To accommodate all submissions and to allow time for exchange/discussion, presenters will please follow assigned times and plan the length of presentations accordingly. **All presentations are to be 6 minutes maximum. Time limits will be enforced.**

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<td>3:30-3:34p</td>
<td><strong>Welcome!</strong></td>
<td>Roy Colven, MD, Session Director University of Washington, Seattle</td>
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<td><strong>Session I: Non-Dermatology resident, pre-medical and pre-clinical medical student education</strong></td>
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<td>Manisha J. Loss, MD Johns Hopkins University School of Medicine</td>
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<td>Bringing skin signs of systemic disease into focus: a new undergraduate medical curriculum</td>
<td>Caroline A. Nelson, MD; Department of Dermatology, Perelman School of Medicine at the University of Pennsylvania</td>
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<td>Aimee Coscarart, MD Tulane University School of Medicine, Department of Dermatology</td>
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<td>The Dermatology Match and the Hidden Costs of Over-Application Behavior</td>
<td>Paul R. Massey, MD, Resident, PGY-3 Division of Dermatology, Dell Medical School, University of Texas at Austin</td>
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<td>Implicit Bias in Dermatology: Attitudes, Awareness, and Education</td>
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Dermatology Education in Internal Medicine Residency Programs: 
A Nationwide Survey of Residency Directors

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Several studies have indicated that residency training inadequately prepares generalist physicians to recognize and treat common dermatologic issues, representing an opportunity for enhanced dermatology education. Though the ACGME mandates ‘opportunities for experience’ in dermatology for internal medicine residents, it does not specify the quantity or quality of these experiences. We sought to assess the status of dermatology education in internal medicine training programs and examine variation in current practices.

We performed a cross-sectional survey of U.S. internal medicine residency directors identified using the publicly available FREIDA Database. Data collected included program size, geography, program type, appointment of a dermatology subspecialty education director, presence of a dermatology residency program, and types of training opportunities in dermatology (i.e. formal didactics, dermatology-specific board review, and dermatology outpatient clinic).

131 of 420 (31.2%) internal medicine residencies participated in the survey. Only 34.4% of programs have an appointed dermatology subspecialty education coordinator; 93.3% of these individuals are dermatologists. 25.2% of programs reported a mandatory dermatology clinic rotation, 53.4% offered optional dermatology rotations, and 10.7% offered no clinical experiences in dermatology. 55% offered trainees less than 1 week of dermatology training over 3 years, with 31.8% of programs offering less than one half week. 29.7% of programs reported dermatology faculty discussants participating in clinical teaching conferences. Hospital and program factors associated with the presence of dermatology subspecialty coordinators were also identified. Our findings illustrate significant variations in dermatology education for internal medicine residents, highlighting opportunities for dermatology subspecialists to help fill a vital educational role.

Notes:
Addressing Minority Representation in Dermatology Through a Structured Mentorship and Instructional Program: Answering a Call to Action

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Alice He, BS- Johns Hopkins University School of Medicine
Ginette A. Okoye, MD- Johns Hopkins University School of Medicine

Importance: Much attention in our field has recently been called to the insufficient representation of African Americans and Hispanics in dermatology, populations which also comprise the majority of those “underrepresented in medicine” (UIM). The insufficient representation of African American and Hispanics in dermatology necessitates action.

Objective: To determine whether a structured mentorship and instructional program can encourage students to pursue careers in dermatology.

Design: Prospective study

Setting: Academic institution

Participants: Thirty African American or Hispanic 11th-grade students enrolled in the Medical Education Resources Initiative for Teens (MERIT) program

Exposure: Four-week dermatology curriculum taught by dermatology faculty and residents, and mentorship shadowing opportunities in clinic

Main outcome and measure: Likelihood of students pursuing dermatology as a career

Results: Average likelihood rating for pursuing career in dermatology increased from 4.7 to 6.2/10 (p=0.04) before to after the program

Conclusions and relevance: Mentoring and instructional programs can encourage UIM students to pursue careers in dermatology. We show that outreach programs need not be long, and even brief interventions may make a difference.

Notes:
Bringing Skin Signs of Systemic Disease into Focus:  
A New Undergraduate Medical Curriculum

Caroline A. Nelson, MD; Department of Dermatology, Perelman School of Medicine at the University of Pennsylvania, Philadelphia, PA, USA; Caroline.Nelson@uphs.upenn.edu; James Treat, MD; Associate Professor of Clinical Pediatrics and Dermatology, Perelman School of Medicine at the University of Pennsylvania. Section of Pediatric Dermatology, Children’s Hospital of Philadelphia, Philadelphia, PA, USA.

Background: Multiple studies have highlighted a deficiency in dermatology training at the undergraduate level. We developed an optional “Skin Signs of Systemic Disease” curriculum for pre-clerkship medical students at the University of Pennsylvania.

Objectives: We aimed to determine what, if anything, students gained from the curriculum and to evaluate its impact on their understanding of the role of dermatology in the work-up of complex medical patients.

Methods: Three interactive case discussions were facilitated by a resident and attending dermatologist between April and September 2016. Students described skin lesions, generated a differential diagnosis, elicited history and diagnostic data to arrive at a final diagnosis, and reviewed digital unknown photos. The content was selected to correspond with the organ system under study. Paper surveys were distributed after each case and matched using self-generated identification codes. In total, we collected 25 surveys from at least 15 students with a 74% response rate and independently coded qualitative data to identify emerging themes.

Results: Themes fell into the categories of knowledge gaps, learning process, and clinical skills. Students identified deficiency of dermatology training relative to other organ systems and lack of awareness that dermatologists consult in the hospital as knowledge gaps. In terms of learning process, students valued the interactive format and step-wise approach to diagnosis. Differential diagnosis was the predominant theme under clinical skills. Additional themes were history taking, integration of knowledge across organ systems, preparation for United States Medical Licensing Examination, skin lesion description, use of diagnostic support technology, and use of the skin examination to avoid unnecessary diagnostic tests.

Conclusion: The “Skin Signs of Systemic Disease” curriculum provides pre-clerkship medical students with a valuable opportunity for clinical skill-based learning.

Notes:
Integrating Dermatology into a Basic Science Curriculum

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As first and second year medical school curricula become more complexly integrated between basic and clinical sciences, dermatology educators should give increasing thought as to how our specialty can complement basic science coursework. At Boston University School of Medicine, I designed and delivered a series of lectures to the first-year students highlighting clinical use of basic science content. I was able to integrate dermatology cases with several first-year courses: biochemistry, genetics, and immunology. In biochemistry, we had a discussion of the mechanisms of select immunosuppressive medications and associated complications, which resulted from their molecular structure and function. Metabolic disorders, including lysosomal storage disorders, were recognized. Clinical features related to the pathophysiology of the disease. Details of collagen and elastin formation were discussed in the context of genetic and metabolic disorders of enzymes or cofactors, that manifested in changes of the skin, hair, and nails. In genetics, inherited conditions that predisposed to malignancy, xeroderma pigmentosum and dyskeratosis congenita were used to highlight mechanisms of DNA repair and telomere synthesis. In immunology, various presentations of lymphadenopathy gave clues that suggested cutaneous or systemic infections, neoplasms, or body-wide inflammatory conditions, such as drug hypersensitivity reactions. Molecular techniques used to diagnose cutaneous lymphomas illustrated key principles in the cellular underpinnings of immunology and oncology, as did targeted melanoma therapy. Evaluations of these sessions were positive. Finding ways to relate dermatology to the basic sciences serves to keep our discipline relevant in a changing curricular structure, and enhances students’ motivation and comprehension of material.

Notes:
Beyond the BCC: A Multidisciplinary Rotation in Oncodermatology

Steven T Chen, MD MPH; Instructor in Dermatology; Harvard Medical School; Director of Medical Education, MGH Department of Dermatology.

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The field of dermatology is increasingly entwined with other medical specialties as we deliver care for complex dermatologic issues in a multidisciplinary fashion. Oncodermatology is a prime example where multidisciplinary approach to care and treatment has become increasingly mainstream.

In an effort to embrace this new model of care delivery from an educational perspective, we designed a new curriculum that focuses on the multidisciplinary care that patients receive when dealing with oncodermatologic issues. In this manner, students rotate for one month through a multidisciplinary cutaneous lymphoma clinic, pigmented lesions and melanoma clinic, and Graft-versus-host Disease clinic. Further experiences that round out the students’ experience includes time with our mohs surgeon, time in our High Risk Skin Cancer Clinic, Melanoma Clinic, and clinics that see a high volume of cutaneous toxicities. Research and academic time is also built into the rotation for work on a scholarly project. Direct mentorship is provided by the clerkship director, and further connections are made depending on the students’ individual interests.

Through this type of rotation, students will rotate through predominantly outpatient clinics, however will also spend time with surgical oncology in the operating rooms. Students will also approach oncodermatologic issues from the view of multiple specialties, including the aforementioned dermatology and surgical oncology, but also medical oncology, radiation oncology, and genetics.

Future directions will include the incorporation of more opportunities at sister institutions that would allow for work in Merkel Cell Carcinoma Clinic and more exposure to a variety of attendings that will have varying views on appropriate treatment and evaluation of oncodermatologic issues.

Notes:
Making your Mark: Increasing Scholarly Activity among Medical Students

Aimee Coscarart, MD
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Virginia Tracey, MD and Andrea Murina, MD
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Intro: Dermatology research opportunities are frequently sought after by medical students (MS) of all levels. Coordination of MS research projects requires departmental support from faculty and residents. Designation of an Education Chief (EC) to coordinate these projects can increase overall scholarly activity.

Objective: Increase MS dermatology research participation especially in the lower classes in 2016.

Methods: One 3rd year resident and the EC expanded the role to work with MS of all years. Members of the Dermatology Interest Group were recruited in Spring 2016 to begin working with the department to initiate IRB approved studies. Rising seniors were paired with MS in pre-clinical years to plan small studies that would be feasible to execute in a four month time period. Faculty and resident coaches were assigned to each project by EC to help through IRB process and carrying out project.

Department research was averaged over the past two years compared to the academic year in which MS received intervention. Non-department scholarly activities, duplicate activities, and state society meetings were excluded. MS were compared by level of training. The specific categories examined were peer reviewed articles (PA), book chapters (BC), and presentations (PRNC) which included abstracts, posters, and oral presentations at national conferences.

Results: There was an average of 3.3 student PRNC pre-intervention compared to 9 post-intervention. 8 MS in pre-clinical years co-authored a PRNC compared to a previous average of 2. Post-intervention there was an average of 1.5 scholarly projects per Tulane senior applying to dermatology. There was an average of 3 PA, 1 BC and 7 PRNC a year pre-intervention. Post intervention in 2016, there was a departmental total of 4 PA, 4 BC, and 19 PRNC.

Conclusion: This intervention enabled MS involvement in department research, and resulted in a 50% increase in the total department amount of scholarly activity.

Notes:
The Dermatology Match and the Hidden Costs of Over-Application Behavior

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Many medical students and program directors acknowledge that the national Match is in need of repair. The dermatology residency application process is of particular note in its competitiveness, highlighting broader concerns about the Match nationally. In 2016, 614 applicants participated in the National Resident Matching Program, competing for 440 positions in dermatology. While U.S. medical school seniors matched overall at rates of 92-94% over the past 10 years, in subspecialties such as dermatology, orthopedic surgery and neurosurgery, match rates are below 80%. In response to this perceived competitiveness, medical students hoping to match into dermatology programs nationwide have begun applying en masse in a broad, non-selective manner to an average of 80 programs per year – a figure now five years old and likely low. Our program in Austin, Texas, for example, received 513 applications in 2016 for 3 residency positions. For students, applying to this number of programs is expensive and time-intensive, with one estimate of $11,000 spent per matched resident – a striking figure for a national student population with a median indebtedness of nearly $190,000. Furthermore, many medical schools now encourage “away” electives for students at their own expense, and there can be significant pressure to enlist in (often unpaid) pre-residency fellowship positions to enhance the odds of a match into dermatology. Game theory-based modeling of the Match suggests that over-application is inefficient: students do not enhance their odds of matching if they and their peers all engage in similar application behavior, but costs rise1. For program directors, non-selective application behavior makes discerning truly interested applicants a challenge, and leads to reliance on test scores or geographic data. A number of proposed changes to the Match have been suggested. One such measure would be instituting a cap on the number of programs to which a student can apply2.

References

Notes:
Implicit Bias in Dermatology: Attitudes, Awareness, and Education

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Background: Disparities in healthcare and inequity in care delivery are persistent and pervasive throughout medicine, including the field of dermatology. Bias by healthcare professionals may contribute to some of these health care inequities — both explicitly and implicitly. Explicit bias refers to the opinions and preferences we are aware of. Implicit bias is a much less tangible concept and refers to preferences that we often do not know we have; however, these preferences significantly influence our decision-making. The Implicit Association Test (IAT) is a well-researched method of identifying an individual's implicit bias. We hypothesize that the use of the IAT and integration of implicit bias training into the dermatology residency curriculum can help residents gain insight into the importance of understanding personal implicit bias and its effect on clinical decision-making.

Objective: To provide a comprehensive educational session on implicit bias for dermatology residents and faculty and to ultimately assess the effect of this training on future decision-making.

Intervention: A one-hour educational session was conducted for all dermatology residents and faculty focusing on the nature of implicit bias and how it influences decision-making. Preparation for this session included voluntary completion of a survey assessing knowledge of implicit bias and the skin tone IAT—results of both were discussed at the session. At the end of the session, attendees were prompted to assess the effectiveness of the one-hour lecture. Responses were measured using a 5-point scale from strongly disagree to strongly agree.

Results: Survey response rate was 40% among dermatology residents and faculty. Of respondents, 50% were unaware of the impact of implicit bias and 80% felt that knowledge of these biases would improve their clinical decision-making and future practice. Ultimately, 90% of respondents noted they would consider the educational session in the future, and 90% believed formal education on implicit bias should be included in graduate medical education.

Conclusion: Overall, the majority of residents and faculty felt that knowledge and education on implicit bias would have a positive influence on their future practice and clinical decision-making.

Notes:
Can Implicit Bias Affect Dermatology Residency Selection?

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William W. Huang, MD, MPH
Wake Forest University School of Medicine Department of Dermatology

America is becoming increasingly diverse. By 2044, no single racial or ethnic group will comprise a majority of the U.S. population. However, the presence of underrepresented minorities in dermatology does not reflect current demographics. African Americans represent 12.8% of the population, but merely 3% of dermatologists. Similarly, Hispanics constitute 16.3% of the population, but only 4.2% of dermatologists. Expanding diversity may help alleviate health care disparities, as minority physicians are more likely to practice in areas with underserved populations. Racial and ethnic concordant encounters yield more effective patient-physician communication as well as greater patient satisfaction and medication compliance. Improving diversity in dermatology necessitates recruiting and training diverse residents. However, unconscious or implicit bias may influence resident selection. Implicit bias describes unconscious beliefs that unintentionally affect one’s attitudes and actions towards various groups. These biases, favorable or unfavorable, are rooted in experience, not fact. Unconscious bias can influence decision-making, including evaluating admission files and selecting residents. In 2016, in an effort to mitigate implicit bias, the Wake Forest University Department of Dermatology encouraged its applicant review committee to complete an online Implicit Association Test before the committee’s initial meeting. The department aimed for reviewers to become aware of their implicit biases before evaluating applications. Following the intervention, the percentage of underrepresented interviewees increased to 41.07% (23/559) from 34.79% (17/507) of applicants the previous year. Additional methods may help individuals and institutions manage unconscious bias, such as providing education and initiating bias-proof policies. Acknowledging and addressing implicit bias is vital to the diversity mission of the AAD and the future of our specialty.

Notes:
Patients’ Perspectives of Clinical Case-Viewing Conferences

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William W. Huang, MD, MPH- Department of Dermatology, Wake Forest University School of Medicine

Background:
Clinical case-viewing sessions or grand rounds are used for medical education and to improve patient outcomes through the collective effort of a department. Although grand rounds are a valuable part of resident education, the experiences of patients during the clinical case-viewing sessions has not been fully explored.

Objective: To determine patients’ perspectives on their participation in clinical case-viewing conferences, to identify ways to improve patients’ experiences in these conferences, and to understand how to increase their willingness to participate.

Methods: 20 patients, over the age of 18, who have agreed to participate in bi-weekly grand rounds are being recruited from the Wake Forest Dermatology at the time of the session. Patients receive written surveys before and after the session to assess their emotional response and suggestions for improvement. One week following the clinical-case viewing, patients are administered a short follow-up survey via telephone, with responses recorded in the study log.

Results: As our study is currently ongoing, we will present the initial results from analysis of survey data at the time of conference.

Limitations: All subjects are patients at a single center; this limits generalization of the results and conclusions to other communities.

Discussion: By understanding the perspective of patients who participate in grand rounds, dermatology programs can work to improve patient comfort and understanding during future sessions, and by doing so, hopefully create an environment where patients can feel at ease when answering questions and discussing their cases. In this way, residency programs can utilize a humanistic approach to improving grand rounds, for both medical education as well as patient satisfaction.

Notes:
The Effect of Level of Training on Rate of Biopsy, Cryotherapy, and Overall Satisfaction of Care

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Background: Compared to medicine residencies, dermatologic residency education usually takes on an “apprenticeship model,” where a dermatology resident functions as an assistant in an attending’s clinic. However, dermatology residents in our program when surveyed, complained of a lack of autonomy. Consequently, resident clinics (RC) were developed, where residents are the primary provider, and attendings provide more autonomy and serve in a preceptor role, similar to a continuity clinic seen in internal medicine.

In creating this new clinical environment, it is unknown how this might change satisfaction rates for patients and providers, and furthermore, how this might change practice patterns, such as rate of biopsy or treatment of actinic keratoses (AK).

Methods: Patients and Providers were surveyed directly after their appointment and during the clinical session to evaluate satisfaction with the experience. Biopsy rates and AK treatment rates were compared between the RC and an attending led clinic deemed to be similar in patient make-up, our urgent access clinic (UAC). A z-test was used to compare biopsy and AK treatment rates with liquid nitrogen.

Results: In two months of data accrued, a total of 73 patients were seen in the RCs, whereas 131 patients were seen in the UACs. A total of 22 biopsies were performed on 20 patients (27%) in the RC, whereas 26 biopsies were performed on 24 patients (18%) in the UAC. The difference between the two group yielded a p = 0.131. In regards to treatment of actinic keratoses (AK), 8 patients (11%) had 12 AKs treated in the RC, compared to 9 patients (6.9%) who had 14 AKs treated in the UAC. The p-value was 0.238.

Conclusion: There is a trend toward more biopsies per patient and more AKs treated per patient in the RC when compared to the UAC; however the findings are not statistically significant.

Future Direction: Survey data will be collected regarding patient and provider satisfaction between these two clinical environments.

Notes:
Leadership Style Self-Assessment – Understanding the Diversity of Personalities in a Residency Program through the Myers-Briggs Type Indicator

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The theory of psychological type comes from Swiss psychiatrist Carl G. Jung (1875-1961) who wrote that “what appears to be random behavior is actually the result of differences in the way people prefer to use their mental capacities.” The purpose of the Myers-Briggs Type Indicator (MBTI) personality inventory is to make the theory of psychological types described by C. G. Jung understandable and useful in people’s lives. The essence of the theory is that random variations in behavior are actually quite orderly and consistent, being due to basic differences in the ways individuals prefer to use their perception and judgment. All preferences are equally valuable and each type brings an important point of view when people interact. A mixture of types is best for a work group or team because many views are represented. The most important aspect of the Myers-Briggs® type theory is that every type has value. Although each type approaches situations differently, and another person’s approach may not be what you would choose, each way can be effective.

There are many benefits to understanding your own preferences, including how they affect you, how they affect your style of communication, and how they are different from what other people prefer. Preferences allow us to have different interests, different ways of behaving, and different ways of seeing the world. While all the preferences are equal, each has different strengths and different challenges. Knowing these personality strengths and challenges for yourself and others can help you understand and appreciate how everyone contributes to a situation, a task, or the solution to a problem.

For the past several years, residents in the Department of Dermatology at Wake Forest University School of Medicine have completed the MBTI and reviewed the results in a group exercise during their annual Resident Retreat to have a better understanding of their own leadership and communication style and those of their resident colleagues.

Notes:
Learning Games for Dermatology Education--Teaching Millennials

Sean Reynolds, MD, Dermatology Resident, Warren Alpert Medical School of Brown University

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Recent papers describing the preferred teaching methods of the millennial resident suggest that the classic lecture format is no longer as well received. The millennial learner wants a more interactive learning experience incorporating technology and collaboration. Games have been used as a fun way to learn and increase engagement. While studies of the effect of gaming on knowledge acquisition in residency education have been mixed, we have introduced some games into our curriculum and found them to be very well received. We are using Jeopardy style games, trivia games with clickers, and buzzer games primarily to teach genodermatoses. The residents enjoy the varied activities, the collaboration with their colleagues, and the healthy competition promoted by gaming. We would like to introduce the topic, and outline the learning theories and evidence base underlying gaming in education. We will review and recommend a number of online resources and programs available that others may be able to incorporate into their own teaching. We will also present the results of our survey, assessing for changes in study behavior and resident attitudes towards this method of instruction.

Notes:
Dermatopathology is an essential part of dermatology training. Many dermatology departments lack good quality material for training their residents in dermatopathology. Finding great dermatopathology cases is a continuous process, and even if a faculty makes the effort to collect cases, it is not long before some slides are lost, faded, broken or even stolen. Having access to a complete diagnostic collection of digital slide would be a great asset for any dermatology department. Even when a department digitizes some of its great cases, downloading and using software is always a pain because of firewalls and software compatibility.

PathPresenter (PP) is a free platform that solves all these issues. PP provides free access to more than 2000 dermatopathology digital slides. It also provides the user ability to integrate whole slide images into folders and rearrange them into study sets. Presenters can also annotate areas of interest in the slides before starting to teach to highlight specific areas. PowerPoint can be integrated with the digital slides to provide context to the slides in case one is presenting in grand rounds, intra/interdepartmental conferences, or tumor boards. PP also provides the ability to upload the user’s own digital slides and use them seamlessly for teaching or presentations.

Getting intradepartmental or intercontinental consults for virtual slides is a breeze. PP also provides easy method for sharing individual slides or entire presentations and developing quizzes and tests for residents. With the AAD Board exam planning to go all digital by 2020, PP provides the platform and tool for any department to provide the best dermatopathology education to its residents. Cases are being added everyday to make the library as comprehensive as possible. In my presentation, I will walk you through the different functionalities of PP and how to use it to provide the best dermatopathology education.

Notes:
Using Google Forms to Efficiently Administer a Dermatology Mock In-Training Examination

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William W. Huang, MD, MPH, Wake Forest University School of Medicine Department of Dermatology

Introduction: Dermatology residents are administered an annual Mock In-Training Examination to assess resident knowledge base, preparedness for the American Board of Dermatology In-Training Examination, and strength of the residency program curriculum. The 2-hour, 160-question multiple-choice exam was previously administered using timed PowerPoint slides and paper answer sheets. Our objective was to create an electronic Mock In-Training Examination resembling the online annual In-Training Examination.

Methods: An online Mock In-Training Exam was prepared using Google Forms. The “Quiz” mode allowed automatic grading of 160 multiple-choice questions. Content areas included basic science, medical dermatology, pediatric dermatology, dermatopathology and surgical dermatology. High-resolution clinical and pathology images were embedded and skipping was prevent by marking “Required” for each question. Email addresses were collected for exam identification. The test was proctored in a room with individual computer stations. Residents opened an e-mailed link and after a 2-hour period, the “Accepting Responses” tab was turned off to prevent further access. Test answers were downloaded into Excel and printed for self-grading.

Results: The online Mock In-Training Examination’s allowed test administration in a similar format to the annual In-Training Examination. Individual examinees could return to previous questions without interrupting the testing progress of fellow residents. Online images were higher quality compared to projected PowerPoint images. Google Forms allowed performance analysis by specific question, individual resident, and the overall resident group.

Conclusion: The goal of the Mock In-Training Examination is to prepare residents for the annual In-Training Examination. Google Forms provides an efficient and secure modality for administering an Mock In-Training Exam similar to the American Board of Dermatology In-Service Exam.

Notes: