DERMATOLOGY RESIDENCY MANUAL

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(Revised 7/2019)

DERMATOLOGY RESIDENCY MANAUL

ISLAND DERMATOLOGY
WESTERN UNIVERSITY OF HEALTH SCIENCES – OPTI WEST

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INTRODUCTION

This document has been developed by the Dermatology Residency Program in order to familiarize residents with Island Dermatology Dermatology Residency and provide information about working conditions, key policies, procedures, and benefits affecting the residency program.

CHANGES IN POLICY

This manual supersedes all previous Dermatology residency manuals and memos. While every effort is made to keep the contents of this document current, CVMC/WUHS Dermatology Residency reserves the right to modify, suspend, or terminate any of the policies, procedures, and/or benefits described in the manual with or without prior notice to employees.

TERMS OF SERVICE

Dermatology Residency training is thirty-six (36) months. The contract will be issued for a period of one year. Contracts for the next year of training will be issued in each year upon satisfactory performance during the current year. The Program Director, Director of Medical Education, the Clinical Competency Committee and the Graduate Medical Education Committee will determine if continuation in the training program will be granted.

Under qualifying circumstances, residencies may be extended through the FMLA. All leaves must be reported to the Program Director and the Director of Medical Education, the Graduate Medical Education Committee, Human Resources and the subcommittee on Residency Training of the American Osteopathic Association and/or American Osteopathic College of Dermatology. All additional time taken off during residency must be made up at the end of the contract year and prior to the next level of training.

You are an employee of the Island Dermatology Inc. As a resident employee, you are responsible to the Clinic Director and Program Director. The clinic is liable for your acts. Remember – You will not be covered by malpractice insurance unless you are on an approved rotation.

MISSION

The mission of the osteopathic dermatology training program is to provide residents with comprehensive structured cognitive and clinical education that

will enable them to become competent, proficient and professional osteopathic dermatologists.

What Is An Osteopathic Dermatologist?

As complete physicians of medicine, D.O.s specialize in all the major specialties and subspecialties. D.O.s who specialize in dermatology have completed a rigorous program of medical education and training that includes:

- Obtaining an undergraduate B.S. or a B.A. degree
- Completing four years of general medical education at one of 20 federally accredited osteopathic medical schools resulting in the awarding of the D.O. (Doctor of Osteopathy) degree
- Completing one year federally accredited internship program in general medicine
- Completing a three year federally accredited residency program in dermatology
- Dermatology subspecialists have one to two more years of subspecialty training

The training for an osteopathic dermatologist is the same as an allopathic of M.D. dermatologist. The curriculum consists of concentrated study of the skin, hair and nails. Although physicians in other specialties, based on their training and level of personal interest may feel comfortable with basic skin problems, the physician emerging from this training, whether D.O. or M.D., will have the greatest degree of knowledge and understanding of how to approach and care for the largest organ of the body – the skin. Dermatologists focus on how your skin, hair and nails affect (and is affected by) your health.

PROGRAM DESCRIPTION

Program Director : Navid Nami, D.O.

The residency program in dermatology encompasses three years. It provides exposure to clinical, surgical and cosmetic dermatology. Multiple diagnostic and dermatologic physical modalities are employed for a variety of neonatal, pediatric, adolescent, adult and geriatric dermatologic conditions.

The training program will adequately prepare the resident to pass the American Board of Dermatology certifying examination and to practice dermatology. The program director and trainers will help guide the resident in an orderly progression from the basic sciences and theories of dermatology to the complexities of diagnosis and treatment.

The program emphasizes supervised, directed patient care and progressive experience, utilizing various surgical and physical modalities that the resident learns during the three years of the residency program. Besides direct patient care, there are daily-directed sessions, as well as reviews of histories, physical examinations and surgical techniques employed by the residents. The residents also attend weekly didactics, a monthly journal club, weekly histopathology sessions and monthly grand rounds at a major university.

PROGRAM GOALS

- To provide training that integrates basic medical sciences with clinical medicine in an orderly, progressive, and academic manner from a defined department of dermatology.
- To provide training that integrates the core competencies.
- To provide the resident with progressive responsibilities, commencing with general medicine skills and progressing to complete care of patients in need of dermatologic care.
- To develop the teaching skills of the dermatology residents.
- To develop medical ethics and interpersonal skills of the residents.
- To develop an interest in and understanding of research in dermatology.
- To develop professional leadership and management skills of the residents.
- To provide learning experiences based on measureable objectives for the education of residents during a three-year residency program.
- To prepare the resident to meet certification requirements of the American Board of Dermatology.

DERMATOLOGY RESIDENCY

FACULTY

Island Dermatology / OPTI West Dermatology Residency is an AOA/AOCD approved and ACGME approved training program with six (6) approved positions.

Director of Medical Education: In Transition
Administrator of Medical Education: Donna Dye

Website : www.westernderm.com

Dermatology Faculty:

- Navid Nami, D.O.
- David Horowitz, D.O.
- Leela Athalye, D.O.
- Leila Ettefagh, M.D
- Mike Kassardjian, D.O.
- Arian Mowlavi, M.D.
- Stephanie Martin, M.D.
- Arline Tsuchiya, M.D.
- Will Kirby, D.O.
- Jennifer Lazarro, D.O.
- Dana Ellis, M.D.

DERMATOLOGY RESIDENCY

FACULTY

Mohs Surgery:

- Stephanie Martin, M.D.

Plastic and Reconstructive Surgery:

- Arian Mowlavi, M.D.

Cosmetic Dermatology:

- Will Kirby, D.O.
- Danna Ellis, M.D.
- Navid Nami, D.O.

Hair Transplantation:

- Christopher Varona, D.O.

Travel and Tropical Medicine:

- David Horowitz, D.O.

Dermatopathology:

- Paul K. Shitabata, M.D.
- Yong Tao, M.D.

DERMATOLOGY RESIDENCY

AFFILIATED TRAINING SITES

Director : Navid Nami, D.O.

Island Dermatology
360 San Miguel Drive #501
Newport Beach, CA 92660

Advanced Dermatology
210 South Grand Ave #208
Glendora, CA 91741

Dermatology Associates of Downey
8345 Firestone Blvd, Ste 310
Downey, CA 90241

Santa Ana Dermatology
2621 South Bristol, Ste 309
Santa Ana, CA 92704

Dermatopathology : Paul Shitabata, M.D.

19951 Mariner Avenue, Ste 150
Torrance, CA 90503
310-963-7284

Harbor UCLA Dermatology Clinic

1000 West Carson Street
Torrance, CA90502
Basement PCDC Clinic C
310-222-1238

Plastic Surgery: Arian Mowlavi, M.D.

32406 Coast Highway
Laguna Beach, CA 92651
949-499-4147

CURRENT RESIDENTS

- Shahjahan Shreef, D.O. – R3
- Anny Xiao, D.O. – R2
- Steve Austad, D.O. – R1
- Renee Lucero, D.O. – R1

APPLICANT REQUIREMENTS

- Have graduated from an AOA accredited college of osteopathic medicine
- Have completed an AOA approved internship
- Be and remain a member in good standing of the AOA
- Be and remain a member in good standing of the AOCD
- Be licensed in California
- Present passing board scores
- Present a curriculum vitae
- Present a personal statement
- Present a list of previous dermatology rotations
- Present three letters of reference, two being from practicing dermatologists
- Present a medical school transcript
- Present a Dean's letter

Important: This is an AOCD/AOA approved program that is privately funded. Income earning opportunities may be available in the second and third year of training.

RESIDENT SELECTION

Residents are selected from eligible applicants on the basis of preparedness and ability to benefit form the Dermatology Residency Training Program. In the selection process, we consider clinical excellence, academic scholarship, past academic performance, motivation, integrity, ability to work with others, interpersonal communication skills, and other unique characteristics. We seek candidates with high potential for leadership. This program does not discriminate with regard to gender, ethnicity, race, age, religion, national origin, sexual orientation, physical or mental disability, marital status or veteran status.

RESIDENT TRAINING SCHEDULE

- **Clinics**
  - Continuity Clinic - Island Dermatology
  - UCLA Harbor – monthly - Delphine J. Lee, M.D.
    - Continuity clinic and in-patient consult rounds
  - Plastic Surgery – weekly (R1) - Arian Mowlavi , M.D.
  - Mohs Clinic – Monthly at specific sites
  - Cosmetic Clinic – 1 week per academic year – Dr. Will Kirby, D.O.

Clinic Performance – Expectations : Outstanding quality of care is expected for all patients seen at all clinical sites. Clinical dermatology is learned by examining and treating patients, and by additional reading directed by recent patient encounters. Residents are expected to show initiative in following through on patient care issues. This means timely completion of notes and consult letters, direct communication with referring physicians when appropriate, notifying attendings of test results, following through on patient communications and acting on test findings, and personally keeping track of outstanding or unresolved issues. ***As physicians and professionals, residents are expected to actively engage in follow-up beyond clinic visits, communicate effectively with colleagues, seek help when needed, and to be vigilant in ensuring that patient matters do not fall through the cracks.*** *Clear, concise notes are expected. Residents must accurately document adequate information to comply with insurer and legal requirements. If the resident has a question, the attending should be consulted. This involves fully documenting all areas of the physical examination done and adequately detailing the problem list, treatment plan, proposed diagnostic evaluations, and patient education. All of the residents in a clinic share the responsibility of ensuring that all patients are seen, even though each resident may have his/her own patient schedule. Do not leave the clinic until all patients are seen or you have checked out with the attending.*

RESIDENT TRAINING SCHEDULE

- **Didactics**
  - Lectures – weekly
    - Andrew's book club – David Horowitz, D.O.
    - Board Review / Clinical Dermatology – Navid Nami, D.O.
    - Cosmetic Dermatology Review – Navid Nami, D.O.
    - Board Review - Mike Kassardjian, D.O.
    - UCI Dermatology Didactics
  - Dermatopathology (UCLA Harbor) – weekly
    - Paul Shitabata, M.D. / Yong Tao , M.D.
  - Journal Club – monthly (Dr. Nami / Dr. Horowitz / Dr. Kassardjian / Dr. Lazzarro)
  - Grand Rounds – UC Irvine Dept Dermatology – twice per month

Attendance - Didactic sessions are a core element of the residency program. Attendance and punctuality are required. Residents are required to sign in with the Chief Resident for all lectures they attend. Residents who arrive more than 10 minutes after the lecture start time may not sign in as present, but may be allowed to attend the remainder of the session at the discretion of the lecturer. Failure to regularly attend didactic sessions may result in academic probation and/or failure to fulfill the professionalism competency.

Cancellation – If at any time for any reason a clinic or resident activity (ie scheduled didactics, lecture, grand rounds, etc) has been cancelled, ***residents are to notify the program director as soon as possible. Cancellation of resident activity does not constitute personal time for the residents****. The program director at that time will make a decision on whether to assign the residents to another clinic, resident activity or study time.*

RESIDENT TRAINING SCHEDULE

- **Meetings / Conferences**
  - AOCD Midyear / AAD Annual
  - Optional - must be approved by program director
    - AOCD Annual
    - Greenway surgical course (3rd year residents)
    - Barron's Dermatopathology Review (3rd year residents)

- **Elective rotations** - 4 weeks (20 days) outside rotation available per year
  - Request must be submitted prior to each academic year

- **Vacation** - 2 weeks (14 days) vacation per year
  - Request must be submitted prior to each academic year
  - Annual vacation leave may not be carried over from one academic year to the next, nor may it be borrowed in advance from the following academic year.

Resident Calendars – Calendar of resident activities is provider at the beginning of each academic year. Due to the dynamic nature of scheduling there may be periodic updates and changes to the calendar. ***It is the residents responsibility to double check and make sure the events and times on the calendar match the schedule on the practice management schedule template at each of their respective clinics****. Situations that need to be avoided are having patients scheduled and no resident available (resulting in patient appointment cancellations) or resident showing up to clinic and patients have not been scheduled.*

MEDICAL MISSIONS

Most every year our residency goes on a medical mission to various countries in need of dermatologic care. This provides a diverse exposure to dermatologic disease for the residents along with much needed help for countries that are under served.

We always like to incorporate medical students when possible for this experience.

Medical missions must be approved by Program Director and will count as elective time.

Medical Missions:

- India – 2017
- Peru – 2015
- Guatmala – 2104
- Dominican Republic – 2013
- Ethiopia – 2012
- Ethiopia – 2011
- Philippines – 2010
- Kenya – 2009
- Guatemala – 2009
- Sinaloa, Mexico – 2008
- Ecuador – 2007
- Ethiopia – 2006
- Ethiopia – 2005

PROGRAM OBJECTIVE

OSTEOPATHIC CORE COMPETENCIES

The objectives of thee training program in dermatology:

A. Provide training which integrates the seven core competencies of osteopathic medicine in the teaching of basic medical sciences and clinical medicine in an orderly, progressive, and academic manner from a defined hospital department/ division of dermatology.

B. Core Competencies of the Osteopathic Profession

1. *Osteopathic Philosophy and Osteopathic Manipulative Medicine*:

   a. Residents must demonstrate and apply knowledge of accepted standards in Osteopathic Philosophy and Practices (OPP)/Osteopathic Manipulative Therapy (OMT)

2. *Medical Knowledge and Its Application into Osteopathic Medical Practice:*

   a. Residents must demonstrate and apply integrated knowledge of accepted standards of clinical medicine and OPP in dermatology, remain current with new developments in medicine and participate in lifelong learning activities, including research.

3. *Osteopathic Patient Care:*

   a. Residents must demonstrate the ability to treat patients and provide medical care that incorporates the osteopathic philosophy.

   b. The resident must demonstrate patient empathy, awareness of behavioral issues and incorporate preventive medicine and health promotion.

4. *Interpersonal and Communication Skills in Osteopathic Medical Practice:*

   a. Residents must demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health-care teams.

PROGRAM OBJECTIVE

OSTEOPATHIC CORE COMPETENCIES

5. *Professionalism in Osteopathic Medical Practice:*

   a. Residents must uphold the Osteopathic Oath in the conduct of their professional activities. This includes promoting advocacy of patient welfare, adherence to ethical principles, collaboration with health professionals, lifelong learning and sensitivity to a diverse patient population.

6. *Osteopathic Medical Practice Based Learning and Improvement:*

   a. Residents must demonstrate the ability to critically evaluate their methods of clinical practice, integrate evidence-based traditional and osteopathic medical principles into patient care, show an understanding of research methods, and improve patient care practices.

7. *System-Based Osteopathic Medical Practice:*

   a. Residents must demonstrate an understanding of health-care delivery systems and provide qualitative osteopathic patient care as well as practice cost-effective medicine within the system.

OVERALL EDUCATIONAL GOALS

Resident Skills and Competencies

Residents must demonstrate competence in the six core competencies delineated by the ACGME and ABMS:

- **Patient Care:** Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, and treatment of disease.
    - Provide care that is sensitive to each patient's age, gender, cultural, economic, and social circumstances.
    - Gather essential and accurate information about the patient
    - Synthesize clinical history, physical examination findings, laboratory results and current scientific evidence to arrive at a correct diagnosis and treatment plan.
    - Provide a written action plan for management of acute and chronic cutaneous problems.
    - Provide to patients and their families information that is necessary to understand illness and treatment.
    - Perform routine physical examination, especially the critical visual examination of the patient's skin; perform appropriate diagnostic and therapeutic procedures.
    - Provide information about skin cancer and melanoma, heritable, occupational and infectious disorders and other conditions in which prophylactic measures are appropriate· Make appropriate referrals to other medical or surgical specialists.
- **Medical Knowledge:** Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
    - Actively participate in designing and implementing basic or clinical research projects; present teaching conferences.
    - Know, critically evaluate and use current medical information and scientific evidence for patient care.
- **Practice-Based Learning and Improvement:** Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
    - Analyze one's practice experience to recognize strengths, deficiencies, and limits in knowledge and expertise.
    - Locating, appraising and assimilating evidence from scientific studies related to patient's health problems.

    - Critically review published medical literature related to patient problems.
    - Use information technology to manage information, access on-line medical information and support their own education.
    - Actively participate in the education of patients, families, students, residents and other health professionals.
- **Communication and Interpersonal Skills:** Residents are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
    - Communicate effectively with patients and families to create and sustain an appropriate professional relationship Enabling patients to be comfortable asking questions about their disease or treatment.
- **Professionalism:** Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.
    - Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest.
    - Demonstrate a commitment to ethical principles pertaining to patient privacy and autonomy, the provision or withholding of clinical care, confidentiality of patient information, informed consent, conflict of interest and business practices.
    - Demonstrate respect for the dignity of patients and colleagues as persons including their culture, age, gender and disabilities.
- **Systems-Based Practice:** Residents are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
    - Work effectively in various health care delivery settings and systems.
    - Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources.
    - Know the relative costs of procedures and treatments; ask patients how they pay for medications.
    - Advocate for quality patient care and assist patients in dealing with system complexities

In addition to the six core competencies, residents must demonstrate the following skills:

Objectives for Medical Dermatology/Resident Clinics

1. Become familiar with managing a dermatology patient in an outpatient setting.

2. Take a focused dermatologic history.

3. Perform a complete dermatologic examination.

4. Recognize and treat common dermatologic disease processes, including atopic dermatitis, psoriasis, acne vulgaris, acne rosacea, seborrheic dermatitis, bacterial infections, dermatophyte infections, viral infections and parasitic infestations.

5. Gain experience in specialized areas including: immunobullous diseases, cutaneous lymphoma, melanoma, allergy and immunology, hair disorders and pediatric dermatology.

6. Perform assessment of and develop differential diagnosis and management plans of skin cancers and pigmented lesions including: actinic keratosis, basal cell carcinoma, squamous cell carcinoma, benign nevus, dysplastic nevus, melanoma, and seborrheic keratosis.

7. Recognize and perform appropriate work-up for systemic diseases with dermatologic manifestation including: pruritus secondary to systemic disease, drug eruption, chronic urticaria, connective tissue disease.

8. Perform assessment of and develop differential diagnosis and management plans of ulcers including: venous insufficiency, arterial, hypertensive, neuropathic, infectious, pressure, pyoderma gangrenosum.

9. Learn basic biopsy and excisional surgery techniques.

10. Perform care of patients through a multidisciplinary approach.

11. Assist or perform cosmetic procedures.

12. Perform basic diagnostic laboratory tests to include:a. KOH b. Mineral oil prep c. Diagnostic hair pull/pluck d. Tzanck smear.

13. Formulate a differential diagnosis based on physical exam only.

14. Become increasingly familiar with topical and systemic therapeutics.

15. Know the principles and how to perform phototherapy.

16. Know the principles and how to perform patch testing and how to counsel patients after patch testing.

17. Recognize the cutaneous manifestations of systemic disease.

18. Understand the importance of documentation.

19. Learn basic components of coding and billing.

20. Provide counseling on skin care and sun protection

Procedures

Residents are provided the opportunity to perform procedures as they arise. Residents are expected to become proficient in the following procedures:

1. Sufficient experience and training to ensure proficiency in the following procedures, including indications, contraindications, complications, limitations and interpretation:

a. Shave biopsy

b. Punch biopsy

c. Osteopathic manipulative treatments

d. Excisional biopsy

e. Elliptical excision

f. Layered closure

g. Cryosurgery

2. Sufficient experience and training to ensure proficiency in the following procedures:

a. Laser therapy

b. Excision by the MOH's technique with supervision

c. Flaps and grafts

Additional precautions are taken to ensure proper technique and supervision:

Formal lectures and hands on instruction are used to introduce the procedure and review anatomy and indications/contraindications of the procedure.

Resident logs are reviewed and the resident is signed off as independent in the procedure.

All procedures are done under the supervision of an attending physician who is responsible for the care of that patient. This supervision can be direct or indirect, depending on the experience of the resident.

Do not start any non-emergency procedure until you obtain permission from the responsible attending physician.

Informed consent must be obtained before starting unless it is an emergency.

Procedure logs must be completed by the resident and signed by the supervising resident/attending.

Each time a procedure log is reviewed, the program director will assign a privilege status as follows:

Level I = Direct supervision only – Dermatology Residency Year 1

Level II = Perform and teach with indirect supervision – Dermatology Residency Year 2

Level III = Perform with indirect supervision; can teach and certify others – Dermatology Residency Year 3

Residents unable to master their skill level as indicated above will be assigned additional procedure assignments until such time that level is mastered. Those residents in their Dermatology Residency Year 3, will not be eligible for graduation until required skills are mastered. Individual adjustments and accommodations are made on a case-by-case basis for those residents unable to master the skills as indicated above and additional training options are constantly evaluated.

Dermatologic Surgery Clinics

1. Develop basic surgical skills and learn concepts of tissue movement.

2. Learn basic anatomy, including superficial facial anatomy, danger zones.

3. Know the various types of local anesthesia and know how to perform local anesthesia.

4. Learn about skin tension lines and orientation of elliptical excisions. 5. Learn about suture materials and needles.

6. Be able to perform suturing, including: simple interrupted, running, running locked, horizontal mattress, vertical mattress, primary layered closure.

7. Learn about flaps and concepts of tissue movement, including: transposition flap, rotational flap, advancement flap.

8. Learn about grafts, including partial thickness skin grafts, full thickness skin grafts.

9. Learn the indications for Mohs' surgery.

10. Perform elliptical excisions, Mohs' surgery, flaps and grafts under supervision.

11. Know the principles of and be able to perform laser therapy.

12. Learn about cosmetic dermatologic procedures, including sclerotherapy, botox, and skin rejuvenation.

13. Learn post-operative wound care and management of complications.

14. Maintain an accurate current surgery log.

15. During rotation through the surgery clinic residents will have thorough review and oral examination of all cutaneous oncology. Readings in Dermatologic Surgery, Cutaneous Oncology, and Dermatopathology will be assigned based on individual strengths and weaknesses.

PROGRAM REQUIREMENTS AND CONTENT

A. The program must have a on-site pre-approval inspection by the AOCD EEC**.**

B. The residency program in dermatology shall be three (3) years or 36 months in duration during which time the residents shall learn the basic classification of diseases and the pharmacodynamics of the various therapeutic agents as they relate or apply to the field of dermatology.

1. The clinical protocol must include recognition and treatment of dermatologic conditions during the chronological progression of the integumentary system (i.e., the neonatal, pediatric, adolescent, adult and geriatric cycles of life) in order to provide total health care as it relates to dermatology.

2. In addition to the basic requirements, the program shall prepare the resident in the following: mycology, allergy and immunology, dermatologic surgery and oncology, medical dermatology and dermatologic physical modalities. The clinical subjects: dermatopathology, therapeutic radiology and phototherapy, medical dermatology and dermatologic physical modalities.

C. The residency program shall include instruction on special dermatological diagnostic and surgical techniques, and other modalities in current use. The modalities shall be supervised by dermatologists proficient in their clinical applications.

D. The residency program shall include in-patient dermatology experience to allow the resident to develop skills necessary to perform standard dermatology consultations.

E. Techniques of medical writing, manuscript preparation, and manuscript presentation shall be incorporated into the residency program.

F. The residency program shall assure that the residents:

1. Provides didactic sessions on the mechanism of disease as it relates to dermatology.

2. Reviews histories, physical examinations, and other pertinent information associated with patient care and training site procedures.

3. Maintains a professional relationship with the allied medical specialties and organizations, and affirms his/her responsibilities towards specific

specialties or organizations related to osteopathic medicine and dermatology.

4. Participates annually in a standard evaluation of expertise in dermatology by oral, written and practical examinations to ascertain his/her progress in the training program.

G. 75% of the training experience must involve direct patient care. The residency program shall ensure that the educational component of patient care outweighs the service component.

H. The residency program shall provide lectures on issues pertinent to training in dermatology. These shall occur on a weekly basis in a clinic or office setting, grand rounds, clinical conferences or journal club.

I. The residency program must provide at least three months and a maximum of twelve (12) months of elective rotations outside the parent institution during the three (3) year training program. A minimum of one month of this elective time shall be provided each year, exclusive of AOCD Annual or Midyear Meetings. These rotations must be approved by the program director, and must meet the requirements of the training program and the AOA. The rotation template for each resident must be available for review.

P. There must be an affiliated dermatopathologist available to integrate clinical manifestations with gross pathology and microscopic pathology.

Q. The program shall provide educational opportunities for faculty development.

INSTITUTIONAL REQUIREMENTS

A. There must be an organized department or division of dermatology.

a. All trainers in the program must be board certified by the AOBD or American Board of Dermatology (ABD).

b. There must be a minimum of two (2) board certified osteopathic dermatologists to be trainers for every four residents.

B. Members of the Pathology department must be available to integrate clinical manifestations with gross pathology and microscopic pathology.

PROGRAM DIRECTOR / FACULTY

A. Updated faculty curricula vitae must be kept on file in the Education Office and available for review. The updated faculty curricula vitae must be submitted to the AOCD.

B. The program director shall have the following qualifications and responsibilities:

1. Qualifications:

a. Be certified in dermatology by the AOA through the AOBD or through the ABD.

b. The program director must be a member in good standing of the AOCD.

c. Have no less than five (5) years of full-time dermatology practice experience prior to assuming the responsibilities of this position.

d. Be capable of teaching a broad program in basic sciences and in clinical dermatology.

e. Maintain staff privileges as a dermatologic consultant at an accredited hospital to provide training and management of inpatient dermatologic cases.

f. The program director must hold a valid state license and be a full-time, practicing specialist in the location in which training is taking place.

2. Responsibilities:

a. The program director shall be responsible for providing a comprehensive training program which meets the goals and objectives described in the program description as well as the training requirements outlined in this document.

b. The Dermatology Residency Program Director is responsible for completion and submission of the AOCD annual report on residents in the training program. The annual reports are submitted on-line by July 31 of each calendar year. Final reports for residents who complete the program in months other than June must be submitted within 30 days of training completion. The Program Director then submits a copy of this report to the Department of Medical Education for inclusion in the resident's file.

c. The program director shall be required to submit semi-annually evaluations to the director of medical education. Copies of these evaluations shall be sent to the AOCD.

d. The program director shall be required to submit annual reports listing the names and status of current residents and new residents to AOCD Education Evaluating Committee by May of each year.

e. The program director must actively participate in at least two (2) educational programs, either the annual or midyear meeting of the AOCD twice during every resident's 3 year training cycle. Participation is defined as presenting two lectures, two "Great Cases from Osteopathic Institutions" or a combination of these.

f. The program director must attend at least two "AOCD Residency Director's Meetings" during the three-year residency program cycle of every resident. These programs will be held in conjunction with AOCD national meetings.

g. The program director shall be responsible for reviewing all oral presentations and manuscripts for publication prior to the resident submitting them. In addition, the program director must submit a signed and dated statement that the resident's oral presentation has been reviewed, thereby allowing the resident to be included in the AOCD meeting program.

h. The program director must maintain and review case reports to assist the resident in their academic evaluations throughout the training program.

i. The program directors must submit a list of their trainers to the (AOCD) every July 1st. All of the listed program faculty in the department/division must be actively involved in training residents.

RESIDENT REQUIREMENTS

1. Applicants for residency training in dermatology must have completed an AOA approved internship or an appropriate OGME1 training program**.**
2. Be and remain a member in good standing of the AOCD during training.
3. All residents, in accordance to California law, must obtain their California Medical License before the start of their second year of dermatology residency: Residents must be licensed to practice medicine in the State of California before the start of the 25th month of postdoctoral training. If, by the end of the PGY2-year a license in not obtained, all patient care and clinical work must cease. Trainees who have not obtained a California medical license within the above mentioned time frame will not be allowed further patient contact or access to patient information including medical records. **A trainee not licensed by July 1st of the required year, or a trainee whose license expires, may not do any clinical work until medical license is secured. During the period of non-licensure, the appointment, including salary, may be suspended. Resumption of training, once a California Medical License has been obtained, will be at the discretion of the Program Director and/or Department Chair.** Thereafter and for the duration of training, the California medical license must be continually maintained as a prerequisite to appointment. Of major importance, application materials and fee payment must be sent to the California Medical Board at least 9 months ahead of the appointment date (send by August for the June 30 deadline). Declining resources at the CA Medical Board have led to substantial delays in reviews of new applications. Also, in some cases, FBI fingerprint clearance may not be available for several months after the data are submitted. California licensing regulations specify that the expiration date of an initial license is the last day of the second birth month of the licensee after the date the license is issued. Therefore, in order to enjoy the full 24-month validity of an initial license, the trainee would obtain licensure during the birth month. However, the primary responsibility is to obtain a valid license by July 1 of the required year of training, regardless of the length of validity that might result. The California Medical Board requires that all physicians complete 12 hours of CME specifically related to Pain Management before the date of their *second* license renewal. For those residents who reach their second CA license renewal during residency, you can complete a free Pain Management CME course offered by the AMA online.
4. During the residency program, the resident must submit an annual report of their training to the AOCD 30 days after the end of each training year.
5. Prepare three (3) manuscript or paper during each year of training, under the direction of the program director, which is suitable for publication in medical journals and is based on assigned topics which incorporate basic and clinical sciences.

a. During the residency, at least once in the 3 year time frame, the resident must submit an abstract at the annual meeting of the AAD to the "Gross & Microscopic Symposium". Proof of an abstract's submission shall be provided along with the resident's annual reports.

b. During the resident's second year of training, the resident must submit a poster at the Annual AOA/AOCD meeting. This poster must be an individual submission, not a group project. Material derived from the work of others must be referenced.

c. During the resident's third year of training, one of the above manuscripts or papers must be presented as 20 minute lecture at the AOCD annual or midyear meetings. This presentation is considered a major presentation and should be referenced and of professional quality.

6. Utilize osteopathic therapeutics and principles on all dermatological cases that warrant these modalities or techniques.
7. Maintain a thorough log which documents supervised procedures, such as excisions, cryotherapy, laser therapy, injectable implants, intralesional therapy, sclerotherapy, electrocautery, hair transplants, PUVA, dermabrasion, chemical peels, and other dermatological surgical procedures. The utilization of osteopathic therapeutics, management of uncommon and difficult cases, (e.g., bullous disease, collagen diseases, exfoliative disorders), and cases requiring more aggressive therapy or special modalities, (e.g., methotrexate, isotretinoin, phototherapy and photopheresis), must also be documented.
8. Review articles for journal club on a monthly basis.
9. Participate in the annual in-training examination with successful completion to the approval of the Education Evaluation Committee.
10. Attend the annual AOCD spring meeting, for the educational component and support of residents.
11. Utilize osteopathic therapeutics and principles on all Dermatologic cases that warrant these modalities or techniques.
12. Shall perform a minimum of fifteen (15) inpatient hospital or nursing home consultations each year of their residency or a total of forty-five (45) in a three (3) year period.
13. Residents must assist in the training and education of interns and externs.
14. Didactic courses attended outside of the training site by the resident must be approved by the program director.
15. The resident must not participate in any outside activity that interferes with the direction or goals of the training program.
16. Because of the breadth of dermatology and the unpredictable nature of which diseases and conditions will be seen in clinical settings, dermatology requires a substantial investment of trainee time in learning outside of the clinical setting. The didactic curriculum will cover the range of diseases seen in

dermatology, but **significant and sustained self-study is absolutely essential in order to become a highly competent dermatologist. Residents have different approaches to this, but on average read 8-12 hours per week.** This reading should be directed in two primary ways: (a) Residents are required to read or review materials such as slides and/or textbook chapters in preparation for didactic sessions and small group microscope sessions. (b) Reading each evening directed by interesting cases seen during the day will facilitate increased uptake and retention of clinical knowledge. Falling behind on this reading requirement places a resident at risk of failure to achieve competence as measured by clinical performance and by the in-service examination.

17. Clinic Attendance - Residents must be available to see patients at the start of the scheduled clinic. If you are going to be late, notify the attending.

18. Patient photographs may not be taken on personal cameras, or on the native camera apps on cell phones, or PDAs. Personal PDAs may only be used for patient photographs when using HIPPA guidelines with no patient identifiers. Residents should not travel outside the clinic or hospital with any patient photos on laptop computers, phones, cameras, or other devices. If a photo needs to be transmitted to another physician from a secure drive, secure e-mail should be utilized.

19. Quality Improvement & Patient Safety Project - mentored by the program director and others, residents participate in an annual quality and safety project in order to improve patient care and learn skills necessary to take on similar types of projects in future practice.

LIST OF BOOKS, PERIODICALS AND JOURNALS @ ISLAND DERAMATOLOGY

- Bolognia ; Dermatology
- Andrews ; Disease of the skin
- Schacner ; Pediatric Dermatology
- Scharzenberger ; Requisites in General Dermatology
- Vidimos ; Requisites in Dermatologic Surgery
- Elston ; Requisites in Dermatopathology
- Pride ; Requisites in Pediatric Dermatology
- du Vier ; Clinical Dermatology
- Fitzpatrick ; Dermatology
- Fitzpatrick ; Color Atlas of Synopsis of Clinical Dermatology
- Lever; Histopathology of the skin
- Elder ; Synopsis and Atlas of Lever's Histopathology
- Hood ; Primer of Dermatopathology
- Mckee ; Pathology of the skin
- Callen; Color Atlas of Dermatology
- Spitz ; A Clinical Guide to Genetic Skin Disorders
- Gross; Mohs Surgery
- Rigel ; Cancer of the skin
- Grimes ; Aesthetic and cosmetic surgery for darker skin
- Wolfe ; Clinical Dermatology
- Ghatat ; Dermatology Differential Diagnosis & Pearls

DERMATOLOGY RESDIENTS
READING ASSIGNMENT

- **1ST YEAR**
  - **Dermatology, Jean Bolognia**
  - **Dermatopathology, Dirk Elston**

- **2ND YEAR**
  - **Pediatric Dermatology, Lawrence Schachner**
  - **Dermatopathology, Dirk Elston**

- **3RD YEAR**
  - **Cosmetic Dermatology, Murad Alam**
  - **Dermatopathology, Dirk Elston**

RESIDENT REQUIREMENTS

Educational Objectives for Dermatology Year I

1. Complete a basic dermatologic examination, including pertinent history and full body skin examination.

2. Learn the complex dermatologic vocabulary, and be able to apply it in clinical as well as didactic situations.

3. Recognize common dermatologic disease processes including:

a. Acne, rosacea and other disorders of sebaceous glands b. Non-scarring and scarring alopecia c. Eczematous dermatitis including atopic dermatitis, contact dermatitis and seborrheic dermatitis d. Psoriasiform dermatitis e. Pityriasis group f. Melanocytic neoplasms g. Vascular neoplasms i. Benign neoplasms such as seborrheic keratoses and dermatofibromas j. Malignant neoplasms such as basal cell carcinoma and squamous cell carcinoma k. Photosensitive dermatitis l. Lichenoid dermatitis m. Pigmentary disorders n. Collagen vascular diseases o. Cutaneous lymphomas p. Drug reactions q. Cutaneous bacterial, viral and fungal infections r. Arthropod infestations s. Sexually transmitted diseases t. Manifestations of HIV disease

4. Perform basic diagnostic laboratory tests to include: a. KOH b. Mineral oil prep c. Diagnostic hair pull/pluck

5. Learn basic therapeutic options for the common dermatologic processes. Become familiar with topical medications.

7. Perform an assessment of and differential diagnosis of pigmented lesions.

8. Perform basic surgical techniques including: a. Shave biopsy b. Punch biopsy c. Excisional biopsy d. Elliptical excision e. Layered closure f. Cryosurgery

9. Know the basis of and how to perform local anesthesia.

10. Maintain an accurate medical and surgical log.

11. Recognize basic histologic diagnoses: a. Malignant versus benign b. Inflammatory patterns c. Common cutaneous benign and malignant tumors of epidermis, dermis and adnexa d. Types of cells typically found in the skin e. Structures of the skin.

12. Provide a patient with counseling on skin care and photo protection.

13. Perform basic skin photography. Understand the requirements and procedure for obtaining consent to photograph.

14. Manage inpatients on the dermatology service and perform inpatient consultations.

15. Attend didactic sessions including lectures, grand rounds, journal clubs and core curriculum.

16. Know the principles and how to perform phototherapy.

17. Understand how a dermatopathology laboratory functions.

18. Know how to photograph glass slides for conferences and manipulate digital images for presentations and manuscripts.

19. Understand the line of responsibility from patient to biopsy/lab result to physician and back to patient.

20. Understand how to properly evaluate a patient with melanoma or lymphoma.

21. Record data accurately in a patient's medical record.

22. Understand the unique patient-physician relationship and its profound ethical implications.

23. Attempt to provide good continuity of care for your patients.

24. Assist in the dermatology education of interns and medical students.

RESIDENT REQUIREMENTS

Educational Objectives for Dermatology Year II

1. Will perform all objectives of YEAR 1 with increasing responsibilities.

2. Recognize the cutaneous manifestations of systemic disease.

3. Become increasingly capable of using and understanding systemic therapy to include:i Phototherapy ii. Antineoplastic therapy iii. Retinoids iv. Immunosuppressives and immunomodulators v. Pulse therapy vi. Antibiotics

4. Know the principles of and be able to perform ulcer care, including types of dressings.

5. Know the principles of radiation therapy.

6. Know the principles of and be able to perform patch testing.

7. Become increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with those disease processes.

8. Know the principles of and be able to perform laser therapy.

9. Perform an excision by the Mohs technique with supervision.

10. Perform simple flaps and grafts with supervision.

11. Perform nail biopsies and nail avulsions.

12. Expand diagnostic capabilities in histopathology. Be able to recognize and describe most dermatopathologic entities.

13. Know the principles of research methodology, and participate in a research project, clinical or basic science. 1

4. Become increasingly familiar with the art and science of consultative dermatology, including inpatients and outpatients.

15. Be familiar with the current literature in dermatology, including articles published in general medical journals.

16. Attend at least one national dermatology meeting per year.

17. Recognize immunofluorescent patterns on histology and be familiar with immunoperoxidase diagnostics.

18. Assist in the dermatology education to other residents, interns, and medical students.

RESIDENT REQUIREMENTS
Educational Objectives for Dermatology Year III

1. Perform all Year 1 and Year 2 objectives with increasing responsibility and patient care decision making.

2. Third year residents will assist in teaching the first and second year residents, interns, and medical students including preparing didactic lectures in core curriculum and dermatopathology.

RESIDENT REQUIREMENTS

Resident Graduated Responsibilities – Patient Care

a. **PGY-2** – First year residents (PGY-2) will be given significant guidance and supervision in all aspects of patient care. Every patient seen by a 1st year resident will be staffed by a member of faculty. Based upon residence progress and knowledge, the resident will be given more autonomy. By the end of the first year, the resident should be able to form a differential diagnosis, plan of treatment and/or diagnostic tests. The resident should also be able to appropriately provide histologic descriptions of their biopsies.

b. **PGY-3** – Second year residents (PGY-3) will be given appropriate supervision by the faculty. Routine follow ups and skin checks may not always be fully staffed by the attending physician. Residents are expected to provide a differential diagnosis, treatment plan, and a viable histopathologic differential for their patients. The residents will participate in teaching of junior residents as well as medical students.

c. **PGY-4** – Third year residents (PGY-4) will often serve as Chief resident if one has not already been assigned or the Chief is on an out rotation. In clinical performance, the resident will have considerable autonomy and must be able to demonstrate clinical competence and excellence. The residents must be active instructors for junior residents and medical students. The residents must show leadership skills in clinic operation and in creating and maintaining rotation schedules.

d. **PGY-2, PGY-3, PGY-4** – For all residents (2, 3, 4), surgical training is intimately tied to the demonstration of competence in increasingly complex procedures.

POLICY FOR SUPERVISION OF RESIDENTS

PURPOSE

The purpose of this policy is to ensure a defined process for supervision by an attending physician of each resident in carrying out patient care responsibilities, and to ensure that there is a mechanism for effective communication between the Graduate Medical Education Committee, the residency programs, and supervising physicians

POLICY

All medical care provided by residents shall be under the supervision of qualified attending physicians or a more senior resident or fellow. The goal of such supervision is to promote assurance of safe patient care, and the resident's maximum development of the skills, knowledge, and attitudes needed to enter the unsupervised practice of medicine.

PRINCIPLES

Supervision

All clinical services provided by resident physicians must be supervised appropriately to maintain high standards of care, safeguard patient safety, and ensure high quality education, based on patient acuity and a resident's graduated level of responsibility. Four levels of supervision are recognized:

Level 1: The supervising physician is physically present with the resident and the patient.

Level 2: Indirect supervision with direct supervision immediately available: The supervising physician is present in the hospital (or other site of patient care) and is immediately available to provide Direct Supervision. The supervisor may not be engaged in any activities (such as a patient care procedure) which would delay his/her response to a resident requiring direct supervision.

Level 3: Indirect supervision with direct supervision available: The supervising physician is not required to be present in the hospital or site of patient care, or may be in-house but engaged in patient care activities, but is immediately available through telephone or other electronic modalities and can be summoned to provide Direct Supervision.

Level 4: Oversight: The supervision is available to provide review of procedures/encounters with feedback provided after care is delivered.

Progressive Resident Responsibility

As they advance in their training program, residents should be given progressive responsibility for care of patients. Resident graded responsibilities for each level

of training are described in the individual goals and objectives for each clinical rotation. The determination of a resident's ability to provide care to patients independently, or to act in a teaching capacity is based on the resident's clinical experience, judgment, knowledge, and technical skill. It is the decision of the supervising physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility.

ROLES AND RESPONSIBILITIES

Program Director

It is the responsibility of each program director to develop written guidelines governing supervision of residents and establish categories of all resident activities according to graduated levels of responsibility and appropriate levels of supervision. These guidelines will vary according to specialty, intensity of patient care responsibilities on a given rotation, level of experience, and educational requirements in accordance with ACGME, AMA, Joint Commission, CMS and other guidelines. The Residency Program director defines the levels of responsibilities for each year of training by preparing a description for the types of clinical activities residents may perform and assures that these levels of responsibilities are communicated to residents, supervising physicians, and the medical staff. The program director establishes schedules which assign qualified faculty physicians, residents or fellows to supervise at all times and in all settings in which residents provide patient care, and informs all members of the health care team of faculty members and residents currently responsible for each patient's care. The program director establishes guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit or end-of-life decisions.

Supervising physician

All patients are the direct responsibility of an attending physician. The attending physician of record is responsible for the quality of all of the clinical care services provided to his or her patients. Accordingly, when the attending staff physician accepts a resident on the service, the attending staff physician becomes the supervising physician responsible for the supervision of the resident's patient care Supervising physicians will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care and the experience, judgment and level of training of the resident being supervised. This responsibility is exercised by observation, consultation, and direction. Fulfillment of such responsibility requires personal involvement with each patient and each resident who is providing care as part of the training experience, with sufficient duration for the supervising physician to individually delegate authority. Supervising physicians may use their discretion in allowing or disallowing residents to perform certain procedures independently, even though a resident may be credentialed to do so. The supervising physician is expected to provide the resident with timely instruction, advice, support, and feedback. The

supervising physician agrees to provide a comprehensive, written evaluation at the end of the rotation.

Supervising physicians are also responsible for determining when a resident is unable to function at a level required to provide safe, high quality care to assigned patients and must notify the Program Director of any deficiencies in medical knowledge, patient care, interpersonal communications, systems-based practice, practice-based learning, or professionalism consistent with their level of training. In addition, the supervising physician must have the authority to adjust duty hours as necessary to ensure that patients are not placed at risk by resident physicians who are overly fatigued, impaired, or otherwise not fit for duty.

Residents

Each resident is responsible for communicating significant patient care issues to the supervising medical staff physician and such communication must be documented in the medical record. Individual residents must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of services. Failure to function within graduated levels of responsibility, communicate significant patient care issues to the supervising physician, or appropriately document the level of supervising physician oversight may result in corrective action, including the removal of the resident from patient care activities. Residents must inform the program director when appropriate attending physician supervision is not readily available.

DOCUMENTATION

The medical record must clearly document the involvement of the supervising medical staff physician in resident patient care. Coding and documentation of care provided by a resident, under the supervision of a teaching physician, must be entered into the medical record by supervising physician or reflected in the resident progress note or other appropriate entries in the medical record (e.g., consultations, procedure reports, discharge summaries.

MONITORING

The quality of resident supervision is monitored through periodic department

The quality of resident supervision is monitored through periodic department reviews such as annual program review, the residents' evaluations of their faculty and rotations, and faculty evaluation of the program. The GME office shall provide oversight by monitoring resident survey responses, the internal review process, and reports of concerns. For any significant concerns regarding Residents supervision, the program director shall submit a plan for its remediation to the GME office for approval and the program director may be required to submit progress notes to the GME office until the issue is resolved.

Faculty Involvement

This protocol is written to guide residents on common circumstances that require faculty involvement.

Levels of Supervision:

Level-**1**: Direct Supervision – The supervising physician is physically present with the resident and patient

Level-**2**: Indirect Supervision:

A: *Direct supervision immediately available* – The supervising physician is physically within the confines of the site of patient care, and immediately available to provide Direct Supervision

B: *Direct supervision available* – The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone, and is available to provide Direct Supervision

Level-**3**: Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered

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	R1 – PGY2	**R2** – PGY3	**R3** – PGY4
Complex patient - Melanoma – New visit	1	2B	3
Complex patient – Melanoma – F/u visit	1	2B	3
Complex patient – SJS / TEN – New visit	1	2B	2B
Complex patient – SJS / TEN – F/u visit	1	2B	3
Transfer patient to hospital or ICU	1	2B	2B
Surgery – Excision & Repair	1	2B	3
Calling consults	1	2B	3
Talking with the patient's family	1	2B	3
Giving bad news to patient/patient's family	1	2B	3

For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and

attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

The program director must evaluate each resident's abilities based on specific criteria. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Senior residents should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. The clinical responsibilities for each resident must be based on PGY- level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

Residents and Attending Staff should inform patients of their roles in the patient's care at every new patient encounter. Faculty should delegate portions of patient care to residents. Residents should serve in a supervisory role to medical students assigned to their clinics. Senior (chief) residents at the PGY-4 levels should also serve in a supervisory role to junior residents at the PGY 1 through PGY-3 levels and to medical students.

Circumstances and events where Residents must communicate with Faculty: Residents are encouraged to communicate with supervising Faculty any time that resident feel the need to discuss any matter relating to patient-care. The following are circumstances and events where residents must communicate with supervising Faculty regardless of of level of training and experience.

- Encounters with any patient in emergency rooms.
- All new patient encounters in intensive care or critical care units or inpatient units.
- If requested to do so by other Faculty in any primary or specialty program.
- If specifically requested to do so by patients or family.
- If any error or unexpected serious adverse event is encountered at any time.
- If the Resident is uncomfortable with carrying out any aspect of patient care for any reason.
- Transferring patients to a higher level of care.
- Code blue response. Evidence of sepsis. Patient becomes hypotensive or hypertensive.
- All cases with the following diagnosis:
    - Malignant Melanoma
    - Steven Johnson Syndrome / TEN
    - DRESS Syndrome / AGEP Drug Rash

RESIDENT REQUIREMENTS

Administrative Chief Resident

- Responsible for developing annual rotation schedule.
- Ensures that all clinics are covered.
- If a clinic is cancelled, the Administrative Chief is responsible for assigning the resident to another clinic. If all clinics are maximally staffed, then the resident should be assigned to dermatopathology. If more than two residents are already assigned to dermatopathology, then residents should be assigned to work on a Department-based project.
- If a clinic is cancelled; the affected resident will contact the Chief Resident for re-assignment. Residents are accountable to the Chief Resident for ensuring that this occurs.
- Attends all didactic sessions on time.
- Communicates with all residents to determine elective requests.
- Follows all policies in resident manual when scheduling elective and vacation time.
- Assists Academic Chief in ensuring that residents are present at all community service activities.
- Assist Academic Chief in identifying conflicts in the schedule.
- Reviews and updates the resident manual as needed.
- Maintains excellent communication and cooperation.
- Works in alignment with the Department mission.
- Functions as Academic Chief in absence of Academic Chief.
- As a member of the Department management team, advocates positively when communicating initiatives with residents.
- In communications with faculty, acts as advocate for the residents.

RESIDENT REQUIREMENTS

Academic Chief Resident

- Responsible for organizing monthly didactic schedules.
- Distributes schedules monthly via email to residents, faculty, and Residency Coordinator.
- Communicates all changes in academic/didactic schedule to all residents, residents, Residency Coordinator, Administrator, and faculty.
- Attends all didactic sessions on time.
- Follows all policies in department resident manual and hospital resident/resident manual.
- Work with Residency Coordinator to organize resident orientation for incoming residents
- Schedules resident sessions for faculty evaluations with Residency Coordinator.
- Follows guidelines as outlined by the American Osteopathic Association as applicable.
- Assists Administrative Chief with the master schedule.
- The Academic Chief is responsible for identifying conflicts far enough in advance to allow the office Administrator time to make alternative arrangements.
- Functions as Administrative/Scheduling Chief in absence of Administrative/Scheduling Chief.
- Responsible for coordinating resident involvement in resident selection processes with Resident Coordinator.
- Maintains excellent communication and cooperation.
- Works in alignment with the Department mission.
- As a member of the Department management team, advocates positively when communicating initiatives with residents.
- In communications with faculty, acts as advocate for the residents.

RESIDENT REQUIREMENTS

LOGS

- Logging your activities is an essential part of any training program. Historically, it has been a challenge for the residents as well as trainers to have the paper work completed in a timely manner. We all tend to procrastinate with paperwork. It is an essential part of practice to adequately document your clinical work. It is a principal adopted by Medicare, third party carriers, as well as the legal profession that "if it is not documented – it did not happen".
- To avoid frustration at the end of the year, and to enhance the satisfaction within a training program, it is extremely important that timely logging of clinical activities take place.
- It is important to realize the essential nature of logging. The principal objectives for this are:
    - 1. Document to certifying agencies that you have accomplished a significant amount of clinical exposure and expertise to have graduated or to be certified and/or credentialed.
    - 2. To document for the Department of Medical Education, the individual program directors and trainers, that the education program is serving their individual educational goals and providing the trainee with adequate opportunity to learn. Outside accrediting inspection agencies do, in the normal course of their review process, examine trainee logs.
    - 3. To document your experience, for the purposes of applying for hospital privileges in the future. This point is the most important and concrete for the individual trainee. It is your personal future! Do not assume that by doing rotations at any particular institution that privileges will automatically flow so that logs need not be kept. Documentation is frequently important when providing letter of reference for future training programs and/or when applying for staff privileges.
- Responsibility of logs lies exclusively on the shoulders of the individual trainee, and is an American Osteopathic Association requirement for graduation from the program. 2
- Log entries should be easily verifiable. It is a normal course of the hospital inspection for an inspector to request records. Charts are pulled for
- verification that the trainee participated in the care of a patient. Therefore, the logs should include some evidence of the level of involvement in the case.
- The responsibility for archiving the logs falls primarily on the shoulders of the trainee. The fact that the original copies are handed to the Medical Education Office, should not give the trainee a false sense of security that the documentation is safely stowed away. Record catastrophes do happen. It is; therefore, strongly emphasized that all logs and records be copied and retained in the intern's personal possession.

- Any continuity clinic encounter should be recorded. Include the patient's name, identification number, or other indicator as well as the diagnosis or multiple diagnoses and level of involvement.
- Procedures are particularly important. Institutions when credentialing frequently request documentation of experiences.
- Any outside educational experience including: Academy meetings, educational seminars, and programs that are not held in-house or recorded in any other manner. We do maintain records internally of lectures, presentations and meetings. All activities out of the institutional walls would be lost unless included in your logs.
- Be as specific as possible. Include name or initials, date, place, preceptor, and level of involvement. This last item is most important for procedures that you may want privileges for (i.e., observed 15 flaps, participated or assisted in 20, did 2 under observation).
- In short, logs help to aid the function of the program, but most directly benefit you. Keep them current, and complete them in an organized manner. Do not procrastinate! The Program Director may call for the logs at any time during the year for spot review. They are your responsibility.
- To underscore the importance of this activity and to insure timely compliance, the policy on log and evaluation completion will be on the same basis as any medical record within the hospital. The educational objective here exceeds assuring mechanical compliance with submitting logs. It is designed to encourage a physician early in his career, the ability to follow through with the medical record in a timely manner. This is a shared expectation of all institutions that you will be involved with, so that it is appropriate to establish good habits from the beginning

CURRICULUM – GOALS AND OBJECTIVES

- **Dermatopathology**
  - Attend all dermatopathology lectures and conferences. Prepare by reading ahead.
  - Understand the clinical behavior, histologic evaluation, staging and treatment protocols of malignant melanoma and cutaneous lymphoma.
  - Spend adequate time at the microscope, both with an attending dermatopathologist and with the glass slide teaching sets, to learn the proper and systematic manner of evaluating a histologic specimen.
  - Become familiar with the histology of normal skin and associated structures.
  - Learn the histopathology of common dermatologic lesions.
  - Understand the clinicopathologic correlations of dermatologic processes, including visual appearances, level of skin involvement and pattern recognition.
  - Be able to develop a differential diagnosis, given an unknown glass slide.
  - Be able to photograph glass slides for conferences and manipulate digital images for teaching.
  - By the third year, be able to evaluate and diagnose routine dermatopathology cases without help from attendings.
  - Publish at least one paper on a topic using dermatopathology (case report, special study) in the three year residency.

- **Surgery**
  - Develop basic surgical skills and learn concepts of tissue movement.
  - Learn basic anatomy, including superficial facial anatomy, danger zones.
  - Know the various types of local anesthesia and know how to perform local anesthesia.
  - Learn about skin tension lines and orientation of elliptical excisions.
  - Learn about suture materials and needles.
  - Be able to perform suturing, including: simple interrupted, running, running locked, horizontal mattress, vertical mattress, primary layered closure.
  - Learn about flaps and concepts of tissue movement, including: transposition flap, rotational flap, advancement flap.
  - Learn about grafts, including partial thickness skin grafts, full thickness skin grafts. 9
  - Learn the indications for Mohs' surgery.

- Perform elliptical excisions, Mohs' surgery, flaps and grafts under supervision. 1
- Know the principles of and be able to perform laser therapy.
- Learn about cosmetic dermatologic procedures, including sclerotherapy, botox, and skin rejuvenation.
- Learn post-operative wound care and management of complications.
- Maintain an accurate current surgery log.

- **Continuity Clinic**
  - The goal of the continuity clinic is to create a Dermatology Clinic experience that is designed to prepare dermatology residents for ambulatory-based dermatology.
  - The Clinic will facilitate the diagnostic and therapeutic skills of physicians in training utilizing patients representing the full spectrum of Dermatology.
  - While all clinics are staffed with an attending physician, each resident's responsibility will progressively increase from year 1 to year 3. This will include patient evaluation, diagnosis, therapeutics and procedures. The resident should become comfortable in all aspects of patient care and evaluation in order to manage patients on his/her own following graduation from residency.
  - Dermatology residents will be supervised by an attending dermatologist. Cases will be discussed and all charts will be reviewed. The resident will be exposed to a broad spectrum of dermatologic cases and will be taught to apply the concepts of disease prevention and health maintenance. Residents are required to maintain an ambulatory log that will be maintained in each resident's personnel file.
  - The resident will be exposed to osteopathic concepts, medical care, medical ethics, medical-legal implications and practice management throughout the course of their training .
  - Residents will be evaluated by the attending physician on their ability to perform a comprehensive history and physical examination.
  - Residents will be evaluated continuously with respect to participation in quality of charting, overall progress in clinic, attitude, professionalism and procedural skills.
  - Teaching during clinic sessions occurs informally with discussion of various dermatology topics as they pertain to the diagnoses of the patients seen in the clinic. Resident notes are reviewed by the supervising clinic attending(s) and teaching points are reviewed with the resident.
  - Charting will be in standard SOAP forma. All charting by residents is reviewed and cosigned by the resident's teaching attending and are completed during the assigned clinic.

- Feedback regarding the resident's documentation will occur during the clinic session and compiled for inclusion in the resident's annual performance review will be made.
- Residents will develop proficiency in various procedures. The preceptor staffs all procedures performed in the Dermatology Clinic.
- Any canceled clinic days requires two (2) weeks advanced notice and will be made up by the resident in discussion with the Clinic Director and staff. The only exception is emergencies, which require immediate notification of the Clinic Director.
- Recognize common dermatologic disease processes, including atopic dermatitis, psoriasis, acne vulgaris, acne rosacea, seborrheic dermatitis, bacterial infections, dermatophyte infections, viral infections and parasitic infestations.
- Gain experience in specialized areas including: immunobullous diseases, cutaneous lymphoma, melanoma, contact dermatitis, hair disorders and pediatric dermatology. '
- Perform assessment of and develop differential diagnosis and management plans of skin cancers and pigmented lesions including: actinic keratosis, basal cell carcinoma, squamous cell carcinoma, common banal nevus, dysplastic nevus, melanoma, and seborrheic keratosis.
- Recognize and perform appropriate work-up for systemic diseases with dermatologic manifestation including: pruritus secondary to systemic disease, drug eruption, chronic urticaria, connective tissue disease.
- Perform assessment of and develop differential diagnosis and management plans of ulcers including: venous insufficiency, arterial, hypertensive, neuropathic, infectious, pressure, pyoderma gangrenosum.
- Learn basic biopsy and excisional surgery techniques.
- Perform care of patients through a multidisciplinary approach.
- Assist or perform cosmetic procedures.
- Perform basic diagnostic laboratory tests to include:
    - a. KOH b. Mineral oil prep / Diagnostic hair pull/pluck
- Formulate a differential diagnosis based on physical exam only.
- Become increasingly familiar with topical and systemic therapeutics.
- Know the principles and how to perform phototherapy.
- Know the principles and how to perform patch testing and how to counsel patients after patch testing.
- Recognize the cutaneous manifestations of systemic disease.
- Understand the importance of documentation.
- Learn basic components of coding and billing.
- Provide counseling on skin care and sun protection

- **Consults – In-patient**
  - Residents will be expected to participate in a minimum of 15 inpatient consultations per year or a total of 45 over the course of their training.
  - Get the patient's name, MR#, attending name and the specific question to be answered.
  - Get a contact person and pager for someone who will be available late in the day/evening so that you can transmit consultation recommendations
  - Always request a full dermatological consultation even if the primary service asks only for a skin biopsy. Should a primary service refuse full consultation, you should still write a consult and biopsy procedure note, but you should document the reason you are not staffing and you should not charge the services.
  - Verify patient identity before beginning examination and/or procedure by checking the patient identification bracelet and asking the patient to confirm their birth date.
  - Review the patient's chart and perform a complete skin examination before staffing with the attending. If a medication reaction is suspected, go through the chart to record start dates of all medications. If the patient was recently admitted and discharged, obtain the archival chart for review as well.
  - Just before staffing, determine the whereabouts of the patients (i.e. if patient is in whirlpool they can be staffed there) and determine most efficient route to see all patients needing consultation that day.
  - Before beginning a procedure, perform and document a timeout. Time-out includes repeating verification of patient identity and confirming that you have the correct patient chart and correct labeling of specimen containers and requisitions. Also confirm that the sites selected for the procedure with the attending present were circled and documented.
  - All inpatient consults will be evaluated and presented to the attending dermatologist on service. Consult forms should be filled out succinctly and completely. The consult form should be countersigned by the attending dermatologist. Remember we provide service not only to patients, but also to referring physicians. Accordingly, we must provide excellent service to physicians who request urgent outpatient consults.
  - If a biopsy is performed on a consultation case, the resident on service will follow-up on the final diagnosis, relay the information to the ward team or to the referring physician, and for inpatients, put a copy of the final dermatopathology report in the patients' chart.
  - Triage the urgency of the consult - this will help you to plan your day. Ask if the patient will be leaving the floor (x-rays, dialysis,

whirlpool, etc). This will help you determine whether the patient may be able to be transported to the outpatient clinic to be seen and staffed with the attending. Please keep in mind that patient care supersedes ease of access of staffing the consult. Patients may need to be kept on the unit/ward if being seen by multiple medical providers, if scheduled for diagnostics tests/procedures, or if the patient's condition does not allow wheelchair transport.

- As the resident, you should review the chart, examine the patient, and document the history and exam prior to staffing with the attending.
- Before you see the patient, read the chart including the initial admission history, recent consultation reports from other services, current and recent med sheets, and laboratory results. Do not rely solely on the verbal history you heard at the time of consult request!
- Examine the patient's entire cutaneous and mucosal surface, if the patient allows. Multiple complete exams are the best way to learn variations of normal as well as to discover unsuspected pathology.
- Write the history and examination before presenting the patient to your attending.
- Before rounding with the attending, gather consult/billing sheets and equipment needed for biopsies/cultures/etc. (even if you think you will not need them).

POLICY GUIDELINES

- **Resident Responsibilities**
  - Maintain the standards of academic honesty and integrity, professional decorum and ethics as set forth by the AOA/AOCD.
  - Abide by all the rules and regulations set forth by the residency program.
  - Utilize osteopathic principles on all dermatological cases that warrant these modalities or techniques.
  - Teach residents, interns, students and other staff when appropriate.
  - Maintain self study and reading program after assigned hours.
- **Didactics**
  - Residents will attend all didactic session unless on vacation or on an away elective.
  - Attendance is mandatory at all scheduled sessions, didactic and clinical. Consistent attendance is the basis of professionalism and demonstrates respect for patients, colleagues, and teachers. We are indebted to society for supporting our medical training and have the good fortune to give back to society by acquiring as much education as possible and helping as many patients as possible. Documentation of attendance is also mandatory. Attendance is a requirement of your employment. Failure to attend violates your contractual relationship.
  - Failure to comply may result in incomplete credit for the training year and failure to receive a certificate. Residents with less than 90% attendance at lectures will not be allowed to do outside elective rotations until such time attendance percentage is achieved. Attendance will be recorded.
  - Excused absences must be approved by the program director.
  - Active participation of each resident in Journal Club is expected. Emphasis is placed on reading the literature critically and learning about recent therapeutic developments that can be utilized in clinical practice.
  - Dermatopathology is allotted two hours per week. Residents are expected to read assigned topics prior to all sessions aside from review sessions. All residents are required to attend.
  - Each week, a faculty member presents a lecture on the topic of his/her expertise. This focus is on practical therapeutics. Lectures include contact dermatitis, bullous diseases, management of common dermatoses, and surgical topics. These lectures provide an excellent way to enhance our therapeutic knowledge-base.
  - Grand Rounds, at which residents and faculty discuss complex cases, is held twice monthly at University of California Irvine Dep of Dermatology. These sessions focus on morphology, differential diagnosis, and management of interesting and challenging clinical

cases.

- **Medical Documentation**
  - The H & P is a working document and is essential for proper case management. It is a requirement to verify weekly that your charts are up to date.
  - Patient workups are to be dictated within 24 hours of admission.
  - When dictating, give patient's name, spelling it if there is any question, sex, age, hospital number, attending physician and date. If using the form, include above. Write legibly and make all marks carefully and neatly so there is no mistaking what is meant.
  - Conclude your note with your signature, printed name. SOAP format is usually acceptable.
- **Electives**
  - Elective rotations are an opportunity for the resident to explore a subject area of particular interest or to improve knowledge or skills required for graduation or future practice.
  - Residents should select rotations with the advise of the trainers to assure that any identified problem areas will be addressed if needed.
  - Residents are required to choose their elective times prior to the start of the academic year.
  - Electives are to be approved by the Program Director before scheduling can take place.
  - All offsite electives, vacations and time away for any reason will be scheduled in a way that avoids overlapping time away by multiple residents to the maximum extent possible.
  - An offsite elective can be up to four weeks (20 days) in duration.
- **Evaluations**
  - Continuing evaluation of the various parts of the Dermatology residency is essential for improvement of the program and the individual residents.
  - The resident evaluation form will be completed every 6 months by the Co-Program Directors and appropriate trainers. The results will be shared with the residents and planning for progression and improvement will occur.
  - Copies of resident's annual reports shall be submitted to the AOCD.
  - Residents will be evaluated after each rotation by the attending physician of record.
  - This evaluation of performance of each resident must be submitted to the AOCD office within 30 days of the completion of each training year. Program Director's Reports shall be reviewed annually by the AOCD Education Evaluating Committee.
  - Residents shall be given a written warning of their deficiencies.
  - We have adopted the ACGME's new milestones evaluation system to track resident competency and performance. The variety of tools above will be mapped to milestone performance. Twice a year the

department's Clinical Competence Committee will review all available data, determine resident milestone progress, and advise the program director on each resident's assessment, competence, and progress through residency.

- The training program is structured to ensure that residents assume increasing levels of responsibility commensurate with individual progress in experience, skill, knowledge, and judgment. In accordance with ACGME guidelines, residents are required to attain competence appropriate for their level of training in the six areas listed below:
  - (a) **Patient Care** that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health.
  - (b) **Medical Knowledge** about established and evolving biomedical, clinical, and cognate sciences as well as the application of this knowledge to patient care.
  - (c) **Practice-Based Learning and Improvement** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence and improvements in patient care.
  - (d) **Interpersonal and Communication Skills** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals.
  - (e) **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds.
  - (f) **Systems Based Practice** as manifested by actions that demonstrate and awareness of and responsiveness to the larger context and system of health care as well as the ability to call effectively on other resources inthe system to provide optimal health care.

- **Remediation**
  - Residents shall be asked to follow an individualized plan for remediation if they are not making satisfactory progress in the program, if they are deficient in any of the Core Competencies of the Osteopathic Profession, or if the program director identifies other concerns.
  - The written remediation plan must be developed by the program director and the resident.
  - The AOCD Education Evaluation Committee shall be informed of circumstances requiring remediation, the remediation plan and the resident's progress by the program director.
  - A copy of this plan, areas of deficiency, and assessment of progress towards remediation shall be placed in the resident's file.

e. When necessary circumstances requiring remediation include, but are not limited to:

i. Unsatisfactory performance on a core rotation

ii. Unsatisfactory clinical skills for level of training

iii. Unsatisfactory or marginal performance in one of the Core Competencies of the Osteopathic Profession for level of training.

iv. Unsatisfactory performance on the In-Training Exam

- The evaluation of faculty participation in teaching shall be noted in the resident's annual report and shall be reviewed annually by the AOCD Education Evaluating Committee.

- **Moonlighting**
  - Dermatology Residents are not required to moonlight, but are permitted to moonlight both internally and externally under certain circumstances.
  - Moonlighting for the purposes of this policy is defined as any direct patient care activity, regardless of reimbursement, other than as assigned or delegated as part of the residency training program.
  - Resident must be at least the second year of residency and licensed in the state of California.
  - Resident must be in good academic and professional standing in the program.
  - Moonlighting must be approved by the Program Director.
  - Moonlighting approval may be withdrawn without notice or cause by the Program Director.
  - Maximum of 40 hours per month. The 12-hour shift cannot be a night shift preceding a regular work day.
  - Residents who moonlight are responsible for their own medical malpractice insurance coverage while engaged in moonlighting activities. Residents who do moonlight are advised to have documented evidence of the malpractice coverage (as well as tail coverage), preferably from the insurance carrier itself.
  - Because residency education is a full-time endeavor, Dermatology Residents must ensure that moonlighting does not interfere with their ability to achieve the goals and objectives of their educational program. Residents are responsible for ensuring that moonlighting and other outside activities do not result in fatigue that might affect patient care or learning.
  - **It is the responsibility of the Dermatology Residents to obtain written permission to moonlight from the Program Director prior to applying for or beginning any**

moonlighting activity, for both "internal" and "external" moonlighting . Any and all patient care activities outside of the specific duties of the residency program are considered moonlighting, including both in-person and telemedicine activities. Other professional activities in any way related to a resident's training or experience as an physician that may generate income in the form of salary, fees, consulting payments, royalties, honoraria, stipends, stock, stock options, ownership rights, expense reimbursement, gifts, or other compensation may be considered moonlighting and must be presented to the program director for review before such activities may occur.

- Any change in moonlighting hours, activities, scope, or supervision require the written approval of the program director
- Residents must report to the program director within one business day any substantial adverse events involving injury to a patient, medical or surgical complications requiring the intervention of another physician, as well as any legal or administrative actions sought or taken against the trainee, which occur during the course of a resident's moonlighting activities.
- Program Responsibility - The Program Director will also monitor resident performance in the program to ensure that moonlighting activities are not adversely affecting patient care, learning, or resident fatigue. If the Program Director determines that the resident's performance does not meet expectations, permission to moonlight will be withdrawn.
- External moonlighting is defined as work for pay performed at a site that does not participate in the resident's training program. External moonlighting hours must be documented (including days, hours, location, and full description of type of service(s) provided) in order to comply with Medicare reimbursement requirements for GME. For external moonlighting, the resident is not covered under the University's professional liability insurance program as the activity is outside the scope of University employment. The resident is responsible for his/her own professional liability coverage (either independently or through the entity for which the trainee is moonlighting), DEA licensure, Medicare, provider number and billing training, and licensure requirements by the California Medical Board and any other requirements for clinical privileging at the employment site. **Residents performing external moonlighting will be required to file copies of all required professional liability insurance with the program coordinator before beginning such activities, as well as paid DEA licensure if prescribing any controlled substances. For dermatology residents, external moonlighting must involve appropriate supervision by a board-certified physician.** Residents must accurately disclose their level of training and position as a resident when moonlighting

externally.
    - Moonlighting must never interfere with residency responsibilities, such as studying, preparation, patient care or on-call duties. Residents will not be permitted to moonlight if their score on their most recent in-service training examination is below the standard set by the program director.
    - A resident moonlighting will need a permanent license from the State Medical Board, and would need his/her own Drug Enforcement Administration (DEA) number in order to prescribe controlled substances. They would be functioning entirely independent from their resident program and its sponsoring hospitals.
- **Work Environment**
    - Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well being. Our program goal is to ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations.
    - All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents are provided with rapid, reliable systems for communicating with supervising faculty.
    - Faculty schedules are structured to provide residents with continuous supervision and consultation.
- **Appearance**
    - The following minimum standards are offered to help the resident meet the expectations of patients, staff and trainers. These guidelines apply to situations involving contact with patients. For other residency activities not involving direct patient contact, the resident may dress in a more casual manner if the situation and supervisor allow.
    - Hair will be clean and well groomed.
    - Offensive odors are not allowed. This will require attention to personal cleanliness as well as the absence of heavy odors including excessive fragrances or cigarette smoke.
    - Clothing will be clean and well maintained.
    - No jeans, capri pants, tee shirts, athletic/open toe shoes are acceptable. Tuck in shirttails and no bare mid-drifts.
- **Needle Sticks**
    - Report the occurrence to their clinical supervisor.
    - Send or transmit a narrative description to the Program Director by the close of the next business day. Note and identify of the patient involved (if knowable).
    - Visit their personal physician for medical follow-up as soon as is prudent. Hepatitis & HIV status of the patient should be

determined within the limits of economic reality and informed consent.

- **Disability**
  - Twelve months of scheduled training must be completed to successfully obtain credit for that year of training. Thirty-six months of training in the Dermatology Residency must be completed to successfully completed the residency training program. This training must fulfill of the AOA/AOCD educational requirements.
  - Should a resident become temporarily disabled during his/her training, he/she may be granted additional leave time without pay or benefits. At the discretion of the Program Director, up to 60 days leave per year may be made up by extending the residency training program. This extension may delay board eligibility by a year for the graduating resident.
- **Absences**
  - An unauthorized absence from duty will result in disciplinary action. Any unauthorized absence of three or more consecutive business days will constitute a voluntary resignation from the program.
  - Residents are expected to work, *at a minimum,* eight hours per day, Monday through Friday at either the assigned rotation/office or fixed didactic program, as per above. If residents are unable to be at the assigned location; will be late or leave early; if the attending takes the day or potion of the day off, etc., the resident must report
  - such to the office of medical education. Failure to do so may result in disciplinary action.
  - Interviews, mini-auditions, and off site travel during the workweek in preparation for practice building or relocation is included within vacation. Residents must keep in mind at the beginning of the year to remember to save vacation time for interviews. Unless institutional policy mandates a longer approval period, all interview time/mini-auditions, etc. must be submitted for approval 12 weeks in advance.
  - The resident must arrange for another resident to cover the service, notify the practice manager, MA station and attending involved that you will be off the premises, and provide the name of the resident covering the service.
  - Sick time is granted at the discretion of the program director. Three(3) days of sick time will be permitted each year. If a resident is unable to report to duty due to illness, he/she is to notify the Program Director, Department of Medical Education, the attending physician that the resident is rotating with.
- **Medication samples**

- Samples are considered to be "owned" by the physician(s) in the office. Residents will not obtain, procure or distribute samples without the permission of the owner of the samples.
- Samples are never to be sold, bartered or traded as currency or trade.

- **Grievance and complaints**
  - Situations may arise in which a resident believes he/she has not received fair treatment by a member of faculty or staff; or has a complaint about the performance, action or inaction of a member of the staff or faculty. Residents are encouraged to discuss their concerns openly with their program director, associate program director as they deem most appropriate. Retaliation against a resident for submitting a dispute through the complaint/grievance procedures will not be tolerated and will result in appropriate disciplinary actions.
  - The resident should consult with his/her program director to seek their assistance in the resolution of the issue. Every effort should be made to resolve the problem fairly and promptly at this level.
  - Complaints not resolved at this level within 30 days should be referred to the attention of the Associate Dean for GME within 2 weeks following the failure to resolve the issue at the department level. The Associate Dean for GME will seek to resolve the issue and may at his/her discretion seek advice from other members of the faculty, house staff, or staff as deemed appropriate. After such evaluation and/or consultation the Associate Dean fro GME will make a decision.
  - If the resident disagrees with the decision of the Associate Dean for GME, he/she must, within 14 days after receipt of the Director of GME's decision, notify in writing, the Director of GME, who will then convene the Review Committee to address that appeal. The review Committee will meet after receipt of the written appeal. Any member of the Review Committee (faculty or house staff) who has a potential conflict of interest, as determined by the Chair of the review Committee will not be permitted to vote. Likewise, if there is a potential conflict of interest between the chair and the appealing residents, the Review Committee will elect a temporary chair of the Review Committee for the purpose of the review. The Review Committee will make a recommendation to the Dean of the Medial School, who will then make the final decision.
- **Duty Hours / Work Environment**
  - Duty hours are defined as all clinical and academic activities related to the residency program, i.e. patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as

conferences. Duty hours do not include reading and preparation time spent away from the duty site.

- Duty hours will be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house teaching sessions, outpatient clinic hours, in- house consult activities and moonlighting. On-call periods spent outside of the hospital do NOT count towards the 80 hour cap.
- Residents will be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four week period. No at-home call can be assigned during these free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- Mandatory Time Free of Clinical Work and Education. Residents must have eight hours off between scheduled clinical work and education periods. There may be circumstances when residents choose to stay to care for their patients. This must occur within the context of the 80hour and the one-day off-in –seven requirement.
- Maximum Clinical Work and Education Period Length – Clinical and educational work periods for residents must not exceed 24 hours of continues scheduled clinical assignments.. Up to four hours of additional time may be used for: Activities related to patient safety, such as providing effective transition of care; resident education; additional resident patient care (clinical work) responsibilities must not be assigned during this time.
- Clinical and Education Work Hour Expectations. On rare occasions, after handing off all other responsibilities, a resident, on their own initiative may elect to remind or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; and/or humanistic attention to the needs of a patient or family; and/or, to attend unique educational event. These exceptional additional hours of care or education must be counted toward the 80-hour weekly limit.
- Duty periods must not exceed 16-hours in the hospital for PGY-1 residents and 24-hours in the hospital for all other residents – this rule should not impact dermatology residents.
- There are no in-house call for this residency program.
- Program Directors must monitor resident stress and fatigue and develop policies for educating faculty and residents to recognize the signs of stress and fatigue and for dealing with residents identified as stressed or fatigued.
- The Program Director determines the training and call schedule for the academic year and is responsible for monitoring the schedule for compliance to the 80-hour workweek requirement. Clinical hours fall well within the 80-hour workweek. The resident should report to either the Program Director if they are concerned they are nearing the 80 hour workweek limit as a result of frequently being

called into the hospital from home while they are on Home Call. Residents should contact the Program Director if they find themselves fatigued due to patient care responsibilities. The resident will be asked to remain at home to rest, and the training clinic and didactic schedule will be modified.

- Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well being. Our program goal is to ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations.
- All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents are provided with rapid, reliable systems for communicating with supervising faculty.
- Faculty schedules are structured to provide residents with continuous supervision and consultation.
- The program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
- The program must educate all faculty members and residents in alertness management and fatigue mitigation processes and adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
- Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective inter-professional teams that are appropriate to the delivery of care in the specialty.
- Monitoring – Each Sponsored Program Evaluation Committee and written Annual Program Evaluation shall incorporate review of the clinical learning environment including works hours and moonlighting.

- **Transitions of Care and Handoffs**
  - Clinical assignments are designed to minimize the number of transitions in patient care. On outpatient rotations, those patients with complex medical problems who are at the highest risk from transitions in care should be cared for in continuity clinics. Residents should document in the medical record adequate information to allow any physician to safely assume the care of all clinic patients, and should communicate with colleagues to ensure patient safety and maximize quality of care.
- **Stress and Fatigue**
  - Faculty assessment: Residents spend many hours each day in face to face interactions with an attending. The faculty assesses by observation residents fatigue and stress levels on a daily basis.
  - Resident self-assessment: If a resident feels that they are fatigued or that any stressors are affecting their ability to ability to function as a resident physician, he/she must bring this to the immediate attention of an attending or one of the program directors.

- If a resident reports being or is found to be under stress or fatigue that impacts his/her ability to function as a resident physician, he/she is sent home and the attending or another resident will cover the responsibility.

- **Academic Due Process and Dismissal Policies**
  - The Dermatology Residency Program abides by the Island Dermatology / Western University of Health Sciences GME Academic Due Process Policy, which sets forth administrative and academic actions. Importantly, this policy also establishes procedures that residents may use to resolve differences when such actions occur, and lays out appeals processes for certain appealable actions.
  - In accordance with the University GME Dismissal policy and the Academic Due Process Policy, a trainee may be dismissed from the Dermatology Residency Program for academic deficiencies. This action is appealable to the Director of Medical Education and the Associate Dean of Graduate Medical Education. Reasons for dismissal may include, but are not limited to the following:
    - A failure to achieve or maintain Dermatology Training Program standards in any competency area
    - A serious or repeated act or omission compromising acceptable standards of patient care, including by not limited to an act which constitutes a medical disciplinary cause or reason
    - Unprofessional, unethical or other behavior that is otherwise considered unacceptable by the Dermatology Training Program
    - A material omission or falsification of an application for the Dermatology Training Program, medical record, medical document, including billing records.
- **Parking**
  - There are designated staff/employee parking at each designated office or location of training.
  - Please request specific parking information from the office manager or coordinator at each specific location.
  - Resident parking in unauthorized locations, ie patient assigned parking may result in the vehicle being ticketed, "booted" or towed away. The residency program is not responsible for the extra costs of these violations.

Dermatology Residency – Core Lecture Series

Program Director : Navid Nami, D.O.

July		
	Wk 1	Structure and Function
	Wk 2	Structure and Function
	Wk 3	Dermatopathology Unknowns
	Wk 4	Dermatopathology Unknowns
August		
	Wk 1	Dermatopathology 101A
	Wk 2	Dermatopathology 101B
	Wk 3	Pharmacology I
	Wk 4	Pharmacology II
Sept		
	Wk 1	Adnexal Neoplasms I
	Wk 2	Adnexal Neoplasms II
	Wk 3	Bullous dz
	Wk 4	Radiation Dermatology
Oct		
	Wk 1	Osteopathic Dermatology
	Wk 2	Vasculitis
	Wk 3	Pemphigoid
	Wk 4	Pemphigus
Nov		
	Wk 1	Medication Reactions I
	Wk 2	Medication Reactions II
	Wk 3	PMN Dermatoses
	Wk 4	Histiocytosis
Dec		
	Wk 1	Melanoma
	Wk 2	Melanoma
	Wk 3	Leg Ulcers
	Wk 4	Leg Ulcers
Jan		
	Wk 1	Pregnancy Dermatoses
	Wk 2	Radiation Oncology

	Wk 3	Immunology
	Wk 4	Atopic Dermatitis
Feb		
	Wk 1	Pediatric Dermatology I - Neonatal
	Wk 2	Pediatric Dermatology II - Childhood
	Wk 3	Pediatric Dermatology III - Pigmentation
	Wk 4	Pediatric Dermatology IV - Genodermatoses
March		
	Wk 1	Pediatric Dermatology V - Vascular
	Wk 2	Coding Review
	Wk 3	Risk Management
	Wk 4	Photo-Dermatology
April		
	Wk 1	Dermatologic Surgery I
	Wk 2	Dermatologic Surgery II
	Wk 3	Dermatology Surgery III
	Wk 4	Nail disease
May		
	Wk 1	Infectious Disease - Bacteria
	Wk 2	Infectious Disease - Viral
	Wk 3	Infectious Disease - Fungi
	Wk 4	Cutaneous Lymphoma
June		
	Wk 1	Podiatry
	Wk 2	Histiocytosis / Xanthomas
	Wk 3	Mucin disorders
	Wk 4	Urticaria

ISLAND DERMATOLOGY
Dermatology Residency

RESIDENCY MANUAL 2019-20

ACKNOWLEDGMENT

I acknowledge that I have received a copy of Island Dermatology Residency Program Manual, and I do commit to read and follow these policies. I am aware that if, at any time, I have questions I should direct them to my Program Director, Director of Medical Education or the Administrative Director of Medical Education. I agree that I shall abide by its provisions. I also am aware that the residency program at any time, may on reasonable notice, change, add to, or delete from the provisions of the company policies.

I also acknowledge that I have received, reviewed and familiar with the following:

Residency Goals and Objections
Residency Milestones
ACGME FAQ

_____ _____
Resident's Printed Name PGY Level

_____ _____
Resident's Signature Date