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Real Talk About Residencies

Ranna Jaraha (00:06):

Welcome to the Practical Dermatology Podcast. In this episode, we hear from International Federation of Psoriasis Foundations Executive Director Frida Dunger, plus a conversation between Dr. Neal Bhatia and Dr. Brad Glick, and the latest news from around dermatology. Now here's Frida Dunger to talk about psoriasis awareness efforts.

Frida Dunger (00:23):

We are the International Federation of Psoriasis Associations, a global federation that represents more than 60 million people living with psoriasis around the world. And we organize different kind of policy and advocacy events. We have research and we also do different kinds of projects and campaigns, and one of them being the World Psoriasis Day. Last week we were at the UN High-Level meeting and the focus this year and this week was the non-communicable diseases and mental health. And as a global patient organization, it's crucial for us to participate in these kind of meetings and share our knowledge and experience. So, the lived experience is really important to have part of these policymaking processes.

(01:09):

We organized a site event together with DevEx, which is a news network, and we were having focusing on the lived experience and how we can include that in the policymaking process. We had IFPA's ambassador there, Kate Reynolds. She's from Canada, works as a librarian, and she's living with a very rare form of psoriatic disease called GPP, generalized pustular psoriasis. She was sharing her experience from her first flare-up where 70% of her body was covered with pustules and how painful that was, and difficulty in getting the right diagnosis because since it is a rare form of psoriasis, not everyone recognized it. And her experience there was very important to share.

(01:55):

And as well for IFPA as a global patient organization, we want to make sure that we are here, where the decision-making is taking place. Having this event with a person living with experience to sharing her knowledge, we are hoping that the lived experience is also becoming seen as an expertise that should be included in these kinds of processes. And I believe that by listening to the lived experience, that's where you can develop holistic solutions. If you don't take that into account, I'm afraid that we will not reach that sustainable solutions. But we are having a lot of different policy and advocacy work, so participating in the UN General Assembly is, of course, one of them. But we also work on research and different kinds of projects and campaigns.

(02:43):

And coming up very soon is World Psoriasis Day on October 29, and which chose the topic, Stop the Domino Effect. And that is also because of UN this year has the focus on non-communicable diseases, and we want to make sure that we place psoriatic disease as a known NCD, non-communicable disease. And it is not among the biggest ones so it's hard to get in there and get the attention. And participating in a meeting like the UN High-Level meeting is, therefore, also a very important step for us. And what we mean by Stop the Domino Effect is to raise that awareness on how psoriasis is linked with other comorbidities. So if you're a person living with psoriasis, you have a higher risk of developing diabetes, obesity, cardiovascular disease, and many other forms, too.

Ranna Jaraha (03:33):

Next, Dr. Neal Bhatia is joined by Dr. Brad Glick.

Dr. Neal Bhatia (03:37):

Hi, I am Dr. Neal Bhatia and I am here today with the best of the best, Dr. Brad Glick. He is a marvelous and entertaining dermatologist, but also well-accomplished and a leader among men as well as women, as well as dermatologists. Dr. Glick, please introduce yourself to the crowd, as we all need to get to know you better.

Dr. Brad Glick (03:58):

Of course. Well, Dr. Bhatia, thank you so much for having me. I am Brad Glick, a board-certified dermatologist. I practice in South Florida. I wear a few different hats; I'm quite hybrid. My most important hat is that I am the Chair and Program Director at Larkin Health System, Palm Springs campus in Miami, Florida. I also work in clinical trials at a research center, which is known as GSI Clinical Research. I've been in practice for about 30 years and I'm happy to be here with you today.

Dr. Neal Bhatia (04:30):

As am I, as it should be. Dr. Glick, in all seriousness, we are here because we have worn similar hats in our careers as residency program directors, as mentors, as well as teachers and seeing the evolution of residency program training, if you will, going from the days of hard labor and sweatshop and carrying 80-pound bags of salt uphill, to a very different generation of teaching, as well as the incorporation of mentorship and different strategies to build the next generation. What have been your observations over the past few years as a program director? What do you see that we're doing right and wrong?

Dr. Brad Glick (05:12):

It's interesting and it's a great topic, because I was a program director for a residency program mostly in the osteopathic world through the AOA for about 14 years. That ended just about 10 years ago and I've seen an amazing change. We were much more ambulatory in our program with a little bit of an institutional component, and yet we were super ambulatory, very much still in the books, if you will. Our technology focus was nowhere near it was today. And Neal, I really think post-pandemic, there was just a big surge. The last 10 years, for sure, but the last five years especially between digital technology, dermatopathology, what our residents were doing 15, 20 years ago in front of microscopes and glass slides, to the transition now where it's not only digitized, but it's also, and we'll get into AI, I'm quite sure, but also the whole AI component, the digitization of dermatopathology is just one big component of the change in residency education. I think also, you mentioned the carrying the books, the papers. There are some significant positives to a digital world that we live in right now. The ability for residents' education to be streamlined is phenomenally efficient for them as residents, as long as, of course, they take advantage of it.

Dr. Neal Bhatia (06:43):

Texture is the word you're looking for, because I think residents have lost texture. The 3D element of looking at a glass slide through a microscope or reading a textbook with images of the textbook. We were groomed with all of the textbooks, going from Fitzpatrick to Andrews to Bologna, to everything in between, textbooks defined us and Lever for dermopath, if you will. And now I think the texture of resources has changed significantly from 3D to 2D. But go ahead and finish what you were saying.

Dr. Brad Glick (07:15):

Yeah, no, I think that's an exceptional observation, and I think there's always the good and the bad and the ugly of everything. I think that books, and I like the way you kind of frame that as 3D to 2D to even 1D, if you will. But I mean, there are advantages to that and I think streamline and efficiency is one component of it. But I think one of the things that we're seeing, not to get too far away from residency training, but I think it is pertinent, the whole idea in medicine and especially in dermatology of that physical touch, that component, it seems to be falling a little further and further away as it's become digital, as we have AI and we incorporate that and we have social media. And that's a whole other layer of the challenges that we even have in our management of our education of and our mentorship of residents in training. It really is a different world in that regard.

Dr. Neal Bhatia (08:14):

Oh, yeah. The old fundamentals were, if you did not put your hands on your patient, you haven't done your job. Because patients, again, they need to feel validated with your hands, with your touch to them. Even if they had the most minimal mole exam or the most extensive psoriasis eruption or bolus eruption that you can think of, if you haven't put your hands on that patient, you have not made them feel whole and they may leave there feeling more sick or more isolated than when they came to see you. And that is, I think, maybe a generational gap, but it's also, I think, a strategy that's lost on the residency training because of not only pandemic, but I think also because of that sense of detachment that, "I'm just here to learn and get out," rather than, "I'm here to become a doctor and learn how to be that patient's doctor in this moment."

(09:07):

So I think there's a training method that has to really come back to that. The other part of it, too, is we were all trained on Socratic method. We all had the crap scared out of us if we didn't know how to describe, how to come up with a differential. I mean, my days of teaching were always about describe and conquer, I used to call it, where you go in, "Here's your morphology, use the vocabulary." And what scares me the most is we're losing our dermatology speak, if you will. Our derm jargon is becoming diluted because residents are not spending the time. They look at it as trivial, whereas, I mean, when we trained in the '90s, if you did not know the language, you did not know your specialty. So it's definitely an interesting trend. And again, the digital world has probably made that worse.

Dr. Brad Glick (09:54):

Yeah, I couldn't agree more. And I still, in clinic, and if you're interviewing someone who's not 64 years old and who's more like 44 years old, you may get a different perspective. Individuals like you and I will bring into that kind of old guard perspective of, "What does this look like? Please describe this for me. What is your differential diagnosis based on the primary lesion that you see?" How I was taught by my grassroots type mentors. But I think the critical point is still taking that mentality and then embracing the new technologies and the digitization that we're talking about and the whole electronic world that we live in.

(10:32):

My fear, though, which started with EMR, is that I don't carry my iPad in the room with me. I don't mind that they're a scribe in the room, but I don't want an iPad or a laptop between me and a patient. And that's something that my residents see in me. There may be some inefficiencies to that, but we still have to be physicians taking care of patients and putting our hands on patients and using the technology where we're touching our patients with a dermatoscope. And again, that's a great example of the physicality of what we do, but using the technology. Something as simple as dermoscopy was still touching the patient and still carefully assessing them, yet using the technology towards their ultimate benefit.

Dr. Neal Bhatia (11:13):

Exactly, which goes right back to what you were touching on before with AI. And what's even worse is the patient's using AI to get to us, to try to big league us on what they have, because they've done all their homework. Went straight to AI, they come to the conclusions, they've read the end of the book before they've even started the book. And we have to spend more time on defense, try to explain to them what they don't have, rather than, "Doctor, what do I have?"

(11:38):

We've now entered the world of, "Hey, provider, I have this so I need this." And the iPad and the phone, they get more attention in the room sometimes than the skin that actually needs to be saved, which I think again, is more proof that the matrix is real, of course, but it's also proof that we need to try to take those phones out of those patients' hands.

Dr. Brad Glick (12:00):

If not, I can tell you that, in my opinion, we have to be able to integrate these types of nuances that we didn't have when we were in training, and educate our residents accordingly so that they understand those balances. And I think that they do. I think my residents that I have currently certainly are digitally and electronically sound, they're used to that. And I think the new generation of physicians are going to have to embrace, to some degree, this idea of Dr. Google coming into the clinic even ahead of time. I mean, who even ever thought that patients would be coming in, they certainly ask us questions, but the knowledge, accurate or not, a lot of times, not that they're coming in kind of creates an obstruction even before we're able to get to their dermatologic concern.

Dr. Neal Bhatia (12:50):

Speaking of concern, there's a concern of how many of our residents maybe mislead us on their intentions when they're applying for residency programs, and how many of them who would say, "I'm going to go see the underserved," end up actually being influencers or treating aesthetics? And how do we avoid getting duped when we're looking at merit instead of quota and try to find the best candidates for those limited positions? It's not very easy when we're not dealing with the truth half the time.

Dr. Brad Glick (13:20):

Neal, recently I was at the Association of Professors of Dermatology meeting, and I was able to present when asked to speak on the topic of how do we vet residents and what are we seeing in residents and how do we differentiate them? And it's a big challenge. One of the big challenges, too, is what does a personal statement mean anymore? Who's really writing it, who has vetted it? I, myself, like the idea of utilizing to some degree various forms of augmented or artificial intelligence, but I vet everything that I utilize. But when we're

reading these personal statements these days, too, it's kind of a big challenge because again, not sure who's writing it, what is the verity of it.

(14:06):

And so I agree with you, it's created some challenges, which is why we still have very specific audition rotations. We have criteria, five critical components of our audition rotations from their general performance, how they answer questions. They do a presentation, how they interact with patients, how they interact with staff. And so these are very important things that very much bypass what should be reasonable common denominators that will enable us to differentiate one individual for another. But a lot of these different factors have kind of changed the face of how we look at things like recommendation and personal statements and the like.

Dr. Neal Bhatia (14:47):

Which, again, goes back to the interview, right? You can't hide in the interview. AI can't do your interview for you. And if you show your true colors and it doesn't match who you are, and we have several friends like that, we won't mention any names, but we do know that if the interview does not match the reality, that we know that something is amiss, needless to say. And I think even more so, just the thought that, "I'm interviewing this candidate, would I want him or her to be my doctor?" And I think that's always a good question to ask.

Dr. Brad Glick (15:19):

Yeah, I think that we are now looking at our residence candidates a little bit differently, Neal. First of all, step one, board scores, step one's pass/fail. Step two, we're looking at different numbers, whether it's the COMLEX in the osteopathic world or USMLE in the allopathic world, and even most of our osteopathic candidates are taking both exams anyway. The numbers matter, but you know what? People matter. And I may be a little bit different, but I believe, and one of the things I said at the podium at the APD meeting was simply that we really do take a holistic approach. We really do try to look at the whole individual. It's not just about board scores, it's not about the letters of recommendation, it's not about that personal statement. Nothing can replace the personal nature of face-to-face audition. And I have four on service right now as we speak and we're doing this interview.

(16:13):

And it enables us to see some of the differences, some of the nuances between individuals. And perhaps the most critical component in my opinion when assessing our residents is just, who do we want to be working with for three years? What is the personal nature of the individual? Are they easy to get along with, do they work hard? Are they going to come in early because we need them to come in early and do they mind staying late? Minding the fact that we have to be worried about hours these days, we have to be worried about making sure our residents don't suffer from burnout. I get it. I worry to some degree, but on the other hand, on the dermatology residency, they're not facing too many overwhelming challenges, except at times where we do get consults, it can get a little bit busy.

Dr. Neal Bhatia (16:56):

Oh, it can be. But again, it's developing not only good residents, developing colleagues for the future. Who would you want to see at a meeting five years later and call them one of your colleagues? Because again, we've seen multiple department chairs and their linears, their trees, if you will, who is in part of that tree, and we know if they came from good stock or not. Because I can tell you if I'm a program director right now, Dr. Glick, I would not take myself as a resident. I would wholeheartedly reject my application. I would rank you, however, not just one, but automatic pass.

Dr. Brad Glick (17:31):

I doubt that seriously, Dr. Bhatia. But it is a different resident these days, too. And I think that the ideal program right now is the one that balances it all. And that's a challenge. All programs, all chairs, all residency program directors may be a little bit different. One thing I must say, while we need to balance medical, surgical, cosmetic dermatology, augmented intelligence, procedural components of dermatology, one of the things we must, must, must do is not forget every single program, every program around the country must continue to embrace medical dermatology.

(18:07):

It is the core of what we do, it is the foundation of what we do. It's still the critical component of our surgical assessments of patients, our understanding even of aesthetics. We talk about skin and skin barrier. It's the foundation of everything we do. And I worry that some of that is getting lost, but I won't let it be lost in my program. We have them as conventional.

Dr. Neal Bhatia (18:29):

You and I have been big proponents of that for the longest time, and we need to be the loudest voices as we should remind our

colleagues.

Dr. Brad Glick (18:37):

I agree.

Dr. Neal Bhatia (18:38):

With that. Dr. Glick, I appreciate your time on this podcast. I appreciate your time on this earth, and thank you very much for everything you've done for all of us here in the homo sapiens category.

Dr. Brad Glick (18:50):

I could only say, Dr. Bhatia, that my earth would not be the same without you.

Dr. Neal Bhatia (18:55):

I'll take it. Thanks, BG.

Dr. Brad Glick (18:57):

Take care.

Ranna Jaraha (18:58):

And now for the news. In our top story, new data from a nationwide French cohort study suggests that systemic antibiotic exposure may shorten biologic therapy persistence in patients with psoriasis. The research team analyzed more than 36,000 adults starting their first biologic between 2012 and 2022, with follow-up through 2024. The results showed a dose-dependent association between antibiotic exposure and biologic discontinuation. Patients who received antibiotics in the six months prior to biologic initiation saw a 12% increase in discontinuation risk, which increased to 29% among patients with two or more antibiotic dispensations. Similar patterns were noted across biologic classes.

(19:39):

The team also noted that gut microbiome disruption may impair immune modulating mechanisms crucial to biologic response, and emphasized that further studies to clarify the relationship between antibiotic use and treatment durability are needed.

(19:53):

A new large-scale analysis offers reassuring news for patients with pemphigus regarding psychiatric comorbidities. The retrospective cohort study, published in JID Innovations, looked at electronic health records for more than 120 million US patients. Study researchers identified more than 5,700 adults with pemphigus and matched them with controls based on demographics and comorbidities.

(20:14):

The authors assessed post-diagnosis risk of depression, anxiety, bipolar and psychotic disorders, substance use disorders and suicidal behaviors. According to their findings for all outcomes and across three different sensitivity analyses, the data indicated no increased psychiatric risk. Researchers added that while the findings suggest no condition-specific increase in psychiatric disorder incidence for pemphigus patients, psychiatric screening should still remain part of disease management.

(20:43):

And finally, in a recent edition of C-Suite Chats, Kyowa Kirin North America Vice President Greg Palko, who also serves as Oncology Franchise head for Kyowa Kirin, discussed ongoing challenges in CTCL, including delayed diagnosis, limited therapeutic options, and the need for better patient support. Here's a clip from that discussion.

Greg Palko (21:01):

One of the things that's really important is that it requires a partnership between not only what we do, but our dermatology group, our patients. We focus a lot on education, so the importance of identifying patients with CTCL or MF and Sezary Syndrome, working with our patients to make sure that our patients' voice are included as early on in the process, whether that be in the support that we can provide as an organization or even in the support we provide to our advocacy groups.

(21:35):

Again, when you think about a patient going through this process, it's rare. There's not many other patients like themselves trying to find

out information. So a lot of what we do in partnering with our patient groups, as well as our physician groups, is really try to provide better education and better effort to either diagnose the disease or even help folks decide when it actually becomes a cutaneous T-cell lymphoma, how do you better stage it so that you can get patients directed to not only experts, but the best therapies and also the best prognosis?