when it is freshest in your mind is most efficient.

12. Unsubscribe from the unused, unessential, unhelpful.

Sort your mail, and trash all junk mail immediately. Discontinue journals that you don't read. Unsubscribe from automated e-mail newsletters and notifications. Taking the extra moment now will save you multiple times over in the future.

13. "Done is better than perfect 90 percent of the time" – Matt Kanzler, M.D.

We have all been schooled to always do our best. It is imperative to recognize though, that sometimes good enough is good enough. Identifying which tasks can

be completed in a "good enough" fashion and getting these off your plate will get you to what must be done in a perfectionist manner more quickly and with more energy in tow.

Further recommended reading:

- *Eat That Frog! 21 Great Ways to Stop Procrastinating and Get More Done in Less Time* by Brian Tracy
- *Getting Things Done: The Art of Stress-Free Productivity* by David Allen 

Message from the Chair



Jeremy Brauer, M.D.

Hello residents and fellows: I hope the educational year continues to be a good one for all of you! The Residents/Fellows Committee (RFC) has definitely been busy this year. As I mentioned in the last issue of *Directions*, the established RFC work groups address areas of interest to residents, including study tools for the board examination, the resident website at aad.org, and volunteer opportunities. Here is an update from the RFC work groups:

- **Educational Materials Work Group** – A new study tool for the ABD exam was developed this year based on the very successful Boards Blitz session from the 2011 Annual Meeting and can be found at: www.aad.org/member-tools-and-benefits/residents-and-fellows/boards-blitz-review/boards-blitz-review. The tool included the audio recordings and PowerPoint presentations from two Boards Blitz speakers. The same study tool will be offered next year using the speakers and presentations from the 2012 Boards Blitz session.
- **Resident Website Workgroup** – This workgroup continues to

improve the Resident website at aad.org by making recommendations on additional features to be added. This year we've added links to take you directly to Dialogues in Dermatology and Derm Clips Web pages.

- **Volunteerism/Philanthropy Work Group** – This new work group focuses on volunteerism and philanthropic opportunities for residents.

See page 7 for a listing of not-to-be-missed sessions and programs at the 2012 Annual Meeting in San Diego. I look forward to seeing you in March!

We are also encouraging the submission of feature articles, and contributions to our Boards' Fodder and Race for the Case features for *Directions* in 2012. These features put you in the spotlight and help your fellow residents. To contribute your ideas, contact Allison Evans, aevans@aad.org.

It's been a productive and exciting time for us. Enjoy your holiday season and I anticipate another good year for dermatology residents in 2012! 

JAAD launches Facebook page, what's not to like?

The *Journal of the American Academy of Dermatology (JAAD)* was one of the top cited dermatology journals for 2010, placing it among the preeminent research publications in dermatology. And now you can get JAAD research updates on Facebook! The publication recently launched an official Facebook page to promote and generate discussion about peer-reviewed research and to increase traffic to www.jaad.org, the journal's online edition. The JAAD presence on Facebook provides AAD members and the public with up-to-date information about important research in the field of dermatology, including articles in print, and those published online-only. To view the page, visit www.facebook.com/aadjournal.

"We intend to utilize this popular social medium to generate excitement and discussion about the wealth of dermatologic research being published in the JAAD," said JAAD Web Editor Robert Dellavalle, M.D., Ph.D., M.S.P.H, chief of dermatology service at the Denver VA Medical Center. "Please be sure to 'like' JAAD on Facebook and join the conversation." 

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