



Gaining clinical confidence

By Dean Monti, Managing Editor, *DW Directions*

When *DW Directions* first reached out to a random group of residents about the topic of clinical confidence, the initial response was close to crickets...which was understandable. Admitting any crisis of confidence in the midst of a highly competitive, challenging medical residency is not something many would care to readily admit. But it is a reality for many and, for most, a natural part of any process of higher education.

Staring down the steep learning curve

There is a very steep learning curve when first-year residents enter a program, a phenomenon observed by Shasa Hu, MD, and Brian Morrison, MD, who spoke with their residents at the University of Miami Miller School of Medicine. "The sheer volume and esoteric nature of dermatology can easily overwhelm a resident," Dr. Morrison said. "Also, the fact that nearly everyone else (senior residents and faculty) seems to have a much better handle on the material can be demoralizing, especially for high achievers like our dermatology residents." Dr. Morrison said this perception of ignorance may prevent residents from asking questions for fear of looking inept or may preclude them from seeking feedback because they want to project an image of competence.

Ata Moshiri, MD, MPH, a dermatopathology fellow at the University of Pennsylvania and a member of the AAD Young Physicians Committee, concurred, saying

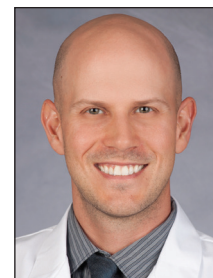
clinical confidence is an extremely important and elusive attribute that is critical to develop during residency. "It is challenging and often it's the last piece of the puzzle to fall into place," Dr. Moshiri said. "It requires the acquisition of a broad and deep knowledge base, a knack for developing rapport quickly with patients, as well as experience with follow-up. Each of these elements takes time and care to develop, and the process is often complicated by a number of issues."

Dr. Moshiri said rapid clinical rotation is one of the factors that can foster anxiety. "Just when you think you've finally figured out how to close a wound on tough back skin, you're whisked away off to pediatrics, where you won't do a procedure for a full month. It's hard to feel good about what you're doing when you do wildly different things in quick succession." He added that working with different attendings — with different styles and expectations — can also be a challenge.

If you think it's hard, you're right

Dermatology study involves acquiring an entirely new level of academic and clinical expertise. Remember that it's going to be intense and keep at it. "Dermatology is a field that many learn next to nothing about during medical school and it has its own complicated language with a whole tome of abstruse diagnoses," Dr. Moshiri said. "Coming off of my preliminary medicine year, I felt

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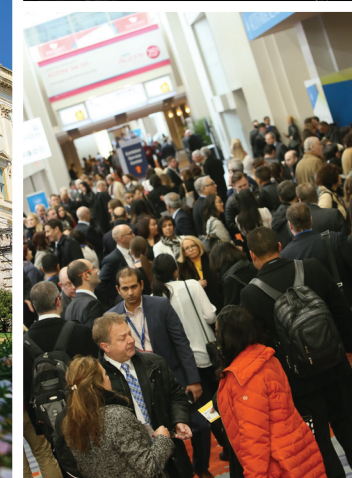
Brian Morrison, MD, is an assistant professor and assistant residency director in the department of dermatology and cutaneous surgery at University of Miami Miller School of Medicine.



Shasa Hu, MD, is an associate professor in the department of dermatology and cutaneous surgery at University of Miami Miller School of Medicine.



Ata Moshiri, MD, MPH, is a dermatopathology fellow at the University of Pennsylvania and a member of the AAD Young Physicians Committee.



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super comfortable managing complex medical cases, but had to really step up my game and my studies when it came to the skin.”

Sink, swim, or call a lifeguard

It may provide you some solace to remember that you're not alone in residency, in fact, it's likely you are surrounded by an excellent support group. “In my experience, this is a common theme in residency: you're thrown into the deep end of a swimming pool and asked to swim,” Dr. Moshiri said. “Luckily, there are many lifeguards around the pool. Nevertheless, it's on you to become proficient quickly, as nobody wants to be the kid with the floaties on while everyone else is doing laps. This seems daunting and motivates you to go home and read or practice throwing sutures rather than throwing on Netflix. Although it sounds like a real drag, it's probably for the best. Remember: we all have to get over the learning curve eventually.” Dr. Moshiri added that getting over that curve as quickly as possible whilst in a supervised setting (i.e. residency) is much better than learning harder lessons when you're on your own.

Shoring up your confidence

If clinical confidence is not naturally in your genes, there are suggested ways to bolster it. First, look at those areas where you lack confidence and see if you can improve your studies in those specialized areas. For example, Dr. Hu said the study and treatment of pigmented lesions is an area where residents sometimes feel insecure. “Dermoscopy training varies significantly by program and by region, as some programs have very small or uniform patient demographics.” This is underscored, she said, by the high attendance rate of basic dermoscopy courses at the AAD meetings (so attend as many AAD meetings as you can).

“For pigmented lesions training, it's important for residents to voice the need for it, advocate for program support on dermoscopy funding, and perhaps invite dermoscopy experts for lectures if no local experts are available,” Dr. Hu said.

Dr. Hu stressed the value of honest feedback during residency.

“If needed, residents should force themselves to ask for feedback from their supervising residents and attendings,” Dr. Hu said. “Asking questions when in doubt to ensure they understand the medical rationale as well as the best possible patient care [is critical to building confidence and competence]. It's important residents know that everyone feels the effect of the steep learning curve in dermatology and that it is normal.”

Healthy competition

Anyone who has sat in on a round of Residency Jeopardy! at the AAD Annual Meeting knows that residents are an inherently competitive species.

“Everyone wants to be thought of highly by their program and peers,” Dr. Moshiri said. “At the very least, everyone wants to be an ‘excellent dermatologist’ because people have worked a tremendous amount and given a great deal of themselves to be in this field.” He added that “this desire tends to motivate people to study and work hard so they're not left behind by their classmates; however, when taken to the extreme, it can create a culture of negativity that can be harmful for the morale of a training program.”

Dr. Moshiri said while there is a tendency to look around and see what others are doing as a gauge of one's own efforts, it's important to keep perspective. “You need to recognize that everyone is coming into residency with different backgrounds and strengths. It's important not to let what others are doing get you down. It's a difficult balance to strike, but the most important thing is the mindset in which the drive for excellence exists. If one is looking to put themselves ahead of others, then this drive can be disastrous. Instead, if one is seeking excellence for themselves and others (for example, the benefit of patients), then such a drive helps foster a collaborative learning environment with fertile soil that will yield professional and personal growth.” **DR**



Lindsey Goddard, MD, is a PG-4 dermatology resident at Loma Linda University.

Race for the Case

By Lindsey Goddard, MD



10-year-old female presented to the ER with a 10-day history of a progressing bullous eruption. She denied fevers, diarrhea, pruritus, or pain. No new medications had been started prior to the onset.

On exam she had discrete round-oval polycyclic bullous lesions with raised beaded rims of varying sizes that involved the trunk, bilateral upper and lower extremities, and buttocks. There were no intraocular or intra-oral mucosal lesions, but there were vesicles around the nares and upper cutaneous lip.

1. What would you expect to see on biopsy and DIF?
2. What is the treatment of choice for this disease?
3. What medications can be triggers for this disease?



Respond online with the correct answers at www.aad.org/RaceForTheCase for the opportunity to win a Starbucks gift card!

Race for the Case: Winner (Fall 2018)

Congratulations to Emily Carr, MD, PGY-3, for submitting the correct responses in the fastest amount of time! Dr. Carr is a dermatology resident at Baylor Scott and White Dermatology in Dallas.

To answer the latest Race for the Case, visit: www.aad.org/RaceForTheCase.

Biopsy techniques

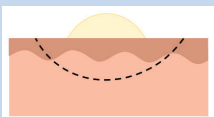
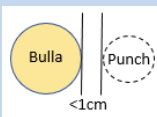
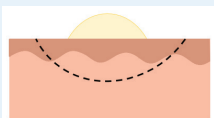
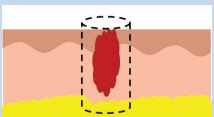

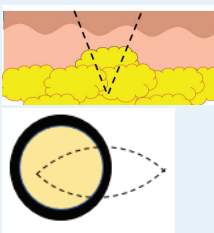

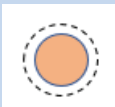
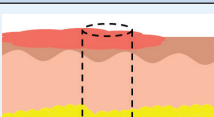
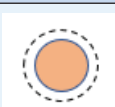
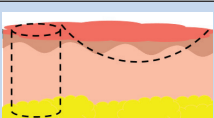
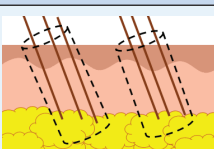
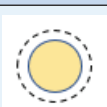
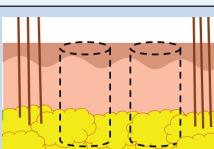
by Jen Seyffert, DO, and Puja Kathrotiya, MD



Jen Seyffert, DO, is a PGY-3 at KCUMB-Advanced Dermatology and Cosmetic Surgery Dermatology Residency of Orlando.

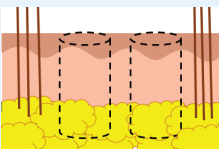
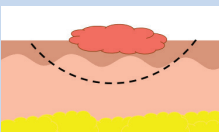
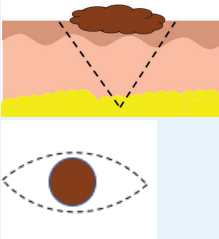

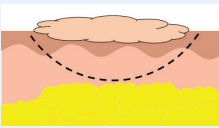

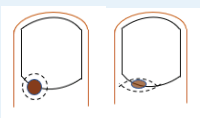
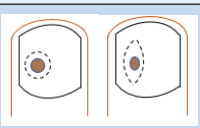


Puja Kathrotiya, MD, is an attending physician at KCUMB-Advanced Dermatology and Cosmetic Surgery Dermatology Residency of Orlando.

Disease	H&E Transport: Formalin		DIF Transport: Normal saline, Michel, Zeus, or LN2		Comments Culture: Non- bacteriostatic saline EM: 2.5% glutaraldehyde solution Flow cytometry: fresh specimen on saline soaked gauze or RPMI medium
Autoimmune bullous disease	Saucerized intact bulla, OR Broad sauceriza- tion of peripheral bulla		Perilesional skin <1cm from bulla		Avoid lower extremities. Trunk skin is preferred. Saline is superior to other DIF transport mediums if delivered to lab within 48 hours.
Epidermolysis bullosa	Saucerized intact bulla, OR Broad sauceriza- tion of peripheral bulla				Avoid blisters >12hrs old. Can induce fresh blister on nearby clinically unin- volved skin
Vasculitis	Punch or deep shave of lesion >72hrs old		Punch or deep shave of acute lesion<24hrs old		Specimens should show both post capillary venule and deep plexus
Panniculitis	Deep incisional biopsy at edge of necrotic focus				6mm punch is the small- est size that can be divided for culture and H&E.
Lupus	>4mm Punch biopsy of lesion >6 months old that is still active		Punch biopsy of lesion >6 months old that is still active		
Dermatomyositis	>4mm Punch biopsy of lesion >6 months old that is still active		Punch biopsy of lesion >6 months old that is still active		
SJS/TEN/SSSS	Shave or punch biopsy of acute lesion including full thickness of epidermis				Can submit desquamating sheets
Scarring Alopecia	Two >4mm punch biopsies of a lesions >6 months old that are still active		>4mm punch biopsy of a lesion >6 months old that is still active		Two biopsies: 1 for verti- cal and one for horizontal sectioning. Avoid active advancing border Place punch at same angle as emerging hairs
Pattern Alopecia or Telogen Effluvium	Two >4mm punch biopsies from an estab- lished area of alopecia				Two biopsies: 1 for verti- cal and one for horizontal sectioning. Submit transverse section or intact specimen for lab to section with HoVert or Tyler techniques

Biopsy techniques (continued)

by Jen Seyffert, DO, and Puja Kathrotiya, MD

Disease	H&E Transport: Formalin	DIE Transport: Normal saline, Michel, Zeus, or LN2	Comments Culture: Non- bacteriostatic saline EM: 2.5% glutaraldehyde solution Flow cytometry: fresh specimen on saline soaked gauze or RPMI medium
Alopecia Areata or Syphilis	Two >4mm punch biopsies of active lesions with recent onset		Two biopsies: 1 for vertical and one for horizontal sectioning. Submit intact
NMSC	Shave or punch biopsy with enough depth to demonstrate invasive pattern and detect perineural invasion		Use more superficial shave techniques on convex sites or thin facial skin
Suspected Melanoma	Complete excisional removal		Saucerization is acceptable Consider scoring or tagging at 12 o'clock for orientation
DFSP	Deep incisional biopsy		
CTCL	Broad shave biopsy below the depth of DEJ		Broad shaves are superior to punch biopsies Consider sending specimens from multiple anatomic sites
Primary Cutaneous B-Cell Lymphoma	Deep incisional biopsy		Punch biopsy or saucerization are superior to shave biopsies
Nail Matrix	Punch biopsy or horizontal distal matrix elliptical excision with Vicryl closure		Total or partial nail plate avulsion is usually done prior to nail matrix biopsy. Punch biopsy <3mm does not need sutured closure
Nail Bed	Punch biopsy or longitudinal elliptical excision with Vicryl closure		Nail plate avulsion is usually done prior to nail bed biopsy, but is not necessary

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2. Elston DM, Stratman EJ, Miller SJ. CONTINUING MEDICAL EDUCATION Skin biopsy Biopsy issues in specific diseases. *J Am Dermatol*. 2016;74:1-16. doi:10.1016/j.jaad.2015.06.033

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Daniela Kroshinsky, MD, MPH, is director of inpatient dermatology and director of pediatric dermatology at Massachusetts General Hospital and is also an associate professor of dermatology at Harvard Medical School.

Career case study

Pursuing a career in a hospital environment

Daniela Kroshinsky, MD, MPH, interviewed by *DW Directions*

Why did you choose to pursue a hospital environment for your practice?

I pursued a career in dermatology with the intention to practice in the hospital. As a medical student, I was drawn to dermatology after rotating with and being inspired by Joaquin Brieva, MD, at Northwestern — one of the pioneers of inpatient dermatology. His mastery of clinical dermatology and impact in the care of hospitalized patients were apparent on a daily basis. He was a valued member of the broader medical team and his input was regularly sought out, particularly for some of the most complicated patients in the hospital. His love of teaching students, residents, colleagues, and patients was palpable and he was incredibly skilled at all that he did.

What personality traits are most desirable and helpful in this type of setting? Is it more social or solitary, do you need good “people” skills?

Inpatient dermatology is definitely a team sport. The ability to work well with others and communicate effectively is critical, both with other clinicians as well as patients and their family members. It is important to be able to embrace unpredictability as the volume and breadth of patients can vary quite a bit on a day-to-day basis. There is also a component of stamina involved as we are on the move throughout rounds and frequently involved in dressing changes or bedside procedures. Patients tend to be far more ill than those managed in the outpatient setting, and you have to be prepared for the fact that despite our best efforts, outcomes do not always go as we hope.

Describe a typical day. What are the various tasks? How much time are you spending with patients, office work, other?

A typical day involves morning clinic where I see a mix of established outpatients and inpatient follow-ups. Afternoons are spent rounding on emergency department and admitted patients at our institution, which is comprised of adult and pediatric patients and also covers a burn hospital and eye and ear infirmary. Almost all of my time is spent in direct patient care and in teaching residents and medical students. There is always some degree of administrative work, such as writing notes, returning phone calls, and filling prescriptions on the outpatient side. On the inpatient side, I am often called upon to participate in team or family meetings or to give lectures. Much of my clinical research is embedded in the hospital so I also spend time on these projects and meet with research collaborators.

Is travel a factor in this profession?

Not for me but there are institutions that cover multiple sites so some inpatient dermatologists do commute between locations.

What areas of your residency training and education are being put to use the most?

I was very fortunate to train in an internship and residency program with a strong focus on resident education, broad clinical exposure, and management of critically ill patients. As a dermatology resident at SUNY Downstate, I had significant inpatient experience at multiple hospitals caring for a diverse patient population with dedicated teaching faculty. There was a focus on physical examination skills as well as diagnostic, procedural, and management competency supported by a strong understanding of dermatopathology. I am grateful for these skills on a daily basis.

In terms of need, workforce, and opportunities, how does it compare? Is it more difficult to land a hospital position than another subspecialty?

There is still ample opportunity to join or create an inpatient practice across the country. Many academic institutions have adopted a hospitalist model and many more are looking to do so. At smaller institutions, there are ways to incorporate a modified hospitalist model to create a strong inpatient focus and expertise despite having lower patient volumes.

If residents are considering practicing in a hospital, what else should they keep in mind? Any special training or ways to increase their proficiency beyond their residency?

As with any subspecialty career, it is important to gain exposure to life in that field, either through rotations in residency or through electives with inpatient dermatologists, as are offered through mentorship programs like that of the Medical Dermatology Society. There are also post-residency training opportunities. Very often, time spent in outpatient clinical practice generates more revenue than similar time in the inpatient setting and funding for positions may vary by institution. The Society of Dermatology Hospitalists has collected data on existing inpatient services and the various means of funding positions in the hospital and can serve as a valuable resource for residents looking to create or negotiate a new position.

Is there something specific to hospital dermatology that is personally rewarding to you? Why will residents feel satisfied with this choice?

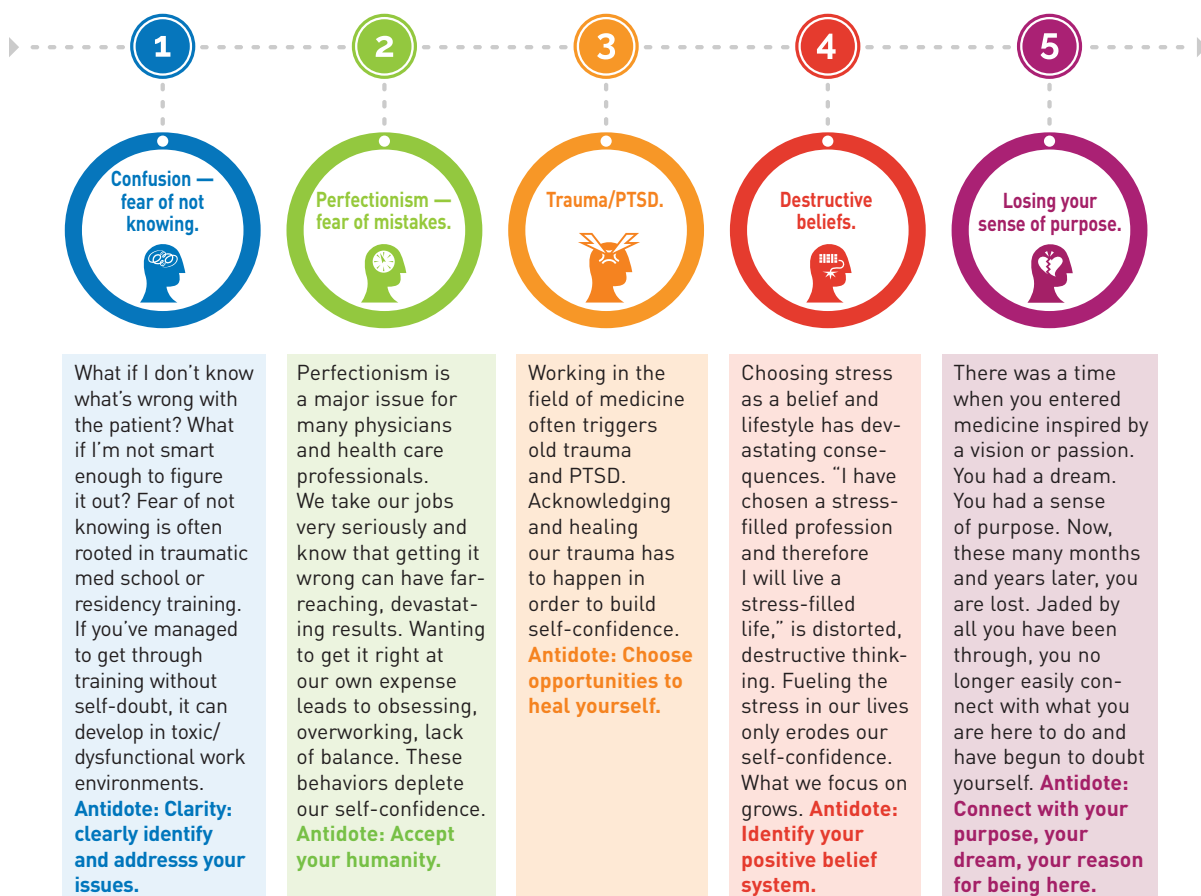
I really appreciate the opportunity to think through complex cases and the ability to participate in the care of patients with serious medical issues. Dermatology is frequently able to change the trajectory of a patient's care and impact prognosis for the better. Being able to work closely and longitudinally with our bright, interesting, hard-working, and dedicated residents is especially rewarding. Every day in the hospital is different and exciting. Working together with other specialties and all members of the medical team to benefit patients provides a tremendous amount of professional and personal satisfaction. **DR**

Job Searching



Check out the Academy's Career Compass for help with job searching: www.healthcareers.org/aad.

Top five warning signs you lack self-confidence (and how to get it back):



From "Top 10 fears that hold doctors back" by Pamela Wible, MD. Used by permission of the author. Read the entire article online at: www.idealmedicalcare.org/top-10-fears-hold-doctors-back/. DR

Resident life hack: A healthy support system

By Felicia Ekpo, DO, and Joseph Claiborne, MD

As resident physicians, we are planning our wedding while in residency. We have limited time and an ongoing to-do list of work to do. However, we cannot neglect our life outside of residency. Although residency may be demanding, we maintain an excellent work-life balance by serving as each other's support system. This encourages us to not lose sight of our passion for medicine while allowing us to excel in our education.

We plan ahead to prioritize ways to help us save time during the week. For example, our love for cooking motivates us to eat healthy during residency by meal prepping weekly. During that time, we teach each other what we have learned while studying. This practice has proven to be very effective in solidifying our knowledge and makes meal prepping and studying seem like less of a chore. Every evening, we also serve as one another's study buddy and hold each other accountable to obtain the goals that we each set forth.

We encourage everyone to find a support system of some sort and enjoy your time during residency by maintaining an adequate balance in all aspects of your life. DR



Felicia Ekpo, DO, PGY-3, is a dermatology resident at St. Joseph Mercy Health System in Ann Arbor, Michigan and **Joseph Claiborne, MD,** PGY-2 is an internal medicine resident at Detroit Medical Center.

Follow the couple on Instagram @drweddingroyal

How do you manage resident life?



Send your photos and pearls of wisdom to Dean Monti at dmonti@aad.org.

Inside this Issue



Tara Oetken, MD, is a PGY-2 dermatology resident at the University of Arkansas for Medical Sciences (UAMS), in Little Rock, Arkansas.

From medical school applications, to matching into a residency program, to scoring that dream job, there are certainly several major milestones in medicine. With each hurdle to jump over or accomplishment to achieve, hopefully we celebrate those major moments of professional growth. Even though tangible “career shifts” like these are undoubtedly important, there are countless other ways we can develop as dermatologists.

Perhaps the most important thing we can all do to become better physicians is to develop confidence in the clinical setting day in and day out. How we utilize our time between big moments like Match Day, interviews, and the Board exam is arguably the most important part to factor in our career goals.

Here are some tips on how to develop your sense of confidence in clinic:

- 1 Seek out growth opportunities.** This might sound simple, but it is so easy to take the back seat and go with the flow during residency. Without showing initiative and boldly stepping out, your confidence will always suffer. Take charge of your own professional development by asking for more leadership in your residency program, whether it is perfecting that one troublesome clinical procedure or putting in the extra hour or two to help a younger resident or med student.
- 2 Develop a community in residency.** Humans are never meant to be totally alone. Isolation causes all sorts of problems, from health issues to personal failings. Studies in psychology and human resources indicate that isolated people often struggle in many areas of their lives. By interacting with others on a regular basis and being held accountable for your goals with the help of your peers, you can gain more professional confidence.
- 3 Set goals for yourself.** Where do you see yourself at the end of residency? What about five or 10 years down the road? Goal-setting allows you to work out the steps you need to take to accomplish these hopes and dreams, and that definitely includes clinical confidence! One popular acronym in professional development is to work out “SMART” goals — specific, measurable, achievable, relevant, and time-bound. **DR**

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