Participants believed that they were not at risk for skin cancer (65 of 100), while 35% believed that they had some risk (35 of 100). Sixty-eight participants indicated that they participated in sun-exposing outdoor activity (41 with no perceived risk, 27 with some perceived risk). Seven percent of subjects who perceived risk for skin cancer (2 of 27) spent less than 2 hours in sun-exposing recreation per week (P = .01 compared with those who perceived no risk). Seventy-four percent of subjects who perceived risk for skin cancer (20 of 27) spent 2 to 5 hours in sun-exposing recreation per week (P = .01 compared with those who perceived no risk). These data are summarized in Table 2. No statistically significant association was found between the use of sunscreen or reaction to the sun and perception of risk for skin cancer in the ethnic population. No statistically significant association was found between ethnicity and perception of risk for skin cancer.

Twenty-two participants had children younger than 12 years who participated in sun-exposing recreation. Fifty-five percent used sunscreen sometimes or most of the time (n = 12) and 32% reported never using any form of sun protection (n = 7).

Comment. While 43% of the subjects in this pilot study of principally African American people reported the ability to sunburn (n = 43), 35% perceived some risk of developing skin cancer (n = 35). Thus, skin cancer risk perception is less than the risk that can be inferred from the biological reaction of experiencing sunburn. The relatively lower incidence of skin cancer in persons with skin phototypes III through VI and the belief that having increased pigmentation reduces the risk of skin cancer may contribute to this low risk perception. Although a trend was noted toward sun-protective behavior among persons with ethnic skin who believed themselves to be at risk, knowledge that sun exposure may increase the risk for skin cancer does not seem to affect sun-protective behavior. Despite 96% of children of ethnic skin subjects having reported sun exposure (n = 22), a third of children with ethnic skin never used sunscreen (n = 7). These findings support the notion that the ethnic-skin adult population perception and behavior patterns appear to be perpetuated in children as well, but larger population studies are necessary.

Mina Kim, BA
Susan L. Boone, MD
Dennis P. West, PhD
Alfred W. Rademaker, PhD
Dachao Liu, MS
Roopal V. Kundu, MD

Correspondence: Dr Kundu, 550 First Ave, New York, NY 10016 (rkundu@nmff.org).

Author Contributions: Study concept and design: Kim, Boone, and Kundu. Acquisition of data: Kim and Kundu. Analysis and interpretation of data: Kim, Boone, West, Rademaker, Liu, and Kundu. Drafting of the manuscript: Kim, Rademaker, and Kundu. Critical revision of the manuscript for important intellectual content: Kim, Boone, West, Rademaker, Liu, and Kundu. Statistical analysis: Rade-

Financial Disclosure: None reported.

Assessment of Incentives for Student Loan Debt Repayment Among Recent Dermatology Residency Graduates

The shortage and geographic maldistribution of dermatologists substantially affects patient access to dermatologic care. At the same time, student loan debt has been rising at a rate far surpassing that of inflation. In light of the oft-cited proposal to use debt repayment to influence physician maldistribution, we designed survey questions to discover whether recent dermatology residency graduates would be willing to practice in underserved areas in exchange for student loan debt repayment.

Methods. Data were collected at a board review course attended by many recent residency graduates, as previously described.

Results. In 2006 and 2007, 52.0% (n = 139 of 261) and 66.0% (n = 162 of 266) of attendees completed the survey (Table). In 2006 and 2007, location was described by 73.1% as “very important” in job selection (n = 220). In 2006, 60.6% of respondents graduated with student

Table. Characteristics of Dermatology Residency Graduates With Regard to Willingness to Relocate in Exchange for Student Loan Repayment

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2006</th>
<th>2007</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents responding to survey, No.</td>
<td>139</td>
<td>162</td>
<td>151</td>
</tr>
<tr>
<td>Dermatology residents attending board review course receiving survey, No.</td>
<td>261</td>
<td>266</td>
<td>263.5</td>
</tr>
<tr>
<td>Response rate among those who received the survey, %</td>
<td>52</td>
<td>66</td>
<td>59</td>
</tr>
<tr>
<td>Capture rate among all graduating dermatology residents, %</td>
<td>46</td>
<td>52</td>
<td>49</td>
</tr>
<tr>
<td>Respondents with student loan debt, No. (%)</td>
<td>84 (60.6)</td>
<td>112 (69.1)</td>
<td>98 (64.9)</td>
</tr>
<tr>
<td>Principal of loan at graduation from residency, mean, $</td>
<td>125,688</td>
<td>139,468</td>
<td>132,578</td>
</tr>
<tr>
<td>Residents with student loan who would relocate to an underserved rural or inner-city area in exchange for repayment of debt, No. (%)</td>
<td>38 (51.4)</td>
<td>27 (28.1)</td>
<td>33 (39.7)</td>
</tr>
<tr>
<td>Minimum student debt repayment offer (paid over 3 y) resident would accept to practice in a rural or inner-city area, $</td>
<td>200,297</td>
<td>207,030</td>
<td>203,664</td>
</tr>
</tbody>
</table>

©2009 American Medical Association. All rights reserved.
loan debt (n=84) (Table), increasing to 69.1% in 2007 (n=112). The average student loan principal was $108,411 (aggregated over 2006 and 2007).

A greater proportion of respondents with debt planned to practice in a rural or inner city area (n = 43, 14.3%) compared with those without debt (n = 28, 9.3%) P = 0.5. When questioned whether they would be willing to move to a rural or inner city area for student loan debt repayment, 39.8% of respondents reported that they would be willing to move (81 of 203) (aggregated average over 2006 and 2007). The minimum repayment amount they would accept was $202,254, paid over a 3-year interval (aggregated average for 2006 and 2007, reported by the 81 respondents who were willing to move in exchange for debt repayment [29.8%]). There was a greater percentage of women among the group unwilling to relocate (74, 67.7%) relative to the group willing to relocate (n = 45, 63.3%) (P = .05). Age, marital, and parental status were not different between groups. Loan debt levels of respondents willing to relocate ($125,160) were significantly greater than those for graduates not willing to move ($106,218) (P < .05).

Comment. Limitations of this analysis include overall response rates and the self-reported nature of the data. In addition, in 2006 and 2007, only 67.8% of survey respondents answered the question on willingness to relocate in exchange for debt repayment (203 of 299).

Current loan repayment programs,6 which provide $25,000 to $30,000 per year, are not likely to influence the decisions of dermatology graduates who cite higher amounts needed for them to move to an underserved area (29.8%). There was a greater percentage of women among the group unwilling to relocate (74, 67.7%) relative to the group willing to relocate (n = 45, 63.3%) (P = .05). Age, marital, and parental status were not different between groups. Loan debt levels of respondents willing to relocate ($125,160) were significantly greater than those for graduates not willing to move ($106,218) (P < .05).

Other solutions to address geographic maldistribution include increased incentives, research funding, accelerated tenure tracks, community health projects, and expanded telemedicine access. The Department of Education plans to eliminate the Economic Hardship Deferment program in 2009, which allows deferment of educational loans during residency. Given rising debt levels, subspecialty organizations need to exert their influence to encourage continuation of these programs.

Emily P. Tierney, MD
Sunil Kalia, MD
Alexa Boer Kimball, MD, MPH

Correspondence: Dr Kimball, Clinical Unit for Research Trials in Skin (CURTIS), Massachusetts General and Brigham and Women's Hospitals, Harvard Medical School, 50 Staniford St, No. 246, Boston, MA 02114 (harvardskinstudies@partners.org).

Financial Disclosure: None reported.

Author Contributions: Study concept and design: Tierney and Kimball. Acquisition of data: Tierney, Kalia, and Kimball. Analysis and interpretation of data: Tierney and Kimball. Drafting of the manuscript: Tierney. Critical revision of the manuscript for important intellectual content: Tierney, Kalia, and Kimball. Statistical analysis: Tierney and Kimball. Obtained funding: Tierney. Administrative, technical, and material support: Tierney, Kalia, and Kimball. Study supervision: Tierney, Kalia, and Kimball.

Previous Presentation: Portions of this work were presented at the Association of American Medical Colleges workforce conference, April 30, 2008; Crystal City, Virginia.


COMMENTS AND OPINIONS

Alibert Lymphoma: Renaming Mycosis Fungoides

In his editorial “Clinical Research in Cutaneous T-Cell Lymphoma Moving Forward,”1 Serry appropriately recognizes dermatology’s leadership role in accurately codifying cutaneous lymphomas and providing the foundation for their current classification.2 The term mycosis fungoides (MF), however, is still retained as the name of the most common type of cutaneous T-cell lymphoma.

In 1806, French dermatologist Louis Alibert, MD,3 published observations of a malady affecting the skin with unsightly tumors. He named the condition MF based on a morphologic description of the cutaneous tumors’ mushroomlike appearance. The spectrum of MF’s clinical expression was subsequently expanded to include scaling patches, infiltrated plaques, erythroderma, and progression involving extracutaneous sites (lymph nodes, blood, and viscera). The pathognomonic histopathologic characteristic was the presence of “monster cells” with cerebriform nuclear contours. The overlapping clinicopathologic features of MF with Sézary syndrome (SS) (exfoliative erythroderma, lymphadenopathy, and circulating cerebriform cells) was described in 1938.4 (For a review of the historical perspective, see Patterson and Edelson.)5

It was not until the 1970s that MF and SS were defined as lymphoma of T-cell origin, leading Edelson6 to introduce the more precise term cutaneous T-cell lymphoma (CTCL). Subsequently, the name CTCL was accepted as a standard cutaneous lymphoma classification but used more broadly to encompass all variants of primary cutaneous lymphomas with a T-cell phenotype. Within the current World Health Organization–European Organization for Research and Treatment of