### Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Contents</td>
<td>2</td>
</tr>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Privacy &amp; Security</td>
<td>3</td>
</tr>
<tr>
<td>Professional Appearance</td>
<td>4</td>
</tr>
<tr>
<td>Vanderbilt Clinical Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>Veterans Hospital</td>
<td>8</td>
</tr>
<tr>
<td>Standing Conferences</td>
<td>11</td>
</tr>
<tr>
<td>Appendices</td>
<td>14</td>
</tr>
<tr>
<td>I. Residency Selection</td>
<td>15</td>
</tr>
<tr>
<td>II. Educational Goals &amp; Objectives</td>
<td>17</td>
</tr>
<tr>
<td>III. Educational Objectives, Activities &amp; Evaluation Methods for Specific Areas</td>
<td>23</td>
</tr>
<tr>
<td>Clinical Dermatology</td>
<td>21</td>
</tr>
<tr>
<td>Medical Dermatology</td>
<td>32</td>
</tr>
<tr>
<td>Pediatric Dermatology</td>
<td>37</td>
</tr>
<tr>
<td>Procedural &amp; Surgical Dermatology</td>
<td>41</td>
</tr>
<tr>
<td>Cosmetic/Aesthetic Dermatology</td>
<td>47</td>
</tr>
<tr>
<td>Dermatopathology/Immunopathology</td>
<td>52</td>
</tr>
<tr>
<td>Contact Dermatitis/Occupational Dermatology</td>
<td>59</td>
</tr>
<tr>
<td>IV. Graded Responsibility and Supervisory Lines of Responsibility for Patient Care</td>
<td>63</td>
</tr>
<tr>
<td>V. Promotion</td>
<td>69</td>
</tr>
<tr>
<td>VI. Duty Hours</td>
<td>71</td>
</tr>
<tr>
<td>VII. Fatigue, Sleep Deprivation &amp; Stress</td>
<td>71</td>
</tr>
<tr>
<td>VIII. Leave Policy</td>
<td>72</td>
</tr>
<tr>
<td>IX. Moonlighting</td>
<td>76</td>
</tr>
<tr>
<td>X. Grievance Procedures</td>
<td>80</td>
</tr>
<tr>
<td>XI. Warnings, Probation &amp; Dismissals</td>
<td>81</td>
</tr>
<tr>
<td>XII. Brown Recluse Spider Bites</td>
<td>87</td>
</tr>
</tbody>
</table>
INTRODUCTION

I start by saying we are in a very exciting time in the history of Vanderbilt Dermatology. At the time of update of this handbook, we are in the final stages of getting a new Director of Dermatology who will transition Dermatology as a division of Internal Medicine to a department.

The dermatology residency at Vanderbilt University is an ACGME accredited program which strictly adheres to the requirements outlined by the American Board of Dermatology and the Vanderbilt University Council on Graduate Medical Education. The polices of the ABD and the VUMC CGME are outlined in the ABD Booklet of Information and the VUMC GME House staff manual respectively and are included by reference in this Handbook. Residents should review these documents. You are accountable for the information and policies contained therein.


The performance of each resident is evaluated by the faculty every month and more formally every 6 months. In the unlikely event that disciplinary action is required, residents are entitled to due process.

Like most dermatology training programs, ours is structured hierarchically. First year residents can expect fewer responsibilities and more supervision. Accordingly, upper level residents are given more overall responsibility, and greater privileges. Each year presents unique duties, challenges, and benefits. Every effort will be made to ensure that everyone is treated equally. If you are unable to resolve a situation, discuss the matter first with the chief residents. When necessary, Dr. Miller may be called upon to mediate.

The program requirements of the ACGME change over time as will the Vanderbilt Training Program. Your experiences within this training program are the last step in your progression to life-long learning; adapting to a changing world is encouraged. Over the coming years, it is anticipated that adjustments in the curriculum will occur to improve our training program and to continue to meet the mandates of the Board and the ACGME.

PRIVACY AND SECURITY.

There is an enormous emphasis on issues of patient privacy and computer security. Words of advice include:

- Do not discuss patient specific information in a public setting.
- DO NOT TAKE PATIENT PHOTOS ON YOUR CELL PHONE unless the photo goes straight into the patient chart without being saved on the phone.
- Our clinic walls are thin – be discrete and soft-spoken in the hallways.
- Do not include any patient identifiers in email unless specifically authorized by the patient (document this!). Always ask if you can leave a message on voice mail and document this. Use the StarPanel messaging system whenever possible.
- Do not leave yourself logged into a computer that is not under your personal observation. Anything that happens on that computer will be attributed to YOU.
- Do not leave a computer screen with patient information on it visible from the door.
- NOTHING YOU DO ON A COMPUTER SHOULD BE CONSIDERED PRIVATE! This applies to everything – emails, internet surfing. This is especially true with social networking sites.
DO NOT view an electronic medical record unless you have a specific reason to do so. Employees have been disciplined and even fired for looking into records without cause. Regular audits are performed though perhaps with more emphasis on employee or VIP patients.

- Do not leave personal information on common use computers.
- You cannot use CD burners or thumb drives at the VA. However, you can transfer files by email attachment. Such files are screened for social security numbers and dates of birth so be aware.

PROFESSIONAL APPEARANCE:
The Department of Medicine has a dress code that is to be followed. Professional dress is expected. Scrubs should be worn only in the appropriate surgical settings. OSHA appropriate and protective shoes should be worn. Residents wearing inappropriate attire will be sent home to change.

VANDERBILT CLINICAL RESPONSIBILITIES

I. Inpatient Admissions

With the move to OHO, most if not all dermatology patients will be admitted to a medical service. If admitted from the dermatology clinic, the clinic attending and resident will write a progress note in StarPanel detailing the reason for admission, relevant physical findings and expected/requested course of treatment. They will make arrangements with VUH to admit the patient under a medical service. The dermatology consult team will be notified immediately and then follow the patient during their hospital stay and provide ongoing dermatological expertise. Alternatively, the clinic attending who started the admission process may elect to work with the consult resident directly but this is likely to be rare.

II. VU Clinics

Right now, the VU Clinics primarily use written and scanned clinic documentation. Residents are expected to assist the attending by writing brief pertinent "subjective" and "objective" notes on the charts before the attending sees the patient. The "assessment" and "plan" is generally written thereafter. As training and experience increase, you are expected to include assessment and plan sections. Even at an early stage you should mentally construct your differential and plan for presentation to the attending. It is also expected that the resident will complete a procedure note for all procedures performed on a patient with which that resident is involved. It will also be approved and signed by the attending.

On Nov 2, 2017 we are changing to EPIC. You will be given times for training and it is MANDATORY that you go to them. After that, most charting will be done online except for a body map that will be scanned when necessary.

It is a Vanderbilt mandate that the problem summary be kept up-to-date. Please be sure that all new medications are listed in the appropriate area and that new diagnoses are added. This is especially true in your resident clinics. YOU ARE RESPONSIBLE FOR MAINTAINING THE PROBLEM SUMMARY FOR YOUR PATIENTS.
Residents are expected to be in the clinic during their assigned time. Be flexible and willing to assist in other clinics when needed. We have tried to evenly distribute residents according to need, but no one can anticipate all problems. A key factor to success is your willingness to bridge the gaps when they arise. If the attending is on vacation, you will be assigned to cover other clinics.

Please note: If a resident must be absent from the clinic for any reason (illness, death in family, etc.), he/she should inform Dr. Miller, the chief resident and attending personally as soon as possible. There is no exception: you should not be absent from a clinic without informing Dr. Miller, the chief resident and attending.

Check your StarPanel (and later EPIC) messages several times a day. Also check your VUMC mailbox daily for messages. You are expected to respond quickly to any patient inquiries and to inform your patients of laboratory and pathological results as quickly as possible.

II. VU Weekday Consults

Dr. Annie Dewan is our dermatology hospitalist. She will be the consult attending Mon – Thurs and will be on for 2 weeks then off for 2 weeks. While on service she will be the attending responsible for seeing the consult patients called in from 5AM – 5 PM. The attending on night and weekend call will be responsible for consult patients on Fridays and holidays as well as night time from 5 PM - 5 AM. The weeks Dr. Dewan is not on service the night/weekend attending will also take the consults Mon – Fri.

Consults are electronically paged directly to the second year consult resident and night/weekend resident via the consult pager when entered by teams in the hospital. The Consult Resident is on the Dermatopathology Rotation on weekday mornings. The consult resident will work in Dr. Dewan’s Thurs AM consult follow-up clinic as well. Between approximately 10:30 – 11:00 AM the Consult Resident will review all pages and consult activity in StarPanel and discuss the day’s consult activity with the Consult Attending. When appropriate, consult patients may be scheduled at OHO the same day or within a few days. Call Judy Montgomery at 615-936-5937 to make these arrangements. The Consult Resident will be available at OHO to see same day consult patients until 2 PM if necessary. All consults received before 5 PM should be seen the day they are requested unless otherwise specified. Consults received between 5 PM and 7 AM will be assessed on an individual basis depending on urgency and seen by the VU weeknight resident on call or the next day as appropriate (See above under weeknight call). “After hours” consults may be seen by photos; encourage the requesting team (usually the ED) to take photos and place them in the chart. Cell phone to cell phone photos SHOULD NOT be sent due to HIPPA rules. Every time you enter a patient’s chart you must have a reason and write at least a short note to explain why you pulled it up. You must also send ALL notes to the attending to review and sign off. Every attempt should be made to review the patient's case in full and write a complete and informative note. Explicit description of dermatologic therapy should be given to facilitate proper implementation. Avoid using dermatology abbreviations when writing consults. Call the covering house staff physicians and explain the diagnosis and treatment. Give them the opportunity to write the orders or ask them if they prefer that you write the orders yourself. Leave your beeper number so you can be contacted if there are any questions. To ensure credit for the consult, make sure the consulting team has placed a consult in the Wizorder electronic ordering system. We do not do “sidewalk consults”; if
asked to look at a patient informally, let the team know they need to place a consult and you must review the case with the attending. This is for your protection.

Weekday consult rounds are arranged on an individual basis with the attending. Unfortunately, when Dr. Dewan is not on the consult service you will probably round after 5 PM so plan non-work activities accordingly during your consult months. Consults called on weeknights or weekends are considered “after hours” (see below).

“Hand offs” between residents should occur in writing either via VUMC email or other devices but in all cases patient privacy must be maintained. With the move to OHO and the necessary delay in Consult Rounds, it is essential that patients remain available until rounds take place. Make sure that the patient is not likely to be discharged before your attending makes rounds. Keep your consult note in "Draft" mode until the consult is staffed. Do not access a patient's medical record unless you will be able to complete a consult note as that will show up on a privacy audit. We will increase access at the OHO clinics for patients in the ED or inpatients soon to be discharged to take some of the pressure off of you. Same day patients will, at best, have to be physically at OHO by 3 PM. Please make sure that any ED patients have insurance plans that are in network for us and are physically able to travel to OHO – we don't want someone with an MI being sent over for a wart! The consult resident will often receive calls from other outpatient clinics at VU with patients they want seen in dermatology that day for an urgent issue. This can often be arranged, but MUST be discussed with the attending that will staff the patient with you. You may add the patient to your continuity clinic if OK with that attending. Dr. Miller is always happy to staff a patient with you in her clinic but the expectation is that the consult resident will see the patient, write the note and then Dr. Miller will staff it. Do not make promises without checking insurance and attending availability first.

The biopsy bag is maintained by the consult resident, and should be kept in as well-stocked and orderly a fashion as possible. It should be left in the residents' room after hours so that it is available for the on-call resident. It is prudent to always check the bag before you go see a patient to be sure all the necessary supplies are in place.

**IV. Weeknight Call**

Weeknight after hours call (Monday through Thursday 5 p.m. to 8 a.m.) is maintained by the VU night call resident on a monthly basis. This call covers inpatient/ER consults as well as all urgent patient phone calls from the entire Vanderbilt Dermatology practice. When the dermatology answering service or VU operator receives a call, the call resident will be paged and given the information. Typical calls include refill requests, inpatient issues, ER and urgent hospital consults and occasional post-op complications (see Mohs Surgery below). If you have questions regarding a patient call, contact the chief resident or the attending on call. Do not promise a patient will be seen the next day or add them to a clinic without the attending’s permission. Remember that not all clinics take all insurance plans and most patients do not appreciate being responsible for a bill that should have been covered. If an appointment is needed, send a StarPanel message to the DermAA box (Judy) or the nurse of the attending caring for the pt. If it is a very urgent matter you can call/page the attending whose patient it is in the morning to inform them of the situation and ensure a quick response to the patient. Appointment availability and insurance issues can then be addressed.
When a consult page is entered it will be listed as routine, urgent, or emergent and the pager should beep automatically. Routine consults can be seen the following day, if that was the primary team’s intention. It is best practice to call back any consult page received regardless of the urgency listed to be sure. It is also essential to check your home Star Panel consult screen, as sometimes problems with the pagers come up and pages don’t go through. Urgent and emergent calls will be addressed within a few hours of receipt. We are trying to set a precedent that the team or physician takes photos and puts them in the chart for you to examine. You are then expected to write a note, call your attending to also review the case and send the note to the attending. IF THE CONSULTING TEAM WANTS YOU TO COME IN, YOU ARE EXPECTED TO DO SO; discuss this with your attending especially if there is a difference of opinion between you and the consulting physicians regarding the need for face to face evaluation. Depending on the case, the resident and the on call attending, that attending may defer the face to face visit to you but ALL cases will be discussed with the consult attending and the attending must sign the note.

VA consults are becoming more common. Wherever possible, have the patient seen in the VA clinic by the VA inpatient resident as soon as possible. After hours consults will be taken by the night/weekend call resident and discussed with the VA attending on call. Which attending is on call is recorded on the attending call schedule.

It is expected that you will be available to respond immediately via telephone to any urgent or stat consult request. Since many dermatology consultations require that in person examinations, make sure that you are immediately available. As a rule, do not find yourself in a location or activity such that you cannot be at the medical campus within 30 minutes of being notified.

If you are unable to contact your attending, either at the VA or at VUMC, please call Dr. Miller and if she is not available please call the Dermatology director (Dr. Byers for now).

The Weeknight Consult Resident will hand off information to the regular Consult Resident first thing in the morning for further action.

V. Weekend call

For residents, weekend call is Friday at 5pm until Monday at 8am. You will be given a weekend call schedule. If you need to change a call weekend, you must clear it with the chief resident and notify the VA operator, and the Vanderbilt operator. The chief resident will change the online schedule. Discuss the timing of consult rounds with the consult attending. It is expected that you will be available to respond immediately via telephone to any urgent or stat consult request. As a rule, when you are on call, do not find yourself in a location or activity such that you cannot be at the medical campus within 30 minutes of being notified.

VI. Dermatopathology

The VU consult resident will also participate in Dermatopathology readouts Monday through Thursday mornings, from 8:00 a.m. to about 10:00-10:30am.

With very few exceptions, pathology specimens must be submitted through PCA. Properly label your specimen with the patient’s name and MR#. Fill out a PCA requisition form (available in our clinic). Very importantly: print out a copy of the patient's insurance
information (available in StarPanel), sign, date and time the requisition form and place it in the biopsy bag. If the insurance information is not available in StarPanel, ask the front desk for assistance. Place the specimen, PCA requisition form and insurance information in the proper specimen bag and place it in the PCA pick-up basket in the appropriate pick up area. Please log the specimen in the logbook. If you have performed a biopsy after-hours, fill out the paper work and leave the biopsy in the resident room. Notify the weekday consult resident who will ensure the PCA courier picks it up.

Situations may arise where emergent cases demand immediate pathology (e.g. TEN versus staphylococcal scalded skin) or a DFA for viral infections. If your attending feels it necessary, this will need to be handled through the surgical pathology dept on the 3rd floor. During daytime hours, you may take the specimen FRESH to the Surgical Pathology cutting room and wait for the frozen to look at with the on-call Surgical Pathology fellow. After hours you will need to page the on-call pathology resident and ask very nicely.

VII. VU Mohs Surgery

2nd and 3rd year residents rotate two months per year on the Mohs surgery service. Please contact Ron or Judy before your month begins for a schedule and for dictation templates. You will rotate with the various attendings, and at times there will be 2 residents on Mohs at the same time. The attendings will help you arrange this so that you are not overlapping. The Mohs physicians mainly use dictation for documentation, and you are expected to dictate new patient notes and letters to referring physicians on all patients with whom you are involved. Discuss with your Mohs attending how they would like documentation to work with their patients.

After hours post-op Mohs calls needing more than resident assistance should first be discussed with the Mohs fellow, who will determine if the attending is necessary.

VETERANS HOSPITAL

I. Overview

The VA currently supports 5 Dermatology Residency positions. It is also a unique learning opportunity with its own set of rewards, requirements and challenges. Be prepared to meet all 3 with good humor and professionalism. Responsibilities are divided as follows:
- PGY4 - surgery, clinics, teaching junior residents and medical students.
- PGY3 - surgery, clinics, photopheresis when first years are in clinic.
- PGY2 – one (“VA1”) - inpatient consults, clinics, Monday surgery, lab OSHA check. When there is only one first year resident at the VA, the “VA1” will also do photopheresis.
- PGY2 – two (“VA2”) – photopheresis patients, clinics, Wednesday surgery

II. Inpatient consults

The vast majority of VA consults will be seen during regular clinic hours. When a consult is received, the responsible residents should call the inpatient team to discuss the case. If the patient is stable enough to come up to the 4th floor clinic, the consult resident should call the
nurses’ station WHEN THE CLINIC IS FINISHING and have the patient brought up to the clinic. The consult resident will evaluate the patient first, formulate a diagnosis and therapeutic plan and then see the patient with the VA attending of the day. If the patient is not stable enough to come up to clinic, discuss with the attending whether you both go together initially or whether you evaluate the patient and then see the patient with the attending.

Every effort should be made to see any after hours consultations the following day in clinic. If the request is emergent, the night or weekend consult resident will call the VA attending on call (this is listed on the attending call schedule) and discuss. If you are unable to contact the VA consult attending, please call Dr. Miller or Dr. Hanlon.

The VA is highly focused on having outpatient consult patients be seen within 30 days. This practice has changed the way patients enter our clinics and forced us to return a much greater percentage of patients to their PCPs. Most consults will be in the "Intake" clinics but some may pop up in other clinic settings. Be aware of this and be sure to write your note using the consult form. This "completes" the consult and gets it off the books. If you write a routine progress note in error, please open up the consult form and write a sentence pointing to the relevant progress note.

III. Photopheresis:

The VA first year is responsible for seeing all photopheresis patients. When there are 2 first years at the VA, this will be done by the “VA2” resident. The second year VA resident will cover photopheresis on Tuesday mornings during the first year’s continuity clinic. The clinic runs Monday - Thursday, with patients receiving two consecutive days of photopheresis either M-Tu or W-Th. These patients will have a paper chart where you will find their vital signs and physician order sheet which needs to be signed. Labs will also be in the chart on day #2, remember that the “post-photopheresis” specimen is not clinically relevant.

Photopheresis patients are often quite ill (usually advanced CTCL) and require a documented heart and lung exam – bring your stethoscope. However, do NOT move the patients once hooked up to the photopheresis machine as this may lose their access. See the patients prior to morning clinic or surgery if possible. Patients will often drift in and need to be seen in shifts, but attempts should be made not to be absent from clinic or surgery for a prolonged period. The patients should all be seen by lunchtime. Their CPRS notes, however, can be done at the end of AM or PM clinic. Most of the patient’s clinical information can be found in the previous notes, but please remember to change the visit number and day number. Identify the appropriate attending and designate him as a cosigner of your note, he will often add any management changes for you. Discuss with the attending any alternative treatments you feel the patient needs.

IV. VA Clinics

A. Notes: All consults need to be discussed with or seen by the attending. You must state that the case was discussed with or seen by the attending only if that physically occurred. Every VA note must be cosigned by the VA attending of the day – be sure to send all notes to the correct attending. Complete the electronic encounter form and a note in CPRS on every patient. Please be extremely careful when "cutting and pasting" content. There is a real problem with this practice. You should only cut and paste material that is relevant to that patient on that day. More and more, inappropriate material is being copied – this material may make it appear that treatments and procedures are in process when in fact they occurred some time in the past.
Also, this practice leads to unnecessarily long notes. For recurring patients, such as in the photopheresis unit, copy only very basic material from note to note, and routinely review and edit out redundant information. **It is extremely important that the day's clinic notes AND encounter forms be completed before leaving the clinic.** "Encounter forms" means coding, which you do as residents at the VA. Choose a level visit (usually 2 or 3), code procedures, and add the attending physician as primary provider. If the patient is being seen as an outpatient consult, please check that box when creating the new note, as this will remove the consult from the pending list.

B. Orders: All patient orders are done online in CPRS and must be completed before the patient leaves clinic. Return-to-clinic orders must be placed to ensure follow up. This f/u order must also be stated at the bottom of the note. If the patient has a simple problem that can be managed by his/her PCP, state so at the bottom of the note and do not schedule a dermatology f/u. Medications are ordered and can be mailed to the patient or picked up that day. If the medication you want to order is “non-formulary”, then a pharmacy non-formulary consult must be completed. Labs are ordered in CPRS except microbiology cultures, which are still filled on a paper form.

C. Biopsies: Biopsies are performed frequently at the VA. Electronic consent must be obtained for all procedures. Call the front desk using the wall pager system to request pt labels and nurse assistance. All biopsies need to be entered into the computer “DermPath log” at the time of biopsy. This log is reviewed monthly to identify patients with incomplete biopsy reports or dispositions. Please see “biopsy tracking” for more info. All of the residents also keep a small notebook with all their biopsies/labs orders, etc so you can follow them up. A pathology requisition also needs to be completely filled out. Patients need a 2-week “biopsy follow up appt” for S/R and f/u. If the pathology is benign, call the patient and cancel the f/u appt, they can then be scheduled for regular f/u as needed with the front desk.

D. Clinic Schedule: For computer scheduling purposes, each resident is assigned a "clinic" and a set number of patients, which is listed at the front desk. Please initial next to each patient as you pick up their chart so we can tell who has been seen. It is best if you see your own return patients; however, the residents do work in a pooled fashion, so just pick up whatever chart is up next. The first and third year residents typically see fewer patients due to learning and teaching duties. The second year resident usually sees more patients.

E. Biopsy tracking At the end of each month the VA-1 1st year completes the monthly quality assurance report for the previous month (i.e. at the end of June, the May report is completed). Use the standard form that will give you instructions on filling. You will use the DermPath log on the computers to access the necessary information. The biopsy results from previous month are reviewed to ensure adequate follow up. This is done by printing the “incomplete case report” from the DermPath log. You will need to make a copy for each resident year and for Donna. Each resident at the VA at that time is responsible for f/u all incomplete cases for their resident year. Any patients not yet scheduled for treatment must be contacted by phone or letter and given a follow-up appointment. The monthly QA report tracks the number of biopsies and surgical procedures performed associated adverse events, the number of inpatient consults and the number of patients with malignant biopsies not yet treated or scheduled. The attempts at follow up must be included with untreated patients (called X times, letter sent X times etc.). The completed report is returned for Dr. Hanlon's monthly QA report. Please complete the report within 2 weeks of the end of the month.
G. VA Surgery VA surgeries occur in the clinic procedure rooms. A 1st year resident (VA1) assists the 3rd year resident and the 2nd year resident assists the Mohs Fellow on Monday mornings. The 2nd year resident operates with the 3rd year resident on Tuesday mornings. The VA 3rd year and 1st year (VA2) operate on Wednesday mornings, at which time the Plastic Surgery Fellow is available for assistance. All prospective cases should be discussed with the VA 3rd year and approved by an attending. A complete pre-operative evaluation, including head map, should be completed at the time of scheduling and placed in the surgery schedule book. A note should also be saved in CPRS. Please take a photo when appropriate to help with location of lesion. Give the patient the pre-printed surgical instructions outlining the date, time and location of the procedure. Call the patient the day before the surgery to remind them. If the patient’s lesion requires Mohs surgery (>1.0cm on the face, >2.0cm on the body, within 1.0cm of eyes, lips) you must enter a Mohs Fee Basis consult in CPRS. Then fill out all the usual paperwork (head map, pre-op form), as well as printing your clinic note WITH MED LIST, and staple to Mohs planning form. This goes in the blue expandable folder at the front desk. If the patient has a very large lesion, consider plastic surgery or ENT consultation and imaging as appropriate.

H. VA Phototherapy We have a full body NB-UVB and UVA phototherapy unit and a hand-foot unit at the VA. Donna does most of the phototherapy. The password for the unit is “photo”. UV goggles and jock straps are in the room – be sure to wear goggles if you are in the room typing notes while the patient is being treated. Record treatments in the log book. Use the built in patient protocols that are set for each skin type.

STANDING CONFERENCE SCHEDULE

I. PATHOLOGY CONFERENCE Tues and Wed 7am-8am. Tuesday text review, Wed unknowns

II. RESIDENT LUNCHTIME CONFERENCES and administrative duties to be coordinated at various locations

III. ATTENDING and CORE CURRICULUM LECTURES will be scheduled on Friday mornings as much as possible

IV. GRAND ROUNDS

ALL RESIDENTS ARE REQUIRED TO ARRIVE BY 7:15 am FOR PATIENT UNKNOWNs

The patient unknown conference provides a venue for presentation of difficult dermatology cases while promoting the acquisition of diagnostic skills requisite to be a skilled clinician. Residents, faculty and community dermatologists are encouraged to bring interesting or difficult cases to the conference. Patients should arrive by 7:15 a.m. Patient viewing ends no later than 7:55 a.m. Residents should not take a history or discuss the case with the patient or with each other. The consult resident is responsible for setting up the microscope/camera in the Library. This should be done before 8:00 a.m.. Many of our community physicians must leave early to arrive at their own clinics on time and we should be as timely as possible. Residents should examine every patient in preparation to provide a gross morphologic description and differential diagnosis. At the discussion, a 1st year resident will present the physical findings and generate as much of a differential as possible, followed by the 2nd and 3rd year residents, faculty and others. Thereafter, the physician responsible for the patient provides a history, any labs, histopathology etc. The group then discusses the possible diagnoses, workup, treatment, etc.
Residents are responsible for returning the conference room to its original set-up after the conferences.

Once annually, each resident will present a 50-minute lecture at dermatology grand rounds on the topic of their choice.

CME forms including the sign-in sheet and evaluation forms will be available in the room.

V. JOURNAL CLUB

Journal club takes place monthly. The subject material alternates between medicine and surgery. Medical dermatology journal club is held the 3rd Monday evening of the month and surgery JC is the 3rd Thursday evening. Resident attendance at all journal clubs is mandatory. The assigned moderator will choose articles in advance. Residents will be assigned an article to present. Each resident will present a brief, one to two minute synopsis of the salient points prior to general discussion. You should be very familiar with your article, including study design, validity of findings, potential pitfalls etc. Although you will likely present only one article, you are required to read all of the assigned articles. Even though only certain articles will be discussed, residents are expected to read the entire Blue Journal and Archives of Dermatology.

Archives of Dermatology will be reviewed with Dr. Ellis on a Friday morning each month.

Residents are also expected to read and take the post-test for the CME article in the JAAD. These are then to be turned in MONTHLY (the same month as the CME article) to Dr. Miller.

VI. NASHVILLE DERM SOCIETY MEETINGS

These are held 2-3 times a year at night – the night of the week varies. This meeting is required for all residents except when notified by Dr. Miller it is not necessary. The Holiday party is not required but a good networking opportunity.

The Tennessee Dermatology Society also has meetings once a year. If the meeting is held in Nashville, all residents are required to attend. If out of town, residents are encouraged to go; there are usually grants available for residents to attend out of town meetings.

VII. ACADEMIC HALF DAY

Documentation of Academic Time Activities:

Documentation of all resident training activities is important and increasingly demanded by review committees and funding agencies such as the VA. Each resident is to prepare a brief monthly summary of activities accomplished during their half-day academic time and submit this to the Residency Coordinator. Time spent on leave or other than academic pursuits should be noted. Although this day may be used on occasion for appointments with physicians, dentists and other things that cannot be done on weekends, it is expected that anything that can be done after hours be done after hours; academic time is to be used for catching up on paperwork, writing journal articles, academic reading and other activities relevant to training.

ACADEMIC HALF DAYS ARE NOT VACATION DAYS. There is always a possibility that you may be pulled to work in the VA or other clinics so if you are planning on being away from your duties during academic half days you need to take vacation time to do it. This is especially
important for those with Friday afternoon academic time – do not make plans you cannot break unless you take vacation time.

VII. Procedure Log Books
You are expected to maintain log books in the New Innovations database. THIS IS REQUIRED FOR YOUR CERTIFICATION so please maintain them at least monthly. It is also required for licensure in some states and for hospital privileges in some areas so maintain these well.
# APPENDICIES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendices</td>
<td>14</td>
</tr>
<tr>
<td>I. Residency Selection</td>
<td>15</td>
</tr>
<tr>
<td>II. Educational Goals &amp; Objectives</td>
<td>17</td>
</tr>
<tr>
<td>III. Educational Objectives, Activities &amp; Evaluation Methods for Specific Areas</td>
<td>23</td>
</tr>
<tr>
<td>Clinical Dermatology</td>
<td>24</td>
</tr>
<tr>
<td>Medical Dermatology</td>
<td>32</td>
</tr>
<tr>
<td>Pediatric Dermatology</td>
<td>37</td>
</tr>
<tr>
<td>Procedural &amp; Surgical Dermatology</td>
<td>41</td>
</tr>
<tr>
<td>Cosmetic/Aesthetic Dermatology</td>
<td>47</td>
</tr>
<tr>
<td>Dermatopathology/Immunopathology</td>
<td>52</td>
</tr>
<tr>
<td>Contact Dermatitis/Occupational Dermatology</td>
<td>59</td>
</tr>
<tr>
<td>Research</td>
<td>63</td>
</tr>
<tr>
<td>IV. Graded Responsibility and Supervisory Lines of Responsibility for Patient Care</td>
<td>69</td>
</tr>
<tr>
<td>V. Promotion</td>
<td>71</td>
</tr>
<tr>
<td>VI. Duty Hours</td>
<td>71</td>
</tr>
<tr>
<td>VII. Fatigue, Sleep Deprivation &amp; Stress</td>
<td>72</td>
</tr>
<tr>
<td>VIII. Leave Policy</td>
<td>76</td>
</tr>
<tr>
<td>IX. Moonlighting</td>
<td>77</td>
</tr>
<tr>
<td>X. Grievance Procedures</td>
<td>80</td>
</tr>
<tr>
<td>XI. Warnings, Probation &amp; Dismissals</td>
<td>81</td>
</tr>
<tr>
<td>XII. Brown Recluse Spider Bites</td>
<td>87</td>
</tr>
</tbody>
</table>
Appendix I: Residency Selection Process

I. Match Program: The Division of Dermatology participates in the National Resident Matching Program (NRMP) and uses the American Association of Medical College's (AAMC) Electronic Residency Application Service (ERAS) as the primary source of resident applicants. On occasion, applicants supported by non-GME sources (e.g.; DOD, IHS), Training Grants, or otherwise have a compelling background of particular value to the program may be selected outside of the NRMP. Currently, Vanderbilt Dermatology matches 4 residents per year.

III. Initial Screen: Completed ERAS applications received by November 1 of each year constitute the applicant pool. Extenuating circumstances are considered for late applications but these are exceedingly rare. Documentation of the application consists entirely of the ERAS files downloaded to the Division.

Applications are initially reviewed by Dr. Miller; any applicant who feels their board scores or other parts of their application are not truly reflective of their candidacy for a dermatology residency may communicate directly with Dr. Miller via email to express this. Because we get to know students who rotate through the Vanderbilt Dermatology program, any student who feels face-to-face evaluation would be advantageous to their application is encouraged to come rotate. Dr. Miller compiles a list of ~ 100 applications that are distributed to other members of the residency selection committee for a more in-depth review. All aspects of the application are considered including letters of recommendation, Dean's letter, transcripts, personal statements, publications, and other information related to ancillary efforts, achievements, degrees, fellowships and leadership or community activities. The applicants selected for interview are generally at or above the accomplishment level considered average for a successful Dermatology resident.

Objective criteria derived from the ERAS application include:
- USMLE Step 1 and 2 (when available) scores.
- Performance in medical school (top half)
- Supportive letters including the Dean's Letter. Letters from dermatology mentors or teachers are particularly important.

Subjective criteria derived from the ERAS application and their performance in the course of an onsite rotation include:
- Applicant's written communication skills
- Leadership positions and presentations
- Research, publications, projects and programs
- Other accomplishments & training
- Excellent clinical rotation
- AOA status
- Academic interest and potential of the applicant.

IV. Interview Selection: Approximately 40 applications are invited for interviews. With few exceptions, students who rotate with us are automatically invited for an interview. Again, those students who feel their application does not accurately reflect contributions they could make to the program should email Dr. Miller at jami.miller@vanderbilt.edu to elaborate on this.
V. Interview Process: Applicants are interviewed in 3 groups in the December – January period. Typically the current residents host the interviewees at a casual dinner the night before. Although attendance at this dinner is not required, it is an opportunity for the dermatology residents to become acquainted with you and so every effort should be made to come to it. The first year residents in particular are members of the residency selection committee.

The following morning is set aside for a general information session and a tour of the facility. Following lunch, the residency selection committee - a group of faculty and residents - interview the applicants. This group represents all aspects of Dermatology (Medical, Pediatric, Surgical and Dermatopathology). The interview group is given access to paper copies or a CD containing the applicants' ERAS application prior to the interview. Immediately following the interviews, the evaluators meet to discuss each applicant and share the interview experience.

VI. Selection Process: The members of the residency selection committee individually submit their rankings and the data are compiled. A meeting of this group is held in early February to review the results. Other faculty members are invited to this meeting to share any information and opinions that they may have. The program director (Dr. Miller) submits the final rank list to the Division Chief for final review and then the rank list is submitted to ERAS for the Match. The final rankings reflect a broad range of considerations including the performance and aspirations of the applicants and their academic potential and related experiences evaluated in the context of the training program.

VII. Archival Process: The ERAS data of those applicants who were interviewed is saved in electronic form and archived. The remaining copies of the ERAS data are deleted from departmental computers and servers. Other relevant materials including final rank lists will also be archived.
Appendix II: Educational Goals and Objectives

**Mission:** The goal of the Vanderbilt University Dermatology Residency Program is to produce Dermatologists who are excellent clinicians, scientists, and leaders in the specialty of Dermatology. This is accomplished by a program that provides a stimulating intellectual environment where state-of-the-art clinical and basic science medicine is taught and practiced within a collegial atmosphere that fosters medical knowledge, scholarship, career-long learning, professionalism, compassion, effective communication with patients and all members of the medical team, as well as sensitivity to the cultural differences and needs of the patients we care for.

**I. Educational Objectives:**

A. Acquisition of a broad based fund of knowledge of Dermatology including the clinical presentation, etiology, pathophysiology, and treatment of dermatological diseases, as evidenced by in-service training examinations, and successful passage of the Dermatology certifying examination.

B. Development of the technical skills required for diagnosis and treatment of all Dermatologic diseases to the level of a practicing general Dermatologist.

C. Development of medical judgment skills required for the management of complex cutaneous disease.

D. Acquisition of knowledge of Dermatopathology to the level of a practicing general Dermatologist, as evidenced by in-service training examinations and successful passage of the Dermatology certifying examination.

E. Development of proficiency in professional communications skills in order to provide effective patient care, collegial professional interaction, and teaching skills to further future physicians’ and health care providers’ knowledge of Dermatology.

F. Acquisition of the use of modern educational tools to maximize lifelong professional learning.

G. Development of knowledge of the systems of medicine and cultural needs of patients and society in order to effectively practice Dermatology.

H. Encourage scientific inquiry and academic excellence through the conduct of research and by faculty support of further training efforts (fellowships), and career development.

**II. Educational Areas**

To accomplish these goals, a faculty dedicated to resident development as witnessed by patient care, teaching, and research will provide the foundation for the Dermatology Residency program. It is expected in turn that each resident will be self-motivated, responsive to guidance and constructive criticism, and dedicated to patient care as evidenced by being willing to invest the time and lifelong effort required to be an exemplary Dermatologist.

Because Dermatology is a complex field that crosses multiple fields of medicine, for the purpose of creating a cohesive program that provides an optimal learning environment, we have defined the following separate areas of Dermatology Education as the foundation of our program. This is done for the purpose of teaching all aspects of Dermatology, and for a framework upon which the annual evaluation of the effectiveness of our program can be performed. The categories are defined below, followed by the goals. The specific curricula for each separate area follow this.
A. Clinical Dermatology: Uncomplicated cutaneous diseases that are managed as an outpatient in a high volume Dermatologic practice. Includes diagnosis of diseases with modalities such as KOH (fungal diseases) and cutaneous biopsies (shave and punch biopsies) as well as treatment with topical and uncomplicated oral regimens (ie. acne), cryosurgery (verruca, actinic keratoses), shave excision (nevi, skin tags), or phototherapy.

B. Medical Dermatology: Complicated cutaneous diseases with systemic involvement that are potentially disabling or life threatening. Includes diseases such as: 1) severe psoriasis, 2) cutaneous T-cell lymphoma, 3) autoimmune blistering disorders (e.g. pemphigus), 4) autoimmune rheumatologic diseases (e.g. systemic lupus erythematosus), 5) severe drug eruptions (toxic epidermal necrolysis), 6) severe infections (e.g. Rocky Mountain Spotted Fever), and 7) pyoderma gangrenosum. These diseases often require complicated drug regimens, including the new biologic therapies, and may require inpatient management.

C. Pediatric Dermatology: Clinical and medical dermatology, along with minor surgery and diagnostic techniques for patients from the new born to 18 years of age. Includes diseases of all severity seen in children.

D. Dermatologic Surgery: Surgical management of benign and malignant cutaneous lesions. Includes Mohs micrographic surgery, laser surgery, and excisional surgery techniques.

E. Cosmetic Dermatology: Treatment of aesthetic conditions such as rhytides, actinic lentigenes, and tattoos. Includes medical and surgical procedures such as botulinum toxin and filler injections, and laser surgery.

F. Dermatopathology and Immunodermatology: Microscopic diagnosis of dermatologic diseases from pathology specimens. Includes H&E routine sections, special stains, and immunostaining.

G. Contact Dermatitis and Occupational Dermatology: Diagnosis and treatment of dermatologic occupational disorders, which to a large part are contact dermatoses. This will include skill in selecting and performing extensive patch tests.

H. Dermatologic Research: Learning research methods and performing research in cutaneous diseases. This includes, but is not limited to such methods as: biochemistry, molecular biology, immunohistochemistry, immunology, epidemiology, and outcomes research. This also includes learning to present scientific data (abstracts) at meetings, and writing scientific articles.

III. General Goals of the Residency Curriculum

A. Clinical Dermatology:

1. Acquire the communication skills required for obtaining a dermatologic history from patients with a variety of social, ethnic, and cultural backgrounds.
2. Demonstrate expertise in performing a complete dermatologic examination, as well as examinations targeted for a given disease.
3. Develop a broad range of differential diagnoses of cutaneous diseases that may be applied effectively to establishing a proper diagnosis.
4. Acquire skill in dermatologic diagnostic procedures (ie. biopsy, KOH, Tzanck smears).
5. Develop expertise in ordering and interpreting the results of diagnostic laboratory tests for dermatological disorders, including the use of the electronic record.
6. Develop expertise in the treatment of dermatological disorders, including understanding the cost of medications and their side effect profiles.
7. Develop the communications skills required to counsel patients with a variety of social, ethnic, and cultural backgrounds regarding their dermatologic diagnosis and treatment.
8. Learn how to function within varying healthcare, documentation, and reimbursement systems.

B. Medical Dermatology:
1. In addition to the above, develop expertise in ordering and interpreting the results of diagnostic laboratory tests for dermatological disorders with associated systemic medical problems.
2. Develop expertise in the treatment of dermatological disorders, including the use of systemic treatments (such as biologic therapy and photopheresis). Also acquire knowledge of the cost of medications and their side effect profiles.
3. Develop the communications skills required to counsel patients regarding their dermatologic diseases with related systemic medical problems.

C. Pediatric Dermatology:
1. Demonstrate proficiency in performing a Dermatologic history and physical for neonates, infants, children, and adolescents, including an understanding of appropriate communication with the patient and the parent or guardian.
2. Learn the diagnoses of age specific pediatric dermatoses.
3. Acquire the skills required for simple pediatric cutaneous biopsies and surgeries.
4. Demonstrate appropriate knowledge for medical therapy of pediatric diseases.

D. Dermatologic Surgery:
1. Acquire the knowledge for obtaining a Dermatologic Surgery history and physical examination.
2. Learn the principles and procedures for simple and complex Dermatologic surgical procedures, including, but not limited to simple excisions, flaps, and grafts.
3. Learn the principles and procedures for Mohs Micrographic Surgery.
4. Learn the principles and procedures for cutaneous laser surgery.
5. Demonstrate skill in postoperative management of postsurgical patients.

E. Cosmetic Surgery:
1. Acquire the knowledge and skill for taking a cosmetic history and physical.
2. Develop an understanding of the principles, risks, and benefits of cosmetic procedures.
3. Develop skills in cosmetic surgery including, but not limited to botulinum toxin and filler injections, and laser surgery.
4. Understand the ethical issues in a cosmetic surgery practice, and apply correct ethical principles in the treatment of patients.

F. Dermatopathology and Immunodermatology:
1. Learn the principles of making a histopathologic diagnosis on slides of cutaneous lesions.
2. Develop an understanding of the special stains used in dermatopathology (ie. immunoperoxidase).
3. Develop an understanding of the use of immunofluorescent stains in cutaneous skin diseases.
4. Develop communication skills required for communicating biopsy results with physicians and other members of the health care team whose patient was biopsied.
5. Acquire knowledge of the molecular techniques used in dermatopathology.

G. Contact Dermatitis and Occupational Dermatology:

1. Learn how to take a dermatologic history and do a physical for occupational dermatoses, particularly contact dermatitis.
2. Acquire the skills in properly applying and reading the required patch tests for a particular disease pattern.

H. Dermatologic Research:

1. Learn research methods to apply to a question regarding cutaneous disease.
2. Present data (abstracts) from research at a national meeting.
3. Write a manuscript from the research findings to submit to a peer-reviewed journal.

IV. Goals for Progression by Residency Year

A. PGY-2

1. Develop competence in performing an appropriate dermatologic history and physical examination through one-on-one management with teaching faculty in a variety of patients, including simple and complex patients, in the outpatient clinic, and in hospitalized patients on the Dermatology service.
2. Develop the ability to formulate a differential diagnoses based upon the primary lesion and the disease pattern through one-on-one management with teaching faculty, unknown patient conference, and kodachrome slide conferences.
3. Learn the skills required for appropriate Dermatologic procedures including but not limited to diagnostic and therapeutic skin biopsies, simple excisions, cryosurgery, acne surgery, electrodesiccation and curettage, phototherapy, photopheresis, and patch testing with teaching faculty through one-on-one management.
4. Learn how to manage simple and complex cutaneous disease, including inpatients and outpatients, topical and systemic therapy through teaching conferences, textbook conferences, and one-on-one management with teaching faculty in the outpatient and inpatient facilities.
5. Acquire core knowledge of Dermatopathology, and the basic science of cutaneous biology and disease consistent with a PGY-2 level in Dermatology through textbook conferences, teaching conferences, and meetings.
6. Prepare case presentations of patients for the quarterly Nashville Dermatology Society meeting. This includes contacting the patient, doing a summary of the medical history, and doing a literature search to present diagnostic and therapeutic options.
7. Begin developing research skills through initiating a project with a chosen mentor.

B. PGY-3

1. Continue to develop further expertise in PGY-2 goals, with increasing responsibility.
2. Develop proficiency in performing inpatient Consultations, with appropriate management and communication skills through one-on-one management with Teaching faculty.
3. Develop proficiency in Dermatopathology through conferences, and rotation on the Dermatopathology service.
4. Begin developing more advanced surgical skills through one-on-one management with teaching faculty, the Dermatologic Surgical Fellow, and senior residents.
5. Acquire proficiency in Pediatric Dermatology through one-on-one management with teaching faculty and teaching conferences.
6. Present an abstract at an appropriate national meeting on the research work started in PGY-2 year.
7. Develop documentation and coding skills.

C. PGY-4

1. Develop further expertise in PGY-2 and -3 goals, with the expectation that at the end of this year the skill level is that of a practicing Dermatologist.
2. Develop proficiency in Dermatologic Surgery, including Laser Surgery, and Cosmetic Dermatology procedures through teaching conferences and one-on-one management with teaching faculty.
3. Arrange and conduct a one month elective at the institution of the resident's choosing that will enhance the resident's education in an area of knowledge and/or skill that the resident had not acquired in the previous 2 years of training. This will include obtaining permission for the elective (memo of understanding from the mentor for the elective), a written proposal of objectives before the elective rotation, a written summary of the elective after the elective, and an evaluation of performance from the mentor for the elective.
4. Demonstrate teaching ability through one-on-one teaching opportunities with medical students and rotating residents at the VA outpatient clinic, as well as in appropriate VU outpatient clinics.
5. Demonstrate administrative ability while chief resident by managing the responsibility for such teaching program essentials as the weekly teaching and clinical resident schedule, and the resident vacation schedule, in consultations with the Program Director. The chief resident is also responsible for attending faculty meeting, assisting the faculty in residency evaluations of PGY-2 and PGY-3 residents, and providing input from the residents to the faculty as well as coordinating the annual resident review of the program and faculty. Third year residents are also responsible for organizing the quarterly Nashville Dermatology Meetings when clinical cases are presented.
6. Submit a paper(s) for publication on the research conducted while a resident.
7. Demonstrate appropriate documentation and coding skills.
V. INSERVICE EXAM (MOCK BOARDS)

The residency is structured to ensure that each resident is eligible to sit for the American Academy of Dermatology (ABD) certification exam. In order to gauge your progress and prepare you for the real board exam, each resident will take the in-service exam each spring. The in-service board is changing and the current iteration is for the first year residents to take a multiple choice exam and at a later date the 2nd ad 3rd year residents will take a more clinically based test. You are required to score at or above the 20th percentile for your resident year. Failure to do so will result in an academic warning. A score above the 20th percentile correlates well with successful future completion of the real board exam. Adequate preparation is a must and the residents work hard as a team to help each other prepare. If you are having difficulty preparing or keeping up, please do not be afraid to let the Chief resident or Dr. Miller know of your concern. It will be kept confidential and we will do everything we can to help out.
Appendix III: EDUCATIONAL OBJECTIVES, ACTIVITIES, AND EVALUATION METHODS FOR SPECIFIC CLINICAL AREAS OF EXPERTISE

CLINICAL DERMATOLOGY
All educational activities have been developed in accordance with the ACGME approved competencies already familiar in medical education. These include: medical knowledge, patient care, professionalism, systems based practice, learning based practice and communication.

i. Objectives

The overarching objective of the Clinical Dermatology subsection of the Vanderbilt University Division of Dermatology Residency Program is to produce dermatologists who fulfill all of the criteria of an excellent dermatologic clinician. More so than any other area of the residency program, the Clinical Dermatology experience aims to provide extensive training in the bedrock fundamental of Dermatology: accurate cutaneous diagnosis and correct standard-of-care treatment carried out in an empathic, educational manner. In order to subdivide this objective into a set of specific goals to provide a comprehensive structure to the Clinical Dermatology program, the following Objectives are established.

A. Acquisition of an ever-expanding, evidence-based fund of knowledge relevant to general dermatologic diagnosis and treatment, both medical and surgical, via clinical experience, reading, and advanced educational tools.
B. Extensive exposure, through working in various clinics as outlined in the Curriculum, to a wide range of styles of experienced practicing clinicians so that the resident may develop his or her own preferred style of practice via role model observation.
C. Mastery of medical decision-making skills relevant to the efficient and effective management of straightforward and complex skin disease.
D. Mastery of technical skills relevant to the efficient and effective management of straightforward and complex skin disease.
E. Acquisition of excellent communication skills essential to optimization of overall disease outcome, overall patient satisfaction, and collegial interaction.
F. Acquisition of excellent organizational skills to ensure that all patient care is carried out in a timely and thorough fashion.
G. Acquisition of technological skills necessary to continue lifelong learning and teaching in the “digital age” of medicine.
H. Development of awareness and knowledge related to societal and financial issues in an ever-changing health care environment.

II. Curriculum Description – Educational Activities

Because clinical dermatology represents the foundation on which all other fields of dermatology are built, the Vanderbilt University Division of Dermatology places great emphasis on creating a comprehensive clinical dermatology experience for our residents. The clinical dermatology curriculum includes protected time for didactic lectures and group learning, extensive rotations in general dermatology clinics staffed by full time faculty in dermatology, individual weekly resident continuity clinics, various weekly educational conferences, and rotations on an active in-patient consultation service.
A. Didactic lectures and group learning – Departmental Conferences

Friday mornings are protected for resident group learning activities. No resident is assigned to assist attending staff with other clinics during this time so that they may assemble as a group to discuss assigned readings from several major textbooks of dermatology. A group of core curriculum lectures will be given by the attending physicians each year; these are designed to be on a 3 year timetable so topics not covered this year will be covered in the next 2-3 years. Eight dermatopharmacology lectures on systemic drugs in dermatology will be taught by Dr. John Zic during this protected didactic time.

B. General Dermatology Clinics – Clinical Teaching

The general dermatology clinics offer the dermatology residents at Vanderbilt an opportunity to interview and examine patients presenting with a vast array of skin complaints under the supervision of board-certified, experienced full-time faculty in dermatology. There are no volunteer faculty members presently assigned to teaching duties. In all of these clinics, the resident interviews, examines, and formulates a diagnosis and treatment plan before formally presenting each patient to the attending physician assigned to that clinic. In this way, the attending physician can critically evaluate every aspect of the resident clinical encounter and assess the resident’s clinical reasoning skills. The focus for the first year dermatology resident is to master the vocabulary of dermatology, apply it accurately to describe what they see, and generate a meaningful differential diagnosis list. The focus for the second year resident is to master all clinic laboratory skills and the management of general dermatologic skin disease. The third year dermatology resident is expected to master the diagnosis and management of complex acute and chronic skin disease.

1. The Vanderbilt One Hundred Oaks General Dermatology Clinic

There is usually at least one dermatology resident assigned to assist the following attending staff during the OHO general dermatology clinics: Drs. Jami Miller, John Zic, Alan Boyd, and Jo-David Fine. Dr. Annie Dewan will be joining us in August. In these TVC clinics the VU dermatology residents see a wide variety of skin disease in a diverse population of patients. Most of the patients present with common dermatoses requiring various levels of complex management. Additionally, many complicated and rare dermatoses are seen as a result of referrals to these clinics.

2. The TVHS, Nashville Campus Dermatology Clinic (VA Medical Center)

The Nashville VA Dermatology Clinic provides the VU dermatology residents with an unsurpassed opportunity to diagnose and manage a vast array of both common and uncommon skin diseases. There is an epidemic of skin cancers that need to be managed within the VA Healthcare System. To keep up with the demand for dermatologic services there are eight general dermatology clinics at the Nashville VA Medical Center, four of which are staffed by a team of three dermatology residents, the other clinics are staffed with two dermatology residents. All eight clinics are staffed by an attending physician physically present for immediate consultation. Every clinic note generated by a dermatology resident is reviewed by the attending physician assigned to that clinic for completeness and appropriate management plan.
3. The Vanderbilt Williamson Dermatology Clinic in Franklin, Tennessee

The Vanderbilt Medical Group Dermatology Clinic in Franklin, Tennessee, is staffed by Drs. Jeff Byers, Rachel Champion and Sally Monahan, approximately 15 miles from the OHO campus. Several different residents rotate with Dr. Byers each week, giving them exposure to a busy private practice setting using the latest electronic medical record technology. In this setting, the residents learn the delicate art of efficient time management in an era of patient-centered clinical encounters.

C. Individual Weekly Resident Continuity Clinics

Each dermatology resident holds their own weekly resident continuity clinic at the OHO site. The first year dermatology resident continuity clinic is held on Tuesday mornings and is staffed by Drs. Jeff Zwerner and Jami Miller. The second year dermatology resident continuity clinic is held on Wednesday mornings and is staffed by Drs. Jami Miller and Jo-David Fine. The third year dermatology resident continuity clinic is held on Wednesday afternoons and is staffed by Drs. Fine and Zwerner. During the clinic session the residents are expected to present every patient to the attending physician whose role is to assess all aspects of the competency based learning objectives and clinical reasoning skills while observing the resident function as the primary dermatologist for the patient. The attending physicians meet each patient, but every effort is made to insure that the patient understands that the resident is their primary dermatologist. It is the expectation of this training program that dermatology residents master the skills necessary to track laboratory and pathology results in a timely fashion and to communicate these results to their patients in this clinic. In addition, residents master the important aspects of coding and physician communication with third party payors through these clinics. The dermatology residents continue to follow their patients throughout their three years of residency training so they can master the management of chronic skin diseases including psoriasis, acne, eczema, and actinic damage leading to multiple skin cancers.

D. Weekly Educational Conferences

1. Friday Morning Kodachrome Sessions – Departmental Conference

During this session, an attending physician presents unknown patient cases to the residents asking one or more residents to describe what they see, generate a differential diagnosis and present management suggestions. This session allows in depth coverage of a variety of common and uncommon skin diseases in a relaxed setting.

2. Wednesday Melanoma Research Conference – Institutional Lecture

During this monthly conference, speakers involved in melanoma research present a one hour lecture on their research. Speakers include nationally and internationally known outside speakers as well as speakers from the Vanderbilt University VICC Melanoma Research Group. This provides the residents with state of the art knowledge on melanoma research. The conference is attended by dermatology, surgical oncology, and oncology attending staff, trainees, and laboratory research
personnel.

3. Thursday Morning Patient Unknown Conferences – Clinical Teaching

Twice monthly, two to ten patients with unusual or difficult to manage skin diseases are invited to come to the patient unknown conference in the Vanderbilt OHO Dermatology Clinic. The Thursday morning conference begins at 0730 where for a half hour the residents, medical students, attending physicians, and visiting private dermatologists examine the patients. The residents are instructed not to interview the patients, but required to generate a differential diagnosis based solely on the physical findings. At 0800 the residents, medical students, attending physicians, and visiting private dermatologists gather in the OHO Dermatology conference room, a state of the art lecture room where one attending physician is assigned to moderate the discussion. During the discussion a selected dermatology resident is asked to present the physical findings of one of the patients and to generate a differential diagnosis. The moderator engages the resident to assess the clinical reasoning skills used to generate the differential. Then the moderator addresses the upper level residents, first, and the other practicing dermatologists, second, to add to the differential. At that point the dermatologist who invited that patient presents the history followed by visual presentation of the skin pathology by Alan Boyd, our chief dermatopathologist, using a state of the art videomicroscope. Overall, this educational experience offers something for every level of dermatologist and dermatologist in training. The dermatology residents see how the attending physicians use their clinical reasoning skills to diagnose and treat patients with skin disease. In addition, a lively discourse of opposing views demonstrates that the art of medicine often allows more than one approach to management. Finally, many unanswered questions arise during the discussion that hopefully stimulates the resident to seek answers for practice improvement.

4. Thursday Morning Dermatology Grand Round Lectures – Individual Projects and Departmental Lectures

Once or twice monthly, a grand round lecture is given in the Vanderbilt Dermatology OHO conference room, a state of the art lecture room. Every first and second year resident is expected to choose a dermatology topic to review and to create a PowerPoint presentation each year for a Dermatology Grand Round Lecture. Each year, the dermatology residents complete a presentation skills workshop to enhance their skills in creating and presenting material in a lecture setting. The presentation skills workshop is moderated by John Zic, M.D., a division faculty member with over a decade of experience.

In addition, visiting professors of dermatology from around the United States and VU dermatology faculty are also invited to give the Thursday morning Dermatology Grand Round lectures. The visiting professors provide state of the art insight into Dermatologic diseases and the latest therapies to treat them.

5. Thursday Morning Internal Medicine Grand Rounds Lectures – Institutional Lectures

Twice a year these lectures are given by the Division of Dermatology. The Dermatology lectures are given either by the faculty on their research or clinical
interests, or by invited lectureships to outside nationally known academic Dermatologists. These lectures are important for dermatology residents because they stimulate thought about systemic diseases which may have cutaneous manifestations and also provide exposure to a variety of diseases and treatments not routinely seen in Dermatology.

6. Lymphoma Conference

Once every 3 months you will be required to attend the Cutaneous Lymphoma conference at 100 Oaks.

E. Inpatient Dermatology Consultation Rotation

Second year dermatology residents are assigned to the inpatient dermatology consultation service for two month rotations. The resident is expected to respond to the consultation request in a timely manner and perform a comprehensive evaluation of the patient. Each day the consult resident rounds with the dermatology consult attending where one-on-one bedside learning takes place. The dermatology inpatient consult service is an active service with an average of one to six consults daily, providing the dermatology resident with a full spectrum of challenging inpatient skin problems. The consult resident also does follow-up visits to help in the diagnosis and management of the patient’s care. The consult resident is exposed to the interaction of multiple disciplines which they must communicate effectively with, and they also are able to follow treatment outcomes. The learning experience is greatly enhanced by the advanced electronic medical record at VUMC sites and on line access to the Vanderbilt Eskind Digital Medical Library.

III. Competency Based Learning Objectives and Evaluation Methods

A. Medical Knowledge

1. Objectives

a. Demonstrate knowledge of and application of the basic and clinical sciences using current medical information and scientific evidence for patient care
b. Utilize investigation and analytic thinking to critically evaluate and apply medical knowledge obtained through didactic teaching programs to serve as an educator to colleagues, students and patients

2. Evaluation Methods

a. Focused Observation and Evaluation: Daily personal performance observation and evaluation by Dermatology faculty in the clinic, inpatient bedside and in multiple weekly teaching conferences with direct feedback being given to the resident at the appropriate time and venue. Periodic verbal quizzes by faculty are given in which the resident is required to demonstrate key clinical knowledge applicable to the patient care setting.
b. Review of procedural logs
c. In-Training Examination: Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
d. Clinical Performance Ratings: Semi-annual written evaluation of resident performance by all faculty members followed by a personal meeting between the resident and Program Director to discuss the results of the performance evaluation.

B. Patient Care

1. Objectives

   a. Demonstrate careful and respectful behavior by providing care that is sensitive to each patient’s age, gender, cultural, economic and social circumstances.
   b. Gather accurate and relevant patient data through the medical interview, patient examination, diagnostic evaluation and utilization of information technology.
   c. Perform an appropriate physical examination with critical visual examination of the skin and skin structures.
   d. Perform appropriate general dermatological procedures such as punch and excisional skin biopsy, cryotherapy and shave excision.
   e. Synthesize clinical history, physical examination findings, laboratory results and current scientific evidence to determine a correct diagnosis and treatment plan.
   f. Develop and apply patient care management plans. Provide a written action plan for management of acute and chronic cutaneous problems.
   g. Counsel and educate patients and families by providing information necessary to understand their illness and treatment.
   h. Provide preventive health services. Provide information about non-melanoma skin cancer, melanoma, heritable, occupational and infectious disorders and additional conditions in which prophylactic measures are appropriate.
   i. Work within a team to make appropriate referrals to other medical or surgical specialists.

2. Evaluation Methods

   a. Focused Observation and Evaluation: Daily personal performance observation and evaluation by Dermatology faculty in the clinic, inpatient bedside and in multiple weekly teaching conferences with direct feedback being given to the resident at the appropriate time and venue. Periodic verbal quizzes are given by the faculty in which the resident is required to demonstrate key clinical knowledge applicable to the patient care setting.
   b. Review of procedural logs.
   c. 360 Evaluations – Done by the nurses, clerks and patients.
   d. Clinical Performance Ratings: Semi-annual written evaluation of resident performance by all faculty members followed by a personal meeting between the resident and Program Director to discuss the results of the performance evaluation.

C. Practice Based Learning and Improvement

1. Objectives
a. Develop an individualized learning plan to acquire new skills, knowledge and/or competencies incorporating self-assessment and evaluation by others.
b. Research, critically evaluate, assimilate and utilize evidence from scientific literature related to the patients’ health problems.
c. Integrate the use of information technology to manage information, assess online medical information and support their education.
d. Actively participate in the education of patients, families, students, residents and other health professionals

2. Evaluation Methods

a. Focused Observation and Evaluation: Daily personal performance observation and evaluation by Dermatology faculty in the clinic, inpatient bedside and in multiple weekly teaching conferences with direct feedback being given to the resident at the appropriate time and venue. The faculty observe and critique the resident’s ability to perform practice based learning and improve from it.
b. Clinical Performance Ratings: Semi-annual written evaluation of resident performance by all faculty members followed by a personal meeting between the resident and Program Director to discuss the results of the performance evaluation.

D. Systems Based Practice

1. Objectives

a. Understand the interaction of their medical practice with the larger health care delivery system.
b. Work effectively in various health care delivery settings and systems to provide quality patient care.
c. Use resources within the system to demonstrate cost-effective resource allocation and prescribing patterns. Know the relative cost of medications and procedures and understand the patient’s ability to pay.
d. Advocate for the patient within the health care system by identifying needed resources and assisting the patient in dealing with the system complexities.

2. Evaluation Methods

a. Focused Observation and Evaluation: Daily personal performance observation and evaluation by Dermatology faculty in the clinic, inpatient bedside and in multiple weekly teaching conferences with direct feedback being given to the resident at the appropriate time and venue. The resident is required to demonstrate knowledge applicable to efficient function in the health care system they are working in.
b. 360 degree global rating evaluations by nurses, clerks, and patients of how the residents function within the health care system.
c. Clinical Performance Ratings: Semi-annual written evaluation of resident performance by all faculty members followed by a personal meeting between the resident and Program Director to discuss the results of the performance evaluation.
E. Interpersonal and Communications Skills

1. Objectives

   a. Learn and demonstrate effective communication strategies with patients and families to provide education about disease and treatment or the delivery of bad news
   b. Communicate effectively with patients and families to develop and foster an appropriate professional relationship to further provide open dialogue to discuss their disease or treatment
   c. Effective communication with colleagues and professional associates demonstrating leadership and fostering exchange of knowledge
   d. Presentation of scholarly work.
   e. Maintain comprehensive, timely and legible medical records

2. Evaluation Methods

   a. Focused Observation and Evaluation: Daily personal performance observation and evaluation by Dermatology faculty in the clinic, inpatient bedside and in multiple weekly teaching conferences with direct feedback being given to the resident at the appropriate time and venue regarding the effectiveness of the resident’s interpersonal and communications skills.
   b. 360 degree global rating evaluations by nurses, clerks, and patients to provide feedback on the interpersonal and communications skills from several angles of observation.
   c. Clinical Performance Ratings: Semi-annual written evaluation of resident performance by all faculty members followed by a personal meeting between the resident and Program Director to discuss the results of the performance evaluation

F. Professionalism

1. Objectives

   a. Demonstrate respect, compassion and integrity encompassing the characteristics of altruism, honesty, empathy and dependability.
   b. Accountability to patients and society with a professional commitment to excellence.
   c. Demonstrate adherence to ethical principles pertaining to continuity of care, patient privacy and autonomy, the provision or withholding of clinical care, confidentiality of patient information, informed consent, conflict of interest and business practices
   d. Demonstrate respect, show sensitivity and value for the diversity of patients and colleagues in regards to culture, age, gender and disabilities

2. Evaluation Methods

   a. Focused Observation and Evaluation: Daily personal performance observation and evaluation by Dermatology faculty in the clinic, inpatient bedside and in multiple weekly teaching conferences with direct feedback
being given to the resident at the appropriate time and venue regarding the resident's professional behavior.

b. 360 degree global rating evaluations by nurses, clerks, and patients of the resident's professional behavior.

c. Clinical Performance Ratings: Semi-annual written evaluation of resident performance by all faculty members followed by a personal meeting between the resident and Program Director to discuss the results of the performance evaluation.

IV. Reading and Information Resource List

A. Textbooks for Clinical Dermatology and Dermatopathology: Each year a major textbook is reviewed. The books are selected in coordination with the Program Director (Clinical Dermatology), and the Director of Dermatopathology (Dermatopathology). The current year's textbooks are:


2. *Barnhill’s Histopathology of the Skin*, David E Elder (Ed.). 2005, Publisher Lippincott, Williams, & Wilkins

3. Previous textbooks for Clinical Dermatology include: *Andrews' Diseases of the Skin: Clinical Dermatology* Eds.; December 2005, Publisher: Elsevier Health Sciences, *Dermatology in Medicine by Fitzpatrick*.

4. Previous Textbooks for Dermatopathology include: *Pathology of the Skin with Clinical Correlations: 2 Volume Set* Eds: February 2005 Publisher: Elsevier Health Sciences

V. Electronic Medical Databases

The Vanderbilt University Eskind Biomedical Library supports a state of the art electronic medical database called the Eskind Digital Library with over 440 medical journals, hundreds of electronic medical textbooks, and access to a broad combination of internal, publicly available and proprietary evidence-based electronic databases and journals. In addition, there are nine Customized Digital Libraries designed to meet the needs of targeted users both within and outside the Vanderbilt Community. Every exam room at The Vanderbilt Clinic has a PC with access to the Eskind Digital Library. The dermatology resident room and the physician work room in the TVC clinic also has PC workstations, all connected to the digital library. In our new space at OHO, each resident has a PC in the Resident's room, and the work stations have multiple PC’s. With VUMC leadership's encouragement, the Eskind Library's focus has been to eliminate print resources in favor of providing widely accessible online resources. Their efforts have revolutionized how our dermatology residents find the most current medical information to manage patients and to complete comprehensive literature searches without ever leaving their PC.

VI. Kodachrome and Digital Slide Collections

The American Academy of Dermatology Teaching Slide Set in the dermatology resident room provides the dermatology residents with access to carefully chosen Kodachrome slides representing the breadth of dermatology. In addition, several faculty members have general dermatology and specialized photographic collections in pediatric dermatology,
pigmented lesions, and cutaneous lymphoma, all accessible to the dermatology residents for their learning and presentations.

The AAD digital slide teaching set is available to the residents through the program director.

MEDICAL DERMATOLOGY

Jami L. Miller, M.D. (Chair), Darrel L. Ellis, M.D., Annie Dewan, M.D., Jo-David Fine, M.D.

I. Objectives:

A. Develop the skills required to obtain a complete history of present illness, past medical history, family and social histories, and review of systems required to make the diagnosis in patients from various ethnic and socioeconomic backgrounds.

B. Refine expertise in a complete dermatologic examination, including pattern recognition of various diseases.

C. Recognize the need for examination of other systems (lungs, joints, etc), and perfect the skills of a directed medical physical examination.

D. Develop expertise in performing diagnostic procedures (punch, shave and wedge biopsies) and in selecting which lesions are most likely to yield the diagnosis.

E. Obtain and interpret the results of diagnostic tests for medical dermatologic disorders (serologic studies, MRI, X-ray, etc.)

F. Develop expertise in the principles and practice of treating the patient’s dermatologic disease in the context of both the skin and any other medical conditions.

G. Develop expertise in the side effects and drug interactions of the medications used to treat medical dermatologic conditions and utilize proper monitoring procedures.

H. Cultivate an understanding of the impact of cutaneous disease on patients and their families.

I. Develop expertise in counseling patients and families regarding the expected course of disease and treatment options for medical dermatologic conditions.

J. Understand the financial impact of medical dermatologic diseases and treatments for the patient, the family and also consider the impact of expensive medications on society.

II. Curriculum Description: Educational Activities

A. Outpatient Clinics:

Vanderbilt dermatology residents will receive most of the Medical Dermatology experience in the outpatient clinic settings, including the Vanderbilt Clinic, the Nashville VA Medical Center and the satellite clinical offices. VUMC Clinics are staffed by one attending physician accompanied by not more than 2 dermatology residents per clinic, while VAMC clinics have 3 residents per attending physician. Each resident is expected to obtain a complete dermatologic history and exam as required by that particular condition and present it to the attending physician. The attending physician then interviews and examines the patient, reviews pertinent data and provides immediate feedback, both positive and constructive, including adjustments needed to be made in the resident’s assessment. Plans for further diagnosis and treatment are made, biopsies and other procedures are performed and appropriate management is discussed.

There are eight dermatology attending physicians who practice medical dermatology on the Vanderbilt faculty. This eclectic mix of practice styles and therapeutic methods
provides exposure to many management algorithms for a given disease. Residents are expected to integrate these practice options in order to derive their own practice style by the time of completion of the residency.

Residents also participate in Resident Continuity Clinics where the resident functions as the primary dermatologic care giver. The attending physician also sees and assists in the diagnosis and management of each patient in this clinic, but the residents are expected to function as a Dermatologist in practice, and are given freedom to explore their own therapies for their patients, within reason. Residents perform all of the documentation, authorizations and out of clinic management for their Resident Continuity Clinic patients.

B. In Patient Dermatology Consultation Service

In patient consultations are performed at the Nashville VA Medical Center and at the Vanderbilt University Medical Center (includes the main hospital, Children’s Hospital, Stallworth Rehabilitation Hospital, and the Psychiatric Hospital). The service is available 7 days a week, 24 hours a day. A second year resident is assigned to the VUMC consultation service Monday through Friday from 8 AM until 5 PM. After hours and weekend consultations are performed by the resident on call, (PGY2-4). All consultations are evaluated by the resident and an attending physician within 24 hours of receiving the request. Any follow up care that may be required is then performed by the resident that evaluated the patient in their Resident Continuity Clinic, whenever possible.

D. Weekly Educational Conferences

Medical dermatology is the emphasis for Monday “Kodachrome” conference. Clinical pictures are shown to the residents by a faculty member, and emphasis is placed on descriptions, differential diagnosis and treatment of the case. This exercise sharpens clinical, diagnostic and therapeutic skills.

III. Competency Based Learning Objectives and Evaluation Methods

A. Medical Knowledge
   1. Objectives:
      a. Learn the medical complications of dermatologic diseases; the dermatologic presentations of medical diseases; and the pathophysiology of dermatologic diseases with systemic complications.
      b. Gain experience and comfort with a wide variety of medications, both topical and systemic for these types of disease. This includes but is not limited to: topical steroids and immune modulators, systemic steroids, systemic immunomodulatory agents including chemotherapeutic agents, biologic agents, phototherapy and extracorporeal photochemotherapy, and antibiotics. Understand the medication side effects, pre-therapy and concurrent therapy laboratory testing requirements for the medications, and the need for concomitant medications (i.e. bisphosphonates, PPD, for chronic systemic steroids, etc).

   2. Evaluation Methods:
      a. Clinical Performance Ratings: Semiannual
b. Observation and Evaluation: one-on-one same day observation and evaluation of the resident’s knowledge base by the attending physician.

c. In-Training Yearly Examination.

B. Patient Care

1. Objectives:

   a. Learn and practice the complete dermatologic examination and appropriate selective medical examination for the patient’s Dermatologic disease.
   b. Understand and either perform proper evaluation and treatment or obtain appropriate consultations when other organ systems are involved. Develop broad differential diagnosis of cutaneous disease and an understanding of its’ possible internal ramifications.
   c. Acquire expertise in performing diagnostic procedures (biopsies, wedge biopsies, excisions, KOH, Tzanck smears).

2. Evaluation Methods:

   a. Clinical Performance Ratings: Semiannual
   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation of the resident’s skills and knowledge base by the attending physician.

C. Practice Based Learning and Improvement

1. Objectives:

   a. Analyze practice by observing diagnostic skills and effectiveness of medications.
   b. Use the medical literature including the electronic databases available to obtain scientific evidence to evaluate patients.
   c. Learn to critically assess the scientific literature for dealing with medical dermatology patients.
   d. Learn to use the electronic inpatient and outpatient medical records at VUMC and VAMC, including Wizorder and StarPanel.
   e. Teach medical students about the medical and dermatologic complications of the medical dermatology patients.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending physician of the resident’s ongoing practice improvement.

D. Systems Based Practice

1. Objectives:
a. Understand costs vs. benefits of the systemic medications required to treat medical dermatology patients. Learn to use the most cost effective regimens for the patient.
b. Learn to order appropriate, cost effective laboratory tests and consultations.
c. Work with the nurses and allied health professionals to provide the best patient care for inpatients and consultations.

2. Evaluation Methods

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending of the resident’s knowledge of the different medical systems and their interaction.
   c. 360 Assessments by nurses and clerks of ability to function within the systems.

E. Interpersonal and Communications Skills

1. Objectives:

   a. Acquire and practice communication skills for obtaining history of present illness, past medical history, allergies, medications, family and social histories, and review of history appropriate to the dermatologic and medical problems of the patient.
   b. Develop communication skills to educate patients and families on the nature of their disease, options and side effects of treatment and cost factors with which patients and their families will need to cope.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending physician in the clinic, bedside, and conferences of the resident’s communication skills.
   c. 360 Assessments: Nurse, clerk, and patient assessment of communication skills.

F. Professionalism

1. Objectives:

   a. Learn to act in the best interest of the patient when selecting drugs for systemic illnesses.
   b. Demonstrate sensitivity to patients’ ethnicity, age, and disabilities.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in
conferences of the resident's integrity, honesty, acceptance of responsibility, and sensitivity to patient's diversity.

c. 360 Assessments: Nurse, clerk, and patient assessment of professionalism.
I. Objectives

A. Develop expertise in the social and communication skills necessary to develop rapport with and obtain cooperation of pediatric patients.
B. Learn proper communication strategies for pediatric patients of different ages.
C. Develop expertise in proper dermatologic examination techniques for children.
D. Learn principles and practice of diagnosing dermatologic disorders of childhood.
E. Develop expertise in diagnostic and therapeutic procedures in children.
F. Utilize current literature and evidence-based medicine to formulate treatment plans for the broad spectrum of pediatric skin disorders.
G. Understand pharmacologic therapy in children and appreciate differences between children and adults regarding drug safety.
H. Develop an understanding of the importance of cost-effective and age-appropriate therapeutic intervention.
I. Develop expertise in counseling pediatric patients and their family members concerning the diagnoses, treatments and outcomes of childhood skin diseases.

II. Curriculum Description

Expertise in pediatric dermatology is gained through a continual process of patient evaluation linked to current management principles throughout the three years of residency training, with major focus in the first and third years. Three elements comprise the learning strategies: (1) clinical apprenticeship with experienced faculty supervision and bedside teaching; (2) formal scheduled educational interactions (pediatric dermatology core lecture series, kodachrome/patient unknown sessions); and (3) self-directed study utilizing current pediatric dermatology literature and textbooks.

Pediatric dermatology clinics are held all day Monday and Thursday at 100 Oaks and adolescent and adult dermatology at the Belle Meade clinic on Tuesdays and Wednesdays. Dermatology residents on the pediatric dermatology rotation will be present at all sessions. In all clinics, the residents first evaluate all new and return patients, and then briefly present their findings to the attending pediatric dermatologist. Residents are strongly encouraged to generate differential diagnoses, evaluation strategies and treatment plans. The residents then participate with the attending faculty in assessment, management and disposition of these patients. Residents are encouraged to participate in the discussions and educational instructions with patients and family. Since the pediatric dermatology clinics are the primary referral and consultation center for pediatric dermatology for Tennessee, southern Kentucky, northern Alabama, northern Mississippi, and northwestern Georgia, the residents have ample opportunity to evaluate a broad array of clinical conditions from common skin problems of childhood to complex infectious, inflammatory, congenital and genetic skin diseases in children of many ethnic and socioeconomic backgrounds.

III. Competency Based Learning Evaluation

A. Medical Knowledge:

1. Objectives:
Residents are expected to develop a thorough knowledge base in pediatric dermatology through self-study, participation in didactic sessions and clinical discussions. During one-on-one sessions in clinic, the residents’ knowledge and application of critical analysis are reviewed in the context of patient care.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in conferences of the resident’s knowledge base.
   c. 360 Assessments: Nurse, clerk, and patient assessment of professionalism.
   d. In-Training Examination: Yearly ABD in-training examination.

B. Patient Care

1. Objectives:

   Residents are expected to develop expertise in the evaluation of pediatric patients, with particular emphasis on age-appropriate history, physical exam and discussion techniques. The evaluation and management of pediatric patients is centered on fundamental principles of child development, and tempered by appropriate consideration of cultural, ethnic and socioeconomic background. Resident interactions with pediatric patients will be observed on a daily basis and suggestions for improvement made when necessary.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in conferences of the resident’s knowledge base.
   c. 360 Assessments: Nurse, clerk, and patient assessment of resident’s skill in conducting an age appropriate examination with appropriate consideration of cultural, ethnic, and socioeconomic background.

C. Practice-Based Learning and Improvement

1. Objectives:

   Residents are expected to continually analyze their own practices in patient care, and to understand areas of strength and weakness. Similarly, the residents are expected to act upon recognized knowledge gaps by self-directed reading, access to medical literature, and questioning of the faculty to stimulate discussion.

2. Evaluation Methods:

b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in conferences of the resident's knowledge base.

D. Systems Based Practice

1. Objectives:

Residents are expected to gain understanding of pediatric dermatology practice within the larger health care system, with particular focus on the need for regular communication with referring pediatricians, and respect for the primary role of the pediatrician in the care of the child. In addition, issues of cost-effective health care and patient advocacy are discussed as needed.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in conferences of the resident's ability to function in a pediatric dermatology practice.
   c. 360 Assessments: Nurse, clerk, and patient assessment of resident’s ability to function in a pediatric dermatology practice.

E. Interpersonal and Communication Skills

1. Objectives:

Residents are expected to listen to and communicate effectively with pediatric patients and families in order to establish an appropriate patient-centered professional relationship. Inclusion of children of all ages in the interview, examination and treatment process is of fundamental importance. Age-appropriate communication is learned through daily interaction with pediatric patients and observation of the communication styles of pediatricians and the pediatric dermatology faculty.

2. Evaluation Methods:

   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in conferences of the resident’s ability to communicate with and interact with pediatric patients.
   c. 360 Assessments: Nurse, clerk, and patient assessment of communication and interpersonal skills.

F. Professionalism

1. Objectives:

Residents are expected to adhere to fundamental ethical principles in their daily practice. Residents are also expected to demonstrate patience, compassion and respect for pediatric patients and their families, with appropriate sensitivity to cultural, ethnic, age,
disability and socioeconomic issues. Evaluations include daily observation, global 360 ratings and semi-annual written critique.

2. Evaluation Methods:
   
   b. Focused Observation and Evaluation: one-on-one same day observation and evaluation by the attending in the clinic, at the bedside, and in conferences of the resident's professional behavior.
   c. 360 Assessments: Nurse, clerk, and patient assessment of professionalism.

G. Reading and Information Resources

1. Textbooks:

   *Dermatology*, Bologna, Jorrizo, Rapini, eds.
   *Pediatric Dermatology*, Schachner, Hansen, eds.
   *Genodermatoses*, Spitz
   *Color Textbook of Pediatric Dermatology*, Weston, Lane, Morelli

2. Pediatric dermatology core lectures:

   *Introduction to pediatric dermatology*  
   *Approach to the pediatric patient*  
   *Acne*  
   *Hair disorders in childhood*  
   *Silver hair syndromes*  
   *Nail disorders in children*  
   *Inborn errors of metabolism*  
   *Lumps and bumps on kids*  
   *Exanthematous diseases*  
   *Immunodeficiencies in childhood*  
   *Management of congenital nevi*  
   *Pigmentary disorders in children*  
   *Ichthyosis and keratinizing disorders*  
   *Parasites*  
   *Mastocytosis*  
   *Vascular birthmarks*  
   *Skin problems in adolescent patients*  
   *Fungal infections in children*  

H. Future Goals

One Year Goals: Recruitment is underway for a second Pediatric Dermatologist.

Five Year Goals: Within the next five years a fellowship in pediatric dermatology will be established at VCH. Approval has been granted by the VUMC GME committee, and application to the ABD is in process.
I. Introduction and Description of Curriculum.
An integral part of the Vanderbilt University Medical Center (VUMC) Department of Dermatology residency training program involves management of cutaneous disorders with procedural/surgical dermatologic techniques. The didactic portion of the procedural/surgery training occurs in all three years of the residency. The procedural/surgical rotations occur during the second and third years of the residency program.

A. Vanderbilt Surgery
During both the second and third year, dermatology residents have two months of:
1. Monday – All day Mohs Micrographic and cosmetic dermatological surgery at OHO under the supervision of Dr. Michel McDonald.
2. Tuesday – All day Mohs Micrographic and general dermatological surgery at OHO under the supervision of Dr. Anna Clayton.
3. Wednesday – Half day Mohs Micrographic and cosmetic dermatological surgery at OHO under the supervision of Dr. Michel McDonald.
4. Thursday - All day Mohs Micrographic and general dermatological surgery at VUMC under the supervision of Dr. Michel McDonald.
5. Friday - Half day Mohs Micrographic and general dermatological surgery at VUMC under the supervision of Dr. Anna Clayton.

B. VA Surgery
All residents also have surgical teaching and experience at the Veterans Affairs Hospital as listed below.
1. Monday – Half day of general dermatologic surgery under the supervision of Dr. George Stricklin with a third year resident assisted by a first year resident. In the second year of residency is a half day of general dermatologic surgery supervised by the Mohs micrographic surgery fellow.
2. Tuesday – Half day of general dermatologic surgery supervised by Dr. John Zic or Dr. Darrel Ellis with a third year and a second year resident.
3. Wednesday – Half day of general dermatologic surgery in the Dermatology Clinic with assistance from the VA Plastic Surgery Fellow.
4. Friday – Elective surgery time for a half day done by first, second and third year residents.

C. Laser Surgery
During both the second and third year, residents have two months of laser surgery one day a week (Thursday – Half day laser surgery under the supervision of Dr. Darrel Ellis).

D. Didactics
In addition, the following lectures related to procedural and surgical dermatology are provided to all of the residents by Dr. Anna Clayton, Dr. Michel McDonald and invited speakers
1. Surgical Anatomy
2. Wound healing
3. Antiseptics, dressings and wound care
4. Local and topical anesthetics
5. Regional anesthesia  
6. Electrosurgery  
7. Cryosurgery  
8. Pre-operative evaluation  
9. Surgical instruments  
10. Basic excision  
11. Advanced excision and closure techniques  
12. Suture materials  
13. Cutaneous flap closures  
14. Skin grafts  
15. Surgical complications  
16. Mohs micrographic surgery  
17. Nail surgery  
18. Laser surgery: Principles and concepts  
19. Laser surgery: Vascular lesions  
20. Laser surgery: Hair removal  
21. Laser surgery: Pigmented lesions  
22. Laser surgery: Resurfacing  
23. Liposuction  
24. Chemical Peels  
25. Botulinum toxin injections  
26. Soft tissue augmentation  
27. Sclerotherapy  
28. Cutaneous oncology – Basal cell carcinoma and Squamous cell carcinoma  
29. Cutaneous oncology – Malignant melanoma  
30. Cutaneous oncology – Merkel cell carcinoma, Dermatofibrosarcoma protuberans, Sebaceous carcinoma, Angiosarcoma. In addition to the lectures, all residents attend and present at Surgery Journal Club every other month which reviews the latest advances in dermatologic surgery.

II. Goals  
After completing the procedural/dermatologic surgical curriculum, dermatology residents should be expert at diagnosing and managing cutaneous disorders in adults and children that are best treated by procedural/dermatological techniques equivalent in efficiency to that of a practicing dermatologist that has recently been certified by the American Board of Dermatology. They are trained in preoperative diagnosis and evaluation as well as postoperative care and complication management. They are trained technically in all aspects of cutaneous procedures and surgery.

III. Objectives and evaluation methods  
A. Patient care  
   1. Objectives  
      a. Respectful behavior  
         Provide care that is sensitive to each patient’s age, gender, cultural, economic and social circumstances  
      b. History taking  
         Obtain accurate history of present illness, past medical, family and social history which should always include (but not limited to) factors which are critical to the surgical procedure such as anticoagulation status, cardiac status, pacemaker/defibrillator status, anesthesia reaction status
c. Physical examination
   form examination including critical visual examination of patient’s skin and
   examination of lymph nodes when indicated

d. Decision making/ Diagnosis
   Utilize information from history, physical examination, laboratory and
   pathology results to arrive at the correct diagnosis and formulate a treatment
   plan

e. Develop management plan
   Create a written plan for management of acute and chronic cutaneous
   problems

f. Counsel and educate patients and families
   Explain diagnosis and treatment plan thoroughly. Explain all aspects of the
   surgical procedure including risks and obtain informed consent

g. Perform procedure
   Technical competence to perform general dermatological procedures (punch
   biopsy, shave biopsy, excisional biopsy) and advanced dermatological
   procedures (Mohs surgery, flaps, grafts, complex closures)

h. Counsel on preventive measures
   Provide patient and family information non-melanoma skin cancer and
   melanoma, heritable and occupational disorders where prophylactic
   measures are appropriate

i. Use interdisciplinary approach when necessary
   Collaborate with/ refer to other specialties when necessary

2. Evaluation Methods
   a. Daily performance observation and evaluation by Dermatology faculty in
      the clinic, at the inpatient bedside and in teaching conferences. Direct
      feedback is given to the resident at the appropriate time in these settings.
      Processes used to evaluate include discussion of readings pertaining to
      the setting, verbal quizzes asking the resident to answer key clinical
      issues that are simultaneously addressed in the patient care setting.

   b. 360 degree global rating evaluations

   c. Review of procedural logs

   d. Percentile performance level on annual American Board of Dermatology
      (ABD) In-Service examination

   e. Semi-annual written evaluation of resident performance by all faculty
      members followed by one-on-one meetings between each resident and
      the Program Director to discuss the results of the faculty evaluation
      process

B. Medical knowledge
   1. Objectives
      a. Investigatory and analytic thinking
         Learn, critically evaluate and utilize medical knowledge obtained through
         conferences to teach other residents and improve patient care

      b. Knowledge and application of basic sciences
         Learn, critically evaluate and utilize current medical information and scientific
         evidence for patient care

   2. Evaluation methods
a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.
b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

C. Practice-based learning and improvement

1. Objectives
   a. Analyze own practice for needed improvement
      Analyze one’s experience in practice to understand strengths and limitations in knowledge and expertise
   b. Use evidence from scientific studies
      Read, understand and utilize evidence from studies related to patient’s dermatologic surgery. Residents learn to utilize electronic databases to access evidence-based studies that address clinical issues of patients.
   c. Application of research methods and statistical methods
      Review published medical literature related to dermatologic surgery. Learn to critically review articles at monthly dermatologic surgery journal club.
   d. Use of information technology
      Use technology to assess medical information online and manage that information. Use technology to educate patients and families
   e. Facilitate others learning by teaching
      Actively educate patients, families, other residents, medical students and other health professionals

2. Evaluation Methods
   a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.
b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

D. Interpersonal and communication skills
   1. Objectives
a. Develop an appropriate professional relationship with patients. Communicate clearly and effectively with patients and their family members. Take the time required to communicate clearly and ensure patient understands.

b. Listening skills
Facilitate patient’s ability to ask questions about their condition

2. Evaluation Methods
a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.

b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

E. Professionalism
1. Objectives
a. Respectfulness-Demonstrate respect, empathy, compassion and integrity in all patient interactions
b. Ethical practice-Uphold ethical principles related to patient privacy and autonomy, informed consent, confidentiality, conflict of interest and business practices
c. Sensitivity-Be aware and considerate of patient’s gender, culture, age and disabilities

2. Evaluation Methods
a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.

b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

F. Systems-based practice
1. Objectives
a. Understand the overall health care delivery system and how their practice interacts within it Work effectively in varied health care delivery settings
b. Knowledge of health care delivery systems
   Understand the differences between varying medical practice and health care
   delivery systems. Understand methods of controlling healthcare costs and
   allocating resources

c. Practice cost-effective care
   Know relative costs of dermatologic surgical procedures and diagnostic
   procedures. Know relative costs of medications. Be aware of how patient’s
   particular coverage or lack of coverage impacts their choices

d. Advocate for patients
   Assist patients in dealing with the complexities of their health care delivery
   system. Encourage quality patient care within the health care delivery system

2. Evaluation Methods
   a. Daily performance observation and evaluation by Dermatology faculty in the
      clinic, at the inpatient bedside and in teaching conferences. Direct feedback
      is given to the resident at the appropriate time in these settings. Processes
      used to evaluate include discussion of readings pertaining to the setting,
      verbal quizzes asking the resident to answer key clinical issues that are
      simultaneously addressed in the patient care setting.

   b. 360 degree global rating evaluations

   c. Review of procedural logs

   d. Percentile performance level on annual American Board of Dermatology (ABD)
      In-Service examination

   e. Semi-annual written evaluation of resident performance by all faculty members
      followed by one-on-one meetings between each resident and the Program
      Director to discuss the results of the faculty evaluation process

IV. Rotation evaluation
   A. All weekly teaching conferences are reviewed annually by the faculty
   B. Residents complete an anonymous questionnaire annually critiquing all parts of the
      training program. Any areas that need to be addressed are reviewed with the
      residents by the Program Director and then reviewed with the entire faculty.
   C. Residents complete an annual evaluation of each faculty member in the department.
      Each faculty member reviews their own evaluation and addresses any weaknesses
      revealed by that evaluation with the Program Director.

V. Reading List
   A. Textbooks
      Dermatology (Physical Treatment Modalities and Surgery Sections pp. 2109-2354)
      Bolognia, Jorizzo and Rapini editors

   B. Journals
      Dermatologic Surgery
      Annals of Plastic Surgery
COSMETIC/AESTHETIC DERMATOLOGY

Michel A. McDonald, M.D., (Chair), William Stebbins, M.D. and Darrel L. Ellis, M.D.

I. Introduction & Description of Curriculum

The Vanderbilt University Dermatology residency training program cosmetic/aesthetic dermatology training focuses on techniques of cosmetic and elective surgery, and the principles for clinical management of these patients. Dr. Michel McDonald is the director of cosmetic/aesthetic dermatology in our Division. Other faculty members (Drs. Clayton, Stasko, and Ellis) also perform cosmetic/aesthetic procedures. Vanderbilt University dermatology residents have the opportunity to receive “hands-on” training of many cosmetic procedures including:

A. Pulse Dye Laser - Candela V-Beam, for port wine stains, hemangiomas, TMEP, verruca, keloids.Q-Switched Nd:YAG Laser – Medlite C6, for tattoos, lentigenes, café au lait macules
B. Long Pulsed Nd:YAG Laser – Candela GentleMax, for hair removal, leg veins
C. CO₂ Fractional Laser – SmartXide, for acne scarring, rhytides, actinic damage
D. Intense Pulsed Light – Candela Ellipse for actinic damage
E. Chemical Peel – superficial and medium depth for comedonal acne and actinic damage
F. Botox – for facial rhytides and axillary hyperhidrosis
G. Dermal fillers – for facial rhytides
H. Sclerotherapy – for spider veins of the legs
I. Photodynamic Therapy – for actinic keratoses
J. Dermabrasion

In addition, the following lectures related to procedural and surgical dermatology are provided to all of the residents by Dr. Anna Clayton, Dr. Michel McDonald, Dr. Darrel Ellis, and invited speakers

K. Laser surgery: Principles and concepts
L. Laser Safety
M. Laser surgery: Vascular lesions
N. Laser surgery: Hair removal
O. Laser surgery: Pigmented lesions
P. Laser surgery: Resurfacing
Q. Liposuction
R. Chemical Peels
S. Botulinum toxin injections
T. Soft tissue augmentation

II. Goals

Upon completion of this curriculum, dermatology residents should be able to demonstrate expertise in the principles and practice of the management of individuals who present for cosmetic/aesthetic dermatological concerns equivalent in efficiency/effectiveness to that of a practicing dermatologist that has recently been certified by the American Board of Dermatology. Residents are advised to pursue post-residency fellowship training in advanced cosmetic/aesthetic techniques if so desired (e.g., liposuction, hair transplantation).

III. Objectives and evaluation methods

A. Patient care
1. Objectives
   a. Careful and respectful behavior
      Provide care that is sensitive to each patient’s age, gender, cultural,
      economic, and social circumstances
   b. Interviewing
      Gather essential and accurate information about the patient including their
      psychosocial motivation for pursuing cosmetic/aesthetic procedures
   c. Informed decision-making
      Synthesize clinical history, physical examination findings, laboratory results
      and current scientific evidence to arrive at a correct diagnosis and treatment
      plan
   d. Develop and carry out patient care management plans
      Provide a written action plan for management of acute and chronic cutaneous
      aesthetic problems
   e. Perform cosmetic/aesthetic procedures
      Perform routine physical examination, especially the critical visual
      examination of the patient’s skin. Perform various cosmetic/aesthetic
      procedures
   f. Work within a team
      Make appropriate referrals to other medical or surgical specialists

2. Evaluation methods
   a. Daily performance observation and evaluation by Dermatology faculty in the
      clinic, at the inpatient bedside and in teaching conferences. Direct feedback
      is given to the resident at the appropriate time in these settings. Processes
      used to evaluate include discussion of readings pertaining to the setting,
      verbal quizzes asking the resident to answer key clinical issues that are
      simultaneously addressed in the patient care setting.
   b. 360 degree global rating evaluations
   c. Review of procedural logs
   d. Percentile performance level on annual American Board of Dermatology (ABD)
      In-Service examination
   e. Semi-annual written evaluation of resident performance by all faculty members
      followed by one-on-one meetings between each resident and the Program
      Director to discuss the results of the faculty evaluation process

B. Medical knowledge
   1. Objectives
      a. Investigatory and analytic thinking
         Know, critically evaluate, and use medical knowledge obtained through
         teaching conferences (i.e. didactic program) to enhance patient care in
         cosmetic procedures.
      b. Knowledge and application of basic sciences to cosmetic procedures.
         Know, critically evaluate and use current medical information and scientific
         evidence for patient care.

2. Evaluation methods
   a. Daily performance observation and evaluation by Dermatology faculty in the
      clinic, at the inpatient bedside and in teaching conferences. Direct feedback
      is given to the resident at the appropriate time in these settings. Processes
      used to evaluate include discussion of readings pertaining to the setting,
verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.

b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

C. Practice-based learning and improvement
   1. Objectives
      a. Analyze own practice for needed improvement Analyze one’s practice experience to recognize strengths, deficiencies, and limits in knowledge and expertise
      b. Use of evidence from scientific studies Locating, appraising and assimilating evidence from scientific studies related to patient’s health problems. Resident should become familiar with the use of electronic databases for accessing evidence-based publications that address current clinical issues relating to dermatopathological diagnosis.
      c. Application of research and statistical methods Critically review published medical literature related to patient problems
      d. Use of information technology Use information technology to manage information, assess online medical information and support their own education
      e. Facilitate learning of others Actively participate in the education of patients, families, students, residents and other health professionals

   2. Evaluation methods
      a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.
      b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

D. Interpersonal and communication skills
   1. Objectives
      a. Creation of an appropriate professional relationship with patients Communicate effectively with patients and families to create and sustain an appropriate professional relationship
      b. Listening skills Enabling patients to be comfortable asking questions about their disease or treatment
2. Evaluation methods
   a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.
   b. 360 degree global rating evaluations
   c. Review of procedural logs
   d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
   e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

E. Professionalism
   1. Objectives
      a. Respectful, altruistic
         Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersede self-interest
      b. Ethically sound practice
         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
      c. Sensitive to cultural, age, gender and disability issues
         Demonstrate respect for the dignity of patients and colleagues as persons including their culture, age, gender and disabilities

2. Evaluation methods
   a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.
   b. 360 degree global rating evaluations
   c. Review of procedural logs
   d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
   e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

F. Systems-based practice
   1. Objectives
      a. Practice cost-effective care
         Know the relative costs of procedures and treatments; ask patient how they pay for medications

   2. Evaluation methods
a. Daily performance observation and evaluation by Dermatology faculty in the clinic, at the inpatient bedside and in teaching conferences. Direct feedback is given to the resident at the appropriate time in these settings. Processes used to evaluate include discussion of readings pertaining to the setting, verbal quizzes asking the resident to answer key clinical issues that are simultaneously addressed in the patient care setting.

b. 360 degree global rating evaluations
c. Review of procedural logs
d. Percentile performance level on annual American Board of Dermatology (ABD) In-Service examination
e. Semi-annual written evaluation of resident performance by all faculty members followed by one-on-one meetings between each resident and the Program Director to discuss the results of the faculty evaluation process

IV. Rotation evaluation
A. All weekly teaching conferences are reviewed semiannually at a combined departmental meeting of residents and faculty. Feedback from residents in this setting is used to initiate any needed changes in the cosmetic/aesthetic curriculum. Residents complete an anonymous questionnaire annually critiquing all parts of the training program. Substantive comments concerning needed changes in the training program received by this mechanism are acted upon by the Program Director following consultation with the program faculty.

B. Residents also complete an annual evaluation of each faculty member in our department. Any weaknesses in faculty teaching approach resulting from this process will be addressed by the Program Director with individual faculty members.

V. Reading list
B. *Procedures in Cosmetic Dermatology Series:*
C. Carruthers & Carruthers – *Botulinum Toxin: Cosmetic and Medical Uses*;
D. Carruthers & Carruthers – *Soft Tissue Augmentation*;
E. Draelos – *Cosmeceuticals*;
F. Goldberg *Lasers and Lights in Skin Surgery, Volume 1 & Volume 2*;
G. Goldman – *Photodynamic Therapy in Cosmetic and Medical Dermatology*
H. Hanke & Sattler – *Liposuction*.
I. Introduction

Proficiency in the evaluation, performance and interpretation of cutaneous pathology specimens has been and remains a critical aspect of dermatology. Practicing dermatologists require a basic understanding of skin histopathology not only for the day to day care of their patients but also for interactions with dermatopathologists who are evaluating their submitted biopsies. In addition, residency graduates sitting for their board examinations will be expected to be able to view glass slides and render a diagnosis as well as be acquainted with the vernacular of the discipline in other areas of the examination. During the 2nd year of residency at Vanderbilt, residents rotate on the dermatopathology and in-patient consultation service simultaneously for 3-4 months, depending on the number of residents in that class. It is during this time period when their most intensive exposure to dermatopathology occurs and when they are exposed to the greatest number of cases both routine and esoteric. In addition, 2nd and 3rd year residents rotate on a separate Immunodermatology rotation at the Vanderbilt One Hundred Oaks Dermatology Clinic on Mondays and Wednesdays. Residents get to see patients with immunobullous diseases in that clinic, where clinical-pathological correlation is obtained.

II. Goals

A. Dermatopathology:

At the completion of their residency, trainees are expected to be proficient in the following:

1. Interpretation of common tumors and inflammatory conditions presenting in the skin
2. Familiarity with typical immunofluorescence patterns associated with various skin conditions
3. Rendering an appropriate differential diagnosis for what is present under the microscope
4. Suggestions for appropriate routine and immunohistochemical stains for a given biopsy
5. Knowledge of the features of routine and immunohistochemical stains available for skin pathology specimens
6. Interpretation of potassium hydroxide, Tzanck and oil treated skin scrapings
7. Interpretation of hair shaft abnormalities
8. Discerning when direct consultation with the clinicians regarding their submitted biopsy specimens is appropriate
9. Medico-legal ramifications of cutaneous pathology evaluations
10. Discerning when and how to obtain appropriate outside consultations for given specimens
11. Knowledge of specimen preparation and interpretation costs

B. Immunodermatology
1. To learn the immunological basis of each type of diagnostic immunofluorescence test and how this technique is performed and interpreted.
2. To learn in which autoimmune dermatological diseases the results of direct and indirect immunofluorescence may be diagnostically helpful, and in which diseases one or both of these diagnostic tests is mandatory.
3. To learn to identify and interpret specific diagnostic immunofluorescence patterns.
4. To learn how specialized indirect immunofluorescence studies (antigenic mapping) may be used to diagnose and subclassify patients with inherited epidermolysis bullosa.

III. Training

A. Dermatopathology

1. During the dermatopathology rotation, residents sit at the microscope with Dr. Boyd for the morning readout on Monday, Tuesday and Thursday for approximately 2 hours. Specimens are obtained from the Vanderbilt Medical Center OHO Dermatology Clinic, VMG Franklin satellite clinics, outside private clinicians and outside consultations. Yearly, our dermatopathology service processes approximately 8,000 accession numbers translating into approximately 13,000 specimens. On Friday, the residents evaluate cases prior to their readout on the following Monday.
2. On Tuesday and Thursday from 7:00 A.M. to 8:00 A.M., conferences for all the residents are held around a multiheaded microscope and flat panel screen monitor. Slides from the weeks reading in the dermatopathology textbook selected for that year are usually reviewed on Tuesday. Thursday is typically devoted to unknown slides the residents have evaluated beforehand. In this conference, they are asked for a differential diagnosis, “think and blinks” where a slide is shown and a diagnosis or differential diagnosis proffered or a set of 10 slides are displayed and diagnoses selected similar to the method employed during their mock board examinations. Clinical aspects of the lesions and conditions shown are also discussed.
3. Dermatology Grand Rounds and Nashville Dermatology Quarterly Meetings consist of patient presentations as well as a presentation of the pathology material available. Residents discuss and comment on the dermatopathology presented.
4. Teaching slide sets are available for resident review at their own pace. Dr. Boyd has a personal set of approximately 3,000 cases and the residents have their own set of approximately 1,000 illustrative cases both of which are available to the residents.
5. Research is required of all residents for each of the three years in the program. Since many write and publish case reports, the dermatopathology involved is typically included and the resident and Dr. Boyd review the slides and obtain photomicrographs for the paper.

B. Immunodermatology

1. Using an active diagnostic immunofluorescence service based within the Division of Dermatology, each resident will learn to read and interpret both direct and indirect immunofluorescence studies with Dr. Jo-David Fine, director of the
laboratory. These slides will be available for review on Monday and Wednesday mornings at the Vanderbilt OHO Dermatology Clinic, which is attended by second- and third-year dermatology residents. Clinical correlation will be possible on those days, since most of the division's autoimmune bullous disease patients, and all of the division's inherited epidermolysis bullosa patients, are evaluated and managed within those two weekly clinical sessions.

2. Hands-on experience will be supplemented by didactic lectures on autoimmune bullous diseases, diagnostic immunofluorescence, and inherited epidermolysis bullosa. These lectures will be given on a yearly or every other yearly basis to the entire residency.

3. Teaching carousels on each of these subjects, prepared by Dr. Fine, will be available for use by the residents throughout the academic year.

IV. Objectives and Evaluation Methods

A. Patient Care

1. Objectives

a. Slide evaluation – Evaluation of a given glass slide with a patterned approach initially at a low power with subsequent evaluation at higher powers where appropriate. Development of a systematic approach to producing a differential diagnosis for the features noted.

b. Clinical correlation – Only after viewing the histopathology is the clinical information provided on the patient evaluated. The differential diagnosis is refined further based on that data.

c. Appropriateness of special stains – Deciding which, if any, special stains are most appropriate for tumor or condition in question and interpreting them accurately if they are obtained.

d. Rendering a final diagnosis

e. Rendering a comment regarding the final diagnosis – This entails listing what, if any, special stains were obtained and their interpretation. If the features present are non-specific, the most appropriate histologic differential diagnosis is rendered.

f. Clinical correlation – Under the “comments” section of the pathology report what additional information or suggestions to the submitting clinician is appropriate. This includes suggested additional studies or biopsies and anything pertinent to the type of biopsy performed and/or the technical processing of the tissues.

g. Clinician consultation – Under which circumstances is it appropriate to contact the submitting clinician to discuss the histologic specimen and/or pathologic findings.

h. Outside consultation – Under which circumstances is it appropriate for patient care and/or medicolegal reasons for asking for a consultation on a given case from a colleague with expertise in dermatopathology?

i. Immunodermatology slide evaluation will be done one-on-one with Dr. Fine supervising the resident’s reading of the microscopic slides. Residents will be expected to develop a systematic approach to producing a differential diagnosis for the immunoglobulin deposition patterns observed.
2. Evaluation Methods

a. Focused Observation and Evaluation: Daily discussions with the resident on the dermatopathology rotation – As this constitutes a one on one session, the resident is typically asked for their interpretation and/or differential diagnosis of each case before it is evaluated further. They are further asked about the usefulness of special stains. Direct feedback is given at that time and before the case is finalized. In Immunodermatology, assessment of competency will be based on the performance of each resident in diagnosing immunofluorescence studies. Each resident will be given feedback on the accuracy of diagnosis and interpretation of each tissue section. Progress will be assessed serially by Dr. Fine, and will be based on each resident's percent accuracy in diagnosis.

b. Structured Case Discussions: Discussion at the Tuesday/Thursday teaching sessions takes place simultaneously with the slide presentations. Residents are queried about differential diagnoses, special stains and clinical features/treatment options.

c. In-Training Exams: Scoring on the dermatopathology section of the in-service examination from the American Board of Dermatology

d. Clinical Performance Ratings: Twice yearly critique of the residents’ performances by the dermatology faculty.

B. Medical Knowledge

1. Objectives

a. Textbook reading – Residents are expected to have read the material from the selected section in the dermatopathology textbook used during that year.

b. Journal reading – Articles selected for discussion at the monthly journal club often involved primary or secondary dermatopathologic features which are discussed by the residents at those meetings.

2. Evaluation Methods

a. Focused Observation and Evaluation: Daily discussions with the resident on the dermatopathology rotation – As this constitutes a one on one session, the resident is typically asked for their interpretation and/or differential diagnosis of each case before it is evaluated further. They are further asked about the usefulness of special stains. Direct feedback is given at that time and before the case is finalized.

b. Structured Case Discussions: Discussion at the Tuesday/Thursday teaching sessions takes place simultaneously with the slide presentations. Residents are queried about differential diagnoses, special stains and clinical features/treatment options.

c. In-Training Examination: Scoring on the dermatopathology section of the in-service examination from the American Board of Dermatology

d. Biannual Clinical Performance Ratings: Six month critiques of the residents' performances by the dermatology faculty.
C. Practice Based Learning and Improvement

1. Objectives
   a. Resident analysis of their practice of dermatopathology for their strengths, deficiencies, and limits and areas in which they might improve.
   b. Resident review of published medical literature in relation to day to day practice of dermatopathology.
   c. Use of on-line information databases for research regarding dermatopathology cases as well as improvement in the general fund of knowledge.
   d. Resident assistance in the teaching of other residents via conferences and dissemination of published research and literature. Use by the residents of given websites dedicated to dermatopathology evaluation and diagnosis.

2. Evaluation Methods
   a. Focused Observation and Evaluation: Daily discussions with the resident on the dermatopathology rotation. As this constitutes a one on one session, the resident is typically asked for their interpretation and/or differential diagnosis of each case before it is evaluated further. Direct feedback is given at that time and before the case is finalized.
   b. Structured Case Discussions: Discussion at the Tuesday/Thursday teaching sessions takes place simultaneously with the slide presentations. Residents are queried about differential diagnoses, special stains and clinical features/treatment options.
   c. Semiannual Clinical Performance Ratings: Twice yearly critique of the residents’ performances by the dermatology faculty.

D. Interpersonal and communication skills

1. Objectives
   a. Knowledge of when and how to seek direct consultation with submitting clinicians regarding their specimens.
   b. Knowledge of when and how to seek outside consultation with colleagues in dermatopathology for assistance in interpretation of difficult cases.
   c. Knowledge of medicolegal aspects of specimen interpretation and report generation.

2. Evaluation Methods
   a. Focused Observation and Evaluations: Daily discussions with the resident on the dermatopathology rotation. As this constitutes a one on one session, the resident is typically asked for their interpretation and/or differential diagnosis of each case before it is evaluated further. Direct feedback is given at that time and before the case is finalized.
   b. Structured Case Discussions: Discussion at the Tuesday/Thursday teaching sessions takes place simultaneously with the slide presentations. Residents are queried about differential diagnoses, special stains and clinical features/treatment options.
c. 360 global rating evaluations
d. Semiannual Clinical Performance Ratings: Twice yearly critique of the residents’ performances by the dermatology faculty.

E. Professionalism

1. Objectives

   a. Professional ethics – building a foundation of ethical principles regarding patient care and privacy, transmittal of information and confidentiality
   b. Respect for the profession – the need for “giving back” to the community populace, community physicians and the less fortunate both home and abroad
   c. Sensitivity to sexual, cultural, religious, disability and age issues.

2. Evaluation Methods

   a. Focused Observation and Evaluation: Daily discussions with the resident on the dermatopathology rotation. As this constitutes a one on one session, the resident’s professional behavior may be observed, and direct feedback is given as appropriate.
   b. 360 global rating evaluations
   c. Biannual Clinical Performance Ratings: Twice yearly critique of the residents’ performances by the dermatology faculty.

F. Systems Based Practice

1. Objectives

   a. Understanding the workings of a service, division and department within a large medical center.
   b. Understanding how a dermatopathology practice interacts with physicians in the local community and at large.
   c. Understanding the role of a dermatopathology service with regards to its role in in-patient dermatology and on other services.
   d. Understanding the costs of dermatopathology services and the methods of billing/reimbursement.

2. Evaluation Methods

   a. Focused Observation and Evaluation: Daily discussions with the resident on the dermatopathology rotation. As this constitutes a one on one session, the resident can be observed to see how they function within the health care system.
   b. Biannual Clinical Performance Ratings: Twice yearly critique of the residents’ performances by the dermatology faculty.

V. Rotation Evaluation
Residents complete a “Resident to Faculty” evaluation on all division rotations with places for noting specific strengths and weaknesses of the program, facilities, curriculum, teaching and material covered. In addition, an annual anonymous numeric assessment of the faculty members is submitted by the residents. Residents are encouraged to make suggestions during the year regarding subjects in dermatopathology on which they would like more in depth teaching and/or slide evaluation.

VI. References

A. Dermatopathology

1. Textbooks
   a. *Pathology of the Skin*, McKee, Calonje, Granter, editors.
   b. *Skin Pathology*, Weedon
   c. *Textbook of Dermatopathology*, Barnhill, Crowson, editors
   d. *Pathology of the Skin*, Farmer, Hood, editors

2. Journals
   a. American Journal of Dermatopathology
   b. Journal of Cutaneous Pathology
   c. Archives of Dermatology
   d. Journal of the American Academy of Dermatology

B. Immunodermatology

1. Textbooks:

VII. Future Goals

A. Dermatopathology

1. One Year: Recruit another Dermatopathologist who will be active in the clinical reading of slides and the teaching of residents.
2. Five Years: Continue to expand the Dermatopathology Service.

B. Immunodermatology

1. One Year: Immediate hands-on and didactic teaching, as described in the curriculum above.

2. Five Years: As a much larger referral base is established, it is planned that one or more residents will use a growing tissue bank of well characterized cryopreserved specimens to participate research projects (under Dr. Fine’s supervision) which are aimed at addressing novel questions regarding diagnosis or pathogenesis of one or more autoimmune diseases.

CONTACT DERMATITIS/OCCUPATIONAL DERMATOLOGY Jo-David Fine, M.D., M.P.H. (Chairman)

I. Curriculum Description

A. Residents throughout their training will learn how to evaluate patients with contact dermatitis, via the tutelage of every faculty member who attends our medical dermatology clinics (Vanderbilt One Hundred Oaks (OHO), VAMC, VMG Franklin).

B. Residents in each of the medical dermatology clinics will learn on a one-to-one interaction with our faculty how to choose appropriate allergens for diagnostic testing.

C. Those residents attending Dr. Fine’s Monday and Wednesday AM OHO clinics will directly observe patch test placement (using a comprehensive bank of over 250 allergens) and their interpretation, under the direct supervision of Dr. Fine, Director of the Vanderbilt University Contact Dermatitis / Patch Testing Unit. Although there is considerable variation in the number of patients being tested, on average about 3-4 patients each week undergo patch testing in our clinic system.

D. Residents will learn how to access resources (books; articles; computerized) which may provide clinically useful information to those patients having positive patch testing results.

E. Objectives

1. To learn how to elicit histories pertinent to contact dermatitis, to include those which are occupational in origin.

2. To learn how to distinguish between irritant and allergic contact dermatidities.

3. To understand the basic science underlying epicutaneous patch testing.

4. To learn in which patients patch testing should be performed, and to learn how to choose which allergens should be included in the testing panels.

5. To learn how to interpret positive and negative patch test results, and how to identify situations which may lead to false-negative and false-positive results.

6. To learn how to treat acute and chronic contact dermatitis, as well as how to assist patients with occupational dermatitis in improving their workplace.

F. Goals

1. To learn how to elicit histories pertinent to contact dermatitis, to include those which are occupational in origin.

2. To learn how to distinguish between irritant and allergic contact dermatidities.

3. To understand the basic science underlying epicutaneous patch testing.

4. To learn in which patients patch testing should be performed, and to learn how to choose which allergens should be included in the testing panels.
5. To learn how to interpret positive and negative patch test results, and how to identify situations that may lead to false-negative and false-positive results.
6. To learn how to treat acute and chronic contact dermatitis, as well as how to assist patients with occupational dermatitis in improving their workplace.

II. Competency Based Learning Objectives and Evaluation Methods

A. Patient Care

1. Objectives
   a. To elicit histories pertinent to contact dermatitis, including occupational etiologies.
   b. To learn to distinguish between irritant and allergic contact dermatitides.
   c. To learn which patients to patch test, how to choose allergens to include in the testing panels, and how to read the patch tests.
   d. To learn how to treat acute and chronic contact dermatitis, and how to help patients with occupational dermatitis improve their workplace.

2. Evaluation Methods
   a. Clinical Performance Ratings – every six months.
   b. Focused Observation and Evaluation – Daily observation by Dr. Fine of the resident’s ability to elicit an appropriate history of possible contactants, discrimination between irritant and allergic contact dermatitis, and ability to order, apply, and read the right patch tests.

B. Medical Knowledge

1. Objectives
   a. To learn the pathophysiology of acute and chronic allergic contact dermatitis.
   b. To learn the mechanisms of action of treatments for allergic contact dermatitis.

2. Evaluation Methods
   a. In-Training Examination – Yearly
   b. Clinical Performance Ratings – Every six months.
   c. Focused Observation and Evaluation - Daily observation of the resident’s fund of knowledge by Dr. Fine.

C. Practice-Based Learning and Improvement

1. Objectives
   a. Critically review the scientific literature that applies to diagnosis and treatment of allergic contact Dermatitis.
   b. Learn how to obtain scientific articles from data bases such as Pub Med.
c. Learn how to use the software available from the American Contact Dermatitis Society to prepare lists of usable topical agents for those patients having positive patch tests.

2. Evaluation Methods

a. Focused Observation and Evaluation - Daily observation of the resident's ability to access and review the medical literature, and to use computer technology available to improve patient outcomes.

b. Clinical Performance Ratings – Every six months.

D. Interpersonal and Communication Skills

1. Objectives

Communicate effectively with patients, their families, and their employers in order to elicit the etiology of their contact dermatitis, and to treat it in the workplace when it is occupational.

2. Evaluation Methods

a. Focused Observation and Evaluation – Daily observation by Dr. Fine of the resident's skill in communication with patients, families, and employers.

b. Clinical Performance Ratings – Every six months.

c. 360 Assessments – Every six months, provides input from patients, staff, and peers regarding communication skills.

E. Professionalism

1. Objectives

a. Demonstrate action in the best interest of the patient when addressing occupational allergic contact dermatitis.

b. Demonstrate sensitivity to patient's ethnicity, age, and disabilities, as these may play a role in the etiology of the disease, as well as in the treatment options available.

2. Evaluation Methods

a. Focused Observation and Evaluation: Daily observation of the resident's ability to act in the patient's best interest, with respect to individual cultural differences.

b. Clinical Performance Ratings – Every six months.

c. 360 Assessments

F. Systems-Based Practice

1. Objectives

a. Provide cost-effective care.
b. Develop knowledge of the workman’s compensation system when working with occupational dermatoses.

2. Evaluation Methods

a. Focused Observations and Evaluation: Daily observation of the resident’s ability to provide cost effective care and work with the Worker’s Compensation system.

b. Clinical Performance Ratings – Every six months.

c. 360 Assessments.

III. Reading and Information Resource List

A. Textbooks: Pertinent textbooks on contact dermatitis and occupational dermatology will be available to our residents in the Dermatology Clinic at Vanderbilt One Hundred Oaks. These include:

B. Informative articles on both topics will be selected for review by residents during our every other month medical dermatology journal club.

C. Residents will be taught how to (a) search PubMed for articles on contact dermatitis, and (b) use software available from the American Contact Dermatitis Society to prepare lists of usable topical agents for those patients having positive patch tests.

IV. Future Goals

A. One Year:
   1. Meet all goals noted above.
   2. Obtain feedback on improving the clinic.

B. Five Years:
   1. Establish a large patient referral basis for patch testing on patients living or working throughout TN, southern KY, MS, and western GA. As a correlate, to develop formal relationships with local industries on employees needing evaluation of potential occupational dermatoses. The latter will be facilitated with the assistance of Vanderbilt's Office for Occupational Health.
Appendix VI: Graded Responsibility and Supervisory Lines of Responsibility for Patient Care

I. PGY-2

A. Vanderbilt University Outpatient Clinics (OHO, Vanderbilt University Children's Hospital, and Franklin, TN):

1. Continuity Clinics – Residents in continuity clinics are expected to see the patient, do an appropriate history and physical examination, generate a differential diagnosis, and a treatment plan. They will document these items appropriately in a clinic note, and will write the prescriptions for the patient. They are also expected to order laboratory and radiographic studies, and follow-up with their patients. This includes letters to referring physicians, and letters to insurance companies. Procedures done in this clinic by the resident will depend upon the experience of the resident, but will at a minimum include biopsies, simple excisions, cryosurgery and electrodessication and curettage. This is done in direct supervision by one of the senior faculty Dermatologists.

2. Attending Clinics – Responsibility in Attending Clinics will vary depending upon the clinic and the faculty attending the clinic. At a minimum, the resident will be expected to see the patient, do an appropriate history and physical examination, generate an appropriate differential diagnosis, and document their findings in the clinic note. With attending guidance, they will write prescriptions for the patient according to the joint medical plan. They will be directly supervised by the attending physician in clinic who will be responsible for the patient care. It is expected procedures performed in these clinics will depend upon the experience of the resident and the sophistication of the procedure.

3. Student Health Clinics – First year residents will be supervised by the PGY-4 resident who is also in this clinic. If questions arise, the Program Director, or the attending physician on call is available to answer them by pager or cell phone. The resident will be responsible for the history, physical examination, diagnosis, treatment plan, documentation, laboratory orders, and medication dispensing from the student health pharmacy or prescription medications. No procedures other than liquid nitrogen cryosurgery are done in this clinic. Procedures may be referred to the resident’s continuity clinic, or to the appropriate attending physician’s clinic at OHO.

B. Vanderbilt University Inpatient and Consult Service:

1. Consult Service - From 5 p.m. until 8 a.m. on weekdays, the first year resident on the inpatient service is responsible for any consultations to Dermatology, as well as all patient phone calls from the entire Division of Dermatology. These are done one-on-one with the attending on call. It is expected that proper hand-offs occur between the PGY-3 consult resident and the PGY-2 resident at 5 p.m. and 8 a.m. so that continuity occurs. This starts in October of the PGY-2 year.

C. VAMC Clinics:

1. General Dermatology Clinics - Residents in the General Dermatology clinics are expected to see the patient, do an appropriate history and physical examination,
generate a differential diagnosis, and a treatment plan. They are also expected to order laboratory and radiographic studies, consultations, and follow-up with their patients. The residents are responsible for entering the clinic note, laboratory requests, and prescriptions in the electronic record. Procedures done in this clinic by the resident will depend upon the experience of the resident, but will at a minimum include biopsies, cryosurgery, electrodessication and curettage, phototherapy, KOH preps, hair preps, and gram stains. One of the senior faculty Dermatologists is available for consultation on all patients, and all new patients and consultations are checked out with them.

2. Dermatologic Surgery Clinics - The resident does simple excisions on uncomplicated patients under the supervision of the third year resident. This clinic is supervised by an attending physician. The resident is responsible for documenting the procedure in the electronic record in this clinic, as well as following up on the pathology of the excision specimen. The resident is responsible for entering the procedures performed in their ACGME log book.

3. Photopheresis Patients - The first year resident on the VAMC Inpatient and Consult Service is responsible for seeing the patient, doing a history and physical, and entering it into the electronic record prior to photopheresis being performed. They will also check the labs and medications of these patients and formulate a treatment plan with the attending physician. The resident is directly supervised by the attending physician who is seeing the patient.

4. Dermatopathology Electronic Biopsy log – First year residents will enter every biopsy into this electronic log, and follow up the biopsies when pathology is available. On a monthly basis, the first year resident will print all incomplete entries in the log, reconcile these, and file a report to the Chairman of the Division of Dermatology at VAMC.

D. VAMC Inpatient and Consult Service:

During the workday (M-F 8 am to 5 pm) the first year resident on the VAMC service manages the inpatients under the supervision of the attending physician for the patient. Responsibilities include a complete medical history and physical, diagnosis, and treatment plan. The resident is responsible for ordering appropriate laboratory tests, consultations, and therapies. All of this is entered into the electronic medical record. The first year resident is also responsible for consultations on inpatients and outpatients at the VAMC. Most patients are seen in the outpatient clinic, with the exception of patients who are not ambulatory and must be seen at the bedside. All patients are seen with the VAMC attending physician for the clinic that day, or the VAMC attending physician on call, who supervises the resident. Residents are responsible for communication with the consulting team, and following up on the patient as required. After hours (M-F 5 pm to 8 am) and on weekends, the inpatients and consultation service is handled by the VUMC resident and attending on call. Appropriate handoffs are the responsibility of the VAMC first year resident and the VUMC resident on call.

II. PGY-3

A. Vanderbilt University Outpatient Clinics:
1. Continuity Clinics – Residents in continuity clinics are expected to see the patient, do an appropriate history and physical examination, generate a differential diagnosis, and a treatment plan. They will document these items appropriately in a clinic note, and will write the prescriptions for the patient. They are also expected to order laboratory and radiographic studies, and follow-up with their patients. This includes letters to referring physicians, and letters to insurance companies. Procedures done in this clinic by the resident will depend upon the experience of the resident, but will at a minimum include biopsies, simple excisions, electrodessication and curettage, cryosurgery, hair preps, KOH preps, and gram stains. During the PGY-3 year, the residents are expected to become responsible for coding the office visits and procedures. This is done in direct supervision by one of the senior faculty Dermatologists.

2. Attending Clinics – Responsibility in Attending Clinics will vary depending upon the clinic and the faculty attending the clinic. At a minimum, the resident will be expected to see the patient, do an appropriate history and physical examination, generate an appropriate differential diagnosis, and document their findings in the clinic note. With attending guidance, they will write prescriptions for the patient according to the joint medical plan. They will be directly supervised by the attending physician in clinic who will be responsible for the patient care. It is expected procedures performed in these clinics will depend upon the experience of the resident and the sophistication of the procedure.

3. VUMC Surgery Clinics - Second year residents rotate on the Mohs surgery service, the cosmetic surgery service, and the laser surgery service. They are expected to perform history and physicals on new surgical patients and document these findings by dictation. They learn and perform procedures in a graded form depending upon their ability and skill level. All surgeries and procedures will be done under the direct supervision of the Dermatologic Surgeon in the clinic. The resident is responsible for entering the procedures performed in their ACGME log book.

B. Vanderbilt University Consult Service:

The second year resident on the VU consultation service is responsible for seeing all consultations that are placed from the VUMC campus during the hours of 8 am until 5 pm. After hours, the resident on call will see the requested consultations. Residents are expected to do an appropriate Dermatologic history and physical examination, and generate an appropriate differential diagnosis, work up, treatment plan, and consultation note in the electronic medical record. The resident is responsible for doing biopsies when needed, and is expected to follow-up on the biopsies by reading the slides with the Dermatopathologist. The resident is also responsible for timely communication with the patient’s health care team about biopsy results and treatment plan. This includes providing education to the residents who obtained the consultation. When medical students or residents from other disciplines are rotating on the consultation service, the resident is responsible for teaching them about the patients. The attending physician on call, who will see the patient with the resident, will directly supervise residents.

C. VAMC Clinics:

1. General Dermatology Clinics:
Second year residents in the General Dermatology clinics are expected to see the patient, do an appropriate history and physical examination, generate a differential diagnosis, and a treatment plan. They are expected to see a greater number of patients than the first year residents who have less experience, and the third year residents who are teaching. They are also expected to order laboratory and radiographic studies, and follow-up with their patients. The residents are responsible for entering the clinic note, laboratory requests, consultations, and prescriptions in the electronic record. Procedures done in this clinic by the resident will depend upon the experience of the resident, but will at a minimum include biopsies, electrodessication and curettage, phototherapy, KOH preps, and gram stains. One of the faculty Dermatologists is available for consultation on all patients, and all new patients and consultations are checked out with them. The second year resident is also responsible for teaching the medical students and residents of other disciplines when the third year resident needs assistance.

2. VAMC Dermatologic Surgery Clinics:
The second year resident does excisions and repairs including uncomplicated flaps on patients under the supervision of the third year resident. An attending physician supervises this clinic. The resident is responsible for the electronic record for this clinic, and for following up the pathology of these specimens. The resident is responsible for entering the procedures performed in their ACGME logbook.

3. VAMC Dermatopathology Electronic Biopsy log – Second year residents will enter every biopsy into this electronic log, and follow up the biopsies when pathology is available. On a monthly basis, they will reconcile all incomplete entries in the log for their PGY year.

III. PGY-4

A. Vanderbilt University Outpatient Clinics:

1. Second year residents in the General Dermatology clinics are expected to see the patient, do an appropriate history and physical examination, generate a differential diagnosis, and a treatment plan. They will document these items appropriately in a clinic note, and will write the prescriptions for the patient. They are also expected to order laboratory and radiographic studies, and follow-up with their patients. This includes letters to referring physicians, and letters to insurance companies. Procedures done in this clinic by the resident will depend upon the experience of the resident, but will at a minimum include biopsies, simple excisions, electrodessication and curettage, cryosurgery, gram stains, hair preps and KOH preps. The resident is expected to be responsible for coding the office visits and procedures. The goal is for the resident to be functioning at the level of a practicing dermatologist in this clinic. This is done in direct supervision by one of the senior faculty Dermatologists.

2. Attending Clinics – Responsibility in Attending Clinics will vary depending upon the clinic and the faculty attending the clinic. At a minimum, the resident will be expected to see the patient, do an appropriate history and physical examination, and generate an appropriate differential diagnosis and treatment plan, and document their findings in the clinic note. With attending guidance, they will write
prescriptions for the patient according to the joint medical plan. The attending physician in clinic who will be responsible for the patient care will directly supervise them. It is expected procedures performed in these clinics will depend upon the experience of the resident and the sophistication of the procedure. At a minimum the resident should be able to perform procedures expected of a practicing general Dermatologist.

3. Student Health Clinics – PGY-4 residents will supervise the PGY-2 or 3 year resident who is also in this clinic, as well as see patients independently. If questions arise, the Program Director, or the attending physician on call is available to answer them by pager or cell phone. The resident will be responsible for the history, physical examination, diagnosis, treatment plan, electronic documentation, and medication dispensing from the student health pharmacy. No procedures other than liquid nitrogen cryosurgery are done in this clinic. Procedures may be referred to the resident’s continuity clinic, or to the appropriate attending physician’s clinic at OHO.

4. VUMC Surgery Clinics - Third year residents rotate on the Mohs surgery service, the cosmetic surgery service, and the laser surgery service. They are expected to further their education in performing procedures in a graded form depending upon their ability and skill level. They are expected to perform history and physicals on new surgical patients and document these findings by dictation. It is expected by the end of the rotation that the resident will be performing at the level of a practicing general Dermatologist. All surgeries and procedures will be done under the direct supervision of the Dermatologic Surgeon in the clinic. The resident is responsible for entering the procedures performed in their ACGME log book.

B. VAMC Clinics:

1. Outpatient Dermatology Clinics: The senior resident at the VAMC clinic will be in charge of seeing patients with and teaching medical students and rotating residents from other specialties. Teaching may be done by “shadowing” for students or residents who have little Dermatology experience, or by having the resident or student see the patient and present the case to the resident. The resident is expected to function in a teaching role just as an attending physician. An attending physician is available at all times for the resident to consult about the patient if needed.

2. Outpatient Dermatologic Surgery Clinics: The third year resident teaches the junior residents basic surgical techniques in the surgery clinic under the supervision of the attending physician. The third year resident is also responsible for the scheduling and conduction of the outpatient surgery clinics, including the clinic conducted with Plastic Surgery, under the supervision of the appropriate attending physician. In the Plastic Surgery/Dermatology Surgery clinic, the third year resident does surgery with the Plastic Surgery Fellow. Residents are allowed to do more extensive outpatient surgeries in this clinic. The resident is responsible for entering the procedures performed in their ACGME log book, and following up the pathology for their excisions.

3. VAMC Dermatopathology Electronic Biopsy log – Third year residents will enter every biopsy into this electronic log, and follow up the biopsies when pathology is available. On a monthly basis, they will reconcile all incomplete entries in the log for patients seen by PGY-4 year residents.
C. Elective Rotation: Third year residents in good standing may arrange and conduct a one month elective at the institution of the resident’s choosing that will enhance the resident’s education in an area of knowledge and/or skill that the resident had not acquired in the previous 2 years of training. Responsibilities include obtaining permission for the elective (memo of understanding from the mentor for the elective), a written proposal of objectives before the elective rotation, a written summary of the elective after the elective, and an evaluation of performance from the mentor for the elective. Residents are expected to perform patient care under the direct supervision of the mentor for this elective. The mentor will be responsible for the responsibility given to the resident in patient care.
Appendix V: Promotion:

I. Vanderbilt University Dermatology Promotion Guidelines, 8-8-09

A. At the completion of each PGY year, the Residency Program Director will submit each resident’s promotion to the faculty for approval. Approval will be based upon the Goals for Progression for each residency year listed below. Approval may be a) in good standing; b) with a warning for academic or clinical performance; or c) with probation for a defined period for academic or clinical performance. Residents who are on warning or probation will have defined goals to meet, after which the resident’s performance is reviewed by the faculty in accordance with the rules outlined in the House Staff Manual. Residents who are not approved for promotion will either have to repeat the year under guidelines approved by the Vanderbilt University GME office and the American Board of Dermatology, or not have their contract renewed and be dismissed. The latter will also be in concordance with the Vanderbilt University GME office.

B. Residents completing their PGY-4 year satisfactorily, with all competencies satisfactorily completed will be approved to take the American Board of Dermatology Examination. This approval will be done by the Program Director electronically on the ABD website.

C. Residents completing their PGY-2 and PGY-3 years satisfactorily with competencies satisfactorily completed for their level will be promoted to the next year. This promotion will be done by the Program Director electronically on the ABD website.

II. Goals for Progression by Residency Year

A. PGY-2

1. Develop competence in performing an appropriate dermatologic history and physical examination through one-on-one management with teaching faculty in a variety of patients, including simple and complex patients, in the outpatient clinic, and in hospitalized patients on the Dermatology service.

2. Develop the ability to formulate a differential diagnoses based upon the primary lesion and the disease pattern through one-on-one management with teaching faculty, unknown patient conference, and kodachrome slide conferences.

3. Learn the skills required for appropriate Dermatologic procedures including but not limited to diagnostic and therapeutic skin biopsies, simple excisions, cryosurgery, acne surgery, electrodessication and curettage, phototherapy, photopheresis, and patch testing with teaching faculty through one-on-one management.

4. Learn how to manage simple and complex cutaneous disease, including inpatients and outpatients, topical and systemic therapy through teaching conferences, textbook conferences, and one-on-one management with teaching faculty in the outpatient and inpatient facilities.

5. Acquire core knowledge of Dermatopathology, and the basic science of cutaneous biology and disease consistent with a PGY-2 level in Dermatology through textbook conferences, teaching conferences, and meetings.

6. Begin developing research skills through initiating a project with a chosen mentor.
B. PGY-3

1. Continue to develop further expertise in PGY-2 goals, with increasing responsibility.
2. Develop proficiency in performing inpatient Consultations, with appropriate management and communication skills through one-on-one management with Teaching faculty.
3. Develop proficiency in Dermatopathology through conferences, and rotation on the Dermatopathology service.
4. Begin developing more advanced surgical skills through one-on-one management with teaching faculty, the Dermatologic Surgical Fellow, and senior residents.
5. Acquire proficiency in Pediatric Dermatology through one-on-one management with teaching faculty and teaching conferences.
6. Present an abstract at an appropriate national meeting on the research work started in PGY-2 year.
7. Develop documentation and coding skills.

C. PGY-4

1. Develop further expertise in PGY-2 and -3 goals, with the expectation that at the end of this year the skill level is that of a practicing Dermatologist.
2. Develop proficiency in Dermatologic Surgery, including Laser Surgery, and Cosmetic Dermatology procedures through teaching conferences and one-on-one management with teaching faculty.
3. Arrange and conduct a one month elective at the institution of the resident’s choosing that will enhance the resident’s education in an area of knowledge and/or skill that the resident had not acquired in the previous 2 years of training. This will include obtaining permission for the elective (memo of understanding from the mentor for the elective), a written proposal of objectives before the elective rotation, a written summary of the elective after the elective, and an evaluation of performance from the mentor for the elective.
Appendix VI: Duty Hours

VANDERBILT UNIVERSITY DIVISION OF DERMATOLOGY
DUTY HOURS POLICY 8-8-2003

1. Residents’ total duty hours will not exceed 80 hours per week, averaged over a four-week period.
2. Residents will be given at least one day out of seven free from all clinical and educational responsibilities averaged over four weeks.
3. Residents will take call from home. Continuous time on call is limited to 24 hours, with up to six additional hours for inpatient and outpatient continuity, transfer of care, educational debriefing, and formal didactic activities. Residents will not assume responsibilities for new patients after 24 hours of in house call. The time spent in the hospital while on call will be counted toward the weekly duty hour limit. Time spent on call at home will not be counted toward the weekly duty hour limit.
4. Residents will be given at least 10 hours for rest and personal activities between daily duty periods.
5. Moonlighting: All moonlighting must be approved by the Dermatology Program Director, the Chief of Dermatology, the Chairman of the Department of Medicine, and the Vanderbilt University GME Office. All moonlighting hours will count toward the total duty hours. Moonlighting must not interfere with the resident’s achievement of the program’s educational goals and objectives.

Appendix VII: Vanderbilt University Dermatology Fatigue, Sleep Deprivation, and Stress Policy 8-5-09

Our residency program is a medium-sized program, and in each clinic an attending physician who sees patients with the resident according to the Medicare teaching physician laws directly supervises the resident. Any impairment in performance or learning due to fatigue, sleep deprivation, or stress would usually be initially observed and discussed directly with the resident by the attending and/or brought to the Program Director’s attention for further action. In addition, Chief Residents are actively involved in faculty meetings, have direct access to the Program Director at all times when fatigue, sleep deprivation, and stress may be an issue, and their opinions regarding residents who may be having these problems are sought whenever this is in question.

The Program Director, or any of the teaching faculty, who serve as mentor, may provide informal counseling. Formal counseling services are available through the Faculty and Physician Wellness Program that is part of the Vanderbilt EAP/WLC program (Employee Assistance Program/Work-Life Connections). This program provides professional confidential counseling to all physicians at Vanderbilt in need. Either the resident or the Program Director may arrange for the resident to use these services. They may be accessed by web site or phone, and all residents get a one-hour introduction to the services that are offered in the weeklong orientation prior to starting residency. A full range of services including psychiatry, and substance abuse counseling are available.
Appendix VIII: Vanderbilt University Division of Dermatology Vacation and Leave Policy

I. Vacations:
   A. Each resident has three weeks (15 working days) of vacation. Approved meeting attendance is not counted as vacation.

   PGY 2 and PGY 3 residents will take vacation in 1-week blocks. PGY 4 residents may take individual days for the 3rd week to accommodate job interviews. You should not plan on leaving Friday before 5 p.m. or until all your duties are complete. This is required even for residents with academic time on Friday afternoons; if you have plans for Friday afternoons you must take annual leave time or you may be pulled to cover a clinic in the unexpected absence of another resident or other scheduling issues.

   Specific vacation time for residents is as follows:
   1. **PGY-2**: 3 weeks taken in 1-week blocks. Residents **MAY** be able to attend portions of the AAD but it is the responsibility of the PGY-2 class to cover the clinics and hospital that week so do not automatically assume you will be able to attend. This is worked out from year to year.
   2. **PGY-3**: 3 weeks taken in 1 week blocks + AAD (5 working days) or another not to exceed 5 total days including weekends
   3. **PGY-4**: 3 weeks (taken in 2 1-weekblocks and a third may be distributed by days for job interviews) + AAD (5 working days) + another not to exceed 5 working days. This includes board review courses.

   B. Holiday leave: Dermatology residents are given holiday leave for 5 days at Christmas OR New Year’s. You may request which time you prefer and final assignments will be made prior to the start of the academic year. Please inform the chief residents in the spring before the academic year starts if you require religious holidays that are not included in the above schedule. Vanderbilt Dermatology adheres to the VUMC GME guidelines that allow religious holidays in addition to the time outlined above (see VUMC resident handbook for additional information) but it is our expectation that you will inform us of those holidays while the schedule is being made or as soon as possible thereafter.

   C. Sick Leave: Sick leave is regulated through GME. Please contact the chief resident, Dr. Miller and clinic attending as early as possible so that schedules may be rearranged accordingly. Ensure that all duties are appropriately covered. Keep the chief resident and your covering resident up to date of your status.

      If some urgent business arises please notify the Chief resident and Dr. Miller immediately. You will be required to take leave for any family or other business to which you must attend so plan your vacations accordingly.

II. Leave for interviews:

As above, PGY-4 residents are allowed 5 days of vacation time to be taken individually for job interviews. The Dermatology Residency Program encourages and supports its trainees to
pursue academic opportunities. Accordingly, PGY3-4 residents are given up to 5 additional working days for interviews for fellowship training programs (typically Dermatopathology, Mohs Surgery, and Pediatric Dermatology Fellowships) or for full-time academic positions. Only 5 such interview days total are permitted over both PGY 3-4 years. Residents are to gain the approval for these requests by the Program Director and Chief Resident including arrangements made for their clinical and other responsibilities. Residents are strongly encouraged to plan ahead as much as possible because short-term clinic cancellations may not be possible. Cross-coverage must be arranged that does not adversely impact existing clinics. If satisfactory coverage cannot be arranged, the interview must be cancelled or rescheduled. Absences for other interview purposes; e.g., private practice positions, are considered annual leave.

III. The Vanderbilt University Division of Dermatology follows the Vanderbilt GME guidelines for leave as outlined in the Vanderbilt University Medical House Staff Manual.

A. LEAVE POLICY
Vanderbilt Dermatology recognizes that a resident may need to be away from work due to medical or family reasons. Leaves of absence are defined as approved time away from residency duties, other than regularly scheduled days off as reflected in a rotation schedule. All leave will be scheduled with prior approval by the Program Director or Chief of Service, with the exception of emergencies or unexpected illnesses. In unexpected/emergency situations, the resident should contact the Program Director or Chief of Service at the earliest possible time. The amount of time a resident can be away from residency duties and still meet Board requirements varies among the specialties and it is the policy of the ABD that a resident may be away for 6 weeks out of a given year or 16 weeks total during the entire residency. If leave time is taken beyond that time the resident is required to extend his/her period of activity in the training program. The resident should request permission to extend their training and should establish a schedule for doing so in consultation with the Program Director. Leave time under any of these categories will not be counted toward Board eligibility. When the need/request for leave is foreseeable, the request should be submitted at least thirty (30) days prior to the leave. When the need for the leave is unforeseeable, the request should be submitted as soon as is practical.

1. Family and Medical Leave Act (FMLA) and Tennessee Parental Leave Act (TPLA) Leave:
Consistent with the FMLA, eligible residents are able to take up to 12 weeks of leave for certain personal medical reasons or for qualifying family reasons. Remember that FMLA /TPLA is separate from the ABD requirements. Though you may take all of the leave to which you are entitled under these laws, the ABD will require extension of your residency if you are away from training for more than 6 weeks in an academic year or 16 weeks total during your 3 year residency. There are eligibility requirements for FMLA/TPLA and they are listed in the VUMC Resident Handbook.

The Occupational Health Clinic (OHC) needs to receive a completed Certification from a health care provider indicating the medical basis for the personal or family member’s condition justifying the leave. OHC notifies the Program Director of medically qualifying leave. FMLA leave may be taken for personal health issues as well as to care for a spouse, child or parent with a serious health condition. If the leave is to care for a newborn, or a recently adopted infant, or infant in foster care, the TPLA provides an additional 4 weeks (up to 16 weeks) for care and bonding with the infant. Leave under FMLA or TPLA is either paid or unpaid. Sick and vacation time are used before a resident goes into unpaid status. Health insurance is maintained throughout the leave period, but if the resident is in unpaid status she/he must continue to pay
her/his share of the cost. A resident who needs medical leave for a pregnancy related condition, or to recover from childbirth, will use FMLA/TPLA from the start of the leave, even if this occurs on a weekend or holiday time. A house officer who is the father of a new born, newly adopted infant, or one placed in his home for foster care may use FMLA/TPLA for infant care. If leave is taken for the residents’ own health a letter of release to work is REQUIRED from your physician before you will be allowed to return to work.

Residents who incurred a serious injury while on active military duty, or one who has a spouse, child, parent who incurred a serious injury while on active military duty or one who is the next of kin to an injured service member, may be entitled to up to 26 weeks of leave in a 12 month period for treatment of her/his injury, or care of the injured service member. Also, a resident whose family member, including next of kin, is called to active duty, or who otherwise incurs a military related exigency, may be entitled to 12 weeks of FMLA to deal with the problems caused by the exigency.

As well as taking FMLA in continuous blocks, for medical conditions, a resident may be entitled to intermittent leave for treatment appointments, or episodic conditions, for her/himself or for care of a qualifying family member. Questions regarding FMLA/TPLA leave should be addressed to the Office of Graduate Medical Education.

2. Parental Leave/Adoption
Parental leave is available to eligible residents for the birth or adoption of a child under the FMLA and the Tennessee Parental Leave Act (TPLA). If certain conditions are met, a resident may be eligible for parental (or other) leave related to adoption, pregnancy, childbirth, and/or nursing an infant for a period of up to four months. Time off under the TPLA and the FMLA runs concurrently. Please see above section on FMLA/TPLA for more information. If paid sick or vacation time is available, it must be used prior to going into unpaid status. Contact the Office of GME for more information about qualifying conditions and the provisions for parental leave under these laws. For care of a newly adopted child, available vacation and then unpaid leave is used.

3. Medical Leave
Medical leave that is not FMLA eligible is available at the discretion of the Program Director in 30-day increments up to a maximum of 52 weeks. Medical documentation is required if the resident is away from work for more than 5 calendar days. Residents will be required to exhaust other forms of leave for which they may qualify prior to being eligible for medical leave. If paid sick or vacation time is available, it will be used prior to going into unpaid status.

4. Education Leave
Education leave may be granted at the discretion of the Program Director.

5. Military Leave/Jury Duty
Residents will be granted military leave or leave for jury duty as required by applicable law. Please contact the Office of GME for specific questions about such leave.

6. Personal Leave
Personal leave may be provided at the discretion of the Program Director in 30-day intervals according to the policies established by the individual residency programs. Residents will be required to exhaust other forms of leave for which they may qualify prior to being eligible for personal leave.
7. Bereavement Leave
If there is a death in your family, you may take up to 3 working days off as leave with pay. For this purpose, "family" is defined as spouse, domestic partner, child, mother, father, mother-in-law, father-in-law, sister, brother, grandparent or grandchild. Except in very unusual circumstances, bereavement leave must be utilized within 14 days of the date of death.
Appendix IX: Vanderbilt University Division of Dermatology
Moonlighting Policy

The Vanderbilt University Division of Dermatology complies with the moonlighting rules as per the House Staff Manual. Because of the heavy reading schedule and research required of Dermatology residents, privileges will only be extended to exceptional residents who have demonstrated an excellent grasp of clinical dermatology for their level.

Vanderbilt University Medical Center House Staff Manual
B. EXTRACURRICULAR PROFESSIONAL ACTIVITY (MOONLIGHTING)

It is the position of VUMC that the primary responsibilities of members of the house staff are to their own postgraduate medical education and to the patients charged to their care. In as much as extramural professional activities, or “moonlighting,” may generally conflict with these responsibilities, Vanderbilt discourages such activities. In some departments, outreach programs at other medical facilities are approved activities, are a part of the established educational program, and are not considered moonlighting. Moonlighting is prohibited during regular VUMC duty hours, as defined by the Program Director and/or Chair of the house staff member’s host Department. Moonlighting during periods of authorized vacation time can occur provided that proper approval of moonlighting activity has been obtained. Individuals may not moonlight on rotations or services to which they are currently assigned as part of their residency or fellowship program. Questions regarding whether a particular request for moonlighting would be prohibited under this section should be directed to the Associate Dean for Graduate Medical Education. The Medical Center or any individual department or division reserves the right to deny any specific moonlighting activity that is deemed inconsistent with University policy regarding conflict of interest or other relevant policies. The individual requesting moonlighting permission acknowledges that his or her performance will be monitored for the effect of the activity, and adverse effects may lead to rescinding of permission. Individual departments or divisions may impose additional restrictions on moonlighting activity.

Violation of these moonlighting rules constitutes a breach of the House Staff Agreement between Vanderbilt University and the individual. Contact the Office of GME for any clarification of these requirements.

General Requirements for ALL Moonlighting:
1. Be in “good standing” in the training program (i.e., not on probation or suspension).
2. This professional activity cannot be used to fulfill a training requirement of the current training program.
3. Possess an unrestricted license to practice medicine in the state of Tennessee (or the appropriate state if moonlighting externally).
4. All requests for moonlighting must be submitted to the GME Office for review and final approval. No moonlighting will commence until this approval has been given. Moonlighting without this approval may result in Corrective Action.
5. After initial approval, the moonlighting activity must be renewed annually each subsequent July 1st.
6. House staff serving at Vanderbilt under military contract may moonlight only with approval from their military authority.

Definition and Additional Requirements for External Moonlighting:
External moonlighting is any extracurricular employment outside of VUMC (VUH, VCH, PHV or the Vanderbilt Clinics).
1. Professional liability coverage is the responsibility of the individual resident. **VUMC Self Insurance Trust does not provide professional liability coverage for this activity.**

2. After initial approval, the moonlighting activity must be renewed annually prior to July 1st.

**Definition and Additional Requirements for Internal Moonlighting:**

*Practicing medicine for pay at VUMC outside the requirements of the training program is considered internal moonlighting. Hours spent in internal moonlighting are subject to the ACGME duty hours requirements.*

Under the internal moonlighting policy, there are both general guidelines (listed above under General Requirements for All Moonlighting) and group specific guidelines. House staff is divided into two groups: Group 1 and Group 2. These groups are as defined below and the requirements for each group are as follows:

**GROUP ONE:** House staff in an advanced or second residency program (i.e., board eligible/certified in another specialty) who wish to bill through the VMG for their professional services. These individuals may practice the specialty for which they are board certified/eligible in an outpatient setting or an emergency department only. These individuals may bill third party payers for their professional services in accordance with the VMG and Medical Staff Bylaws.

NOTE: Moonlighting is prohibited during regular VUMC duty hours, as defined by the Program Director and/or Chair of the house staff member’s host Department. This includes weekends and/or holidays while you are on call.

**Additional Requirements for Group One:**

In order to qualify for internal moonlighting as a Group One physician, the house staff must fulfill all of the following prerequisites:

a. Successful completion of an ACGME Training Program;

b. Board eligible/certified in a specialty for which they are moonlighting;

c. The individual must have a part-time Vanderbilt School of Medicine faculty appointment in the hiring department/division. However, the primary appointment will remain either “resident or clinical fellow.” Appointment to the Medical Staff will follow the usual credentialing process.

d. Professional Liability coverage will be provided through the VUMC Self Insurance Trust. The additional cost will be prorated to the hiring department.

e. Within a department and/or division, internal moonlighting opportunities should be made known to all qualified house staff at any specific level of training. **However, the house staff should not be or feel pressured to participate in moonlighting activities.**

**GROUP TWO:** House staff who are not board certified/eligible and/or are not billing for their professional services. These individuals may **not** bill for their professional services. NOTE: Moonlighting is prohibited during regular VUMC duty hours on when the resident is on call, as defined by the Program Director and/or Chair of the house staff member’s host Department.

**Additional Requirements for Group Two:**

In order to qualify for internal moonlighting as a Group Two physician, the House staff must fulfill all of the following prerequisites:

1. Professional Liability coverage will be provided through the VUMC Self Insurance Trust. The additional cost will be prorated to the hiring department.
2. Within a department and/or division, internal moonlighting opportunities should be made known to all qualified house staff at any specific level of training. **However, the house staff should not be or feel pressured to participate in moonlighting activities.**

3. This individual cannot bill for their services. If the service is to be billed by the attending, the house officer must be supervised, and work documented, under CMS guidelines. All attending billing must comply with Medicare requirements.

4. There must be an identified supervising attending physician.

**Moonlighting Policy for the Department of Medicine**

The ACGME has called for increased supervision of physicians-in-training, tighter limits on moonlighting, and reduced work hours for first-year residents. It is the expectation that duty hours will continue to be limited to 80 hours per week, averaged over a four week period, and inclusive of all in-house call activities and all moonlighting. Individual programs are now responsible to monitor all moonlighting to ensure that duty hours are appropriately maintained. The stated goal is to reduce medical errors, ensure patient safety and improve quality of care.

Moonlighting is considered by the Department of Medicine to be an optional activity which, if approved for a given resident or fellow, must be contained within the 80 hour work week, fully documented, and void of any distraction from the academic and service components of our housestaff and fellowship programs. To be eligible for moonlighting, the applicant must:

1. Be PGY 2 or higher.
2. Have scored at the 50th %tile or higher on their previous year's In-Training Exam.
3. Be limited to two shifts per week (non-consecutive days) when serving on a non-inpatient rotation. (Moonlighting is not permitted when serving on an inpatient rotation.)
4. Be approved with a written statement from the Program Director or Associate Program Director that is made part of the resident's file. (The residents' performance will be monitored for the effect of Moonlighting activities upon performance and adverse effects may lead to withdrawal of permission.)
5. Have demonstrated no concerns with variation from implied or explicit moonlighting policy.
6. Be independently licensed to practice in the State of Tennessee and, where applicable, have adequate malpractice coverage.

While any moonlighting must be monitored for compliance with the aforementioned concerns, external moonlighting comes under closer scrutiny. Accordingly, the Department of Medicine has determined to require periodic validation of external moonlighting hours, i.e., a retrospective audit. At a minimum, individuals, groups, or institutions with whom you contract for services may be required to provide documentation of hours you have worked within a specified time frame.

Believing that interest in moonlighting will continue or increase, the medical center has agreed to provide an increased opportunity for internal moonlighting. For example a second shift will be added to the Scoville Service – details to follow. Additional moonlighting shifts are under consideration at the Veterans Administration Hospital.

To be eligible for external moonlighting, in addition to the general moonlighting rules, the applicant must:

1. Be a Fellow at the PGY 4 level or higher
2. Contract with entities which are willing and able to provide meaningful information regarding hours spent in moonlighting activity.
Appendix X: Vanderbilt University Division of Dermatology Grievance Procedures

Vanderbilt University Division of Dermatology Grievance Procedures are stated in Section V. of the House Staff Manual: (See Below).

HOUSE STAFF COMPLAINT/GRIEVANCE PROCEDURES
Situations may arise in which a resident believes he/she has not received fair treatment by a member of the faculty or staff of the Medical Center, or has a complaint about the performance, action or inaction of a member of the staff or faculty. Retaliation against a resident for submitting a dispute through the complaint/grievance procedures will not be tolerated and will result in appropriate disciplinary actions.

PROCEDURE-HARRASSMENT/DISCRIMINATION/RETLALIATION
If the complaint involves allegations of sexual harassment and/or perceived unlawful discrimination or retaliation, refer to the sections in this House Staff Manual (Section I.G on Equal Employment and Affirmative Action).

PROCEDURE–OTHER COMPLAINTS
The House Officer should be directed as soon as possible to the person(s) whose actions or inactions have given rise to the complaint and not later than ninety (90) days after the event. If the person(s) involved is not the department chair or program director, the resident should consult with his/her program director and/or department chair 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 two 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 for 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 direct the chair of the GMEC to convene the Review Committee (as defined in IV.C.2.g) to address the appeal. The Review Committee will meet within 14 days 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 resident, the Review Committee will elect a temporary chair of the Review Committee for the purpose of the review. Neither party will have legal counsel present during the Review Committee’s deliberations. The Review Committee will make a recommendation to the Dean of the Medical School, who will then make the final decision.

APPROVED BY THE MEDICAL CENTER MEDICAL BOARD
March 26, 1998
Appendix XI: Vanderbilt University Dermatology Warning, Probation, and Dismissal Policy

I. Overview: Academic Warning

*Effective July 2010 based upon results of Mock Boards 2010.*

Residents participate in the Mock Boards each year as one measure of their academic progress relative to Dermatology Residents across the nation. It is the experience of this program and others that poor performance on this examination correlates with equally poor performance on the Boards. Residents will be placed on an Academic Warning Status for Mock Board Scores at the 20th Percentile and lower and will be strongly urged to substantially improve their academic efforts. For residents on academic warning, the second meeting permitted in the PGY4 year is restricted to those events with significant educational value; e.g., Board Review Courses, as approved by the Program Director or Divisional Director in her absence.

The Division of Dermatology follows the official published policy of the Vanderbilt University Graduate Medical Education Office in the Vanderbilt University House Staff Manual in handling academic discipline, and resident complaints and grievances. These are summarized and modified to fit the Division of Dermatology as below:

IV. GRADUATE MEDICAL EDUCATION EVALUATION AND DISCIPLINARY GUIDELINES

**Length of Appointment**

Appointments are made for a one-year term, with renewal of the appointment based on satisfactory performance by the house officer and the availability of a position. Terms and conditions of the appointment are specified in the yearly contracts and are further described in this House Staff Manual.

**A. Evaluation**

1. A written evaluation of a house officer addressing medical knowledge, competence in patient care, professionalism, system-based practice, interpersonal and communication skills, and practice-based learning and improvement will be completed semiannually. The program director or faculty designee will share the evaluation(s) with the house officer and provide feedback in accordance with ACGME requirements. The evaluation will include a written review of performance, and a discussion of areas of deficiency and plans for improvement.

2. The written evaluation and any documentation regarding the meeting is permanently maintained in the departmental file.

3. Know that it is becoming more common for states to which you apply for licensure and hospitals to which you apply for credentials to request information about disciplinary actions.

4. Any information, materials, incident or other reports, statements, memoranda, or other data which are subject to the Tennessee Medical Peer Review statute (T.C.A. §63-6-219) are privileged and are not to be copied or released without the prior authorization of the Associate Dean for Graduate Medical Education or his/her designee.

5. The evaluations, evaluation summaries and/or other non-privileged documents provided by the GME Office and/or department to the Review Committee, as determined by each program, will be reviewed by the house officer with the Program Director, the Associate Dean for Graduate Medical Education, or an individual designated by the Associate Dean for Graduate Medical Education upon request.

5. Copies of correspondence between the house officer and the Program Director, or any other correspondence directed to or on which the house officer was copied, will be provided to the
house officer upon request to the Program Director. This provision only applies to correspondence maintained in program, departmental, or GME files.

B. Informal Counseling
In addition to evaluations, Program Directors and attending or supervising physicians provide and document timely feedback on an ongoing basis, which includes positive feedback as well as minor performance or conduct concerns as they occur and are documented as such.

C. Corrective Action
1. Corrective Action is taken to address any concern about the house officer’s performance or conduct which is too serious to be resolved by Informal Counseling or was not corrected by Informal Counseling. Performance or conduct issues subject to corrective action include, but are not limited to, the following examples.
   • Insufficient medical knowledge.
   • Inability to apply medical knowledge effectively, whether in patient care, research, or performance technical skills.
   • Any deficiency or conduct which adversely bears on the individual's performance, such as attitude, conduct, interpersonal or communication skills, or other misconduct.
   • Failure to progress or perform at the expected level of training.
   • Violations of professional responsibility, University or Medical Center by-laws, policies and procedures, state or federal law or any other applicable rules and regulations.

2. Initiation of Corrective Action
There may be concerns regarding the performance or conduct of a house officer that have not been remedied or should not be addressed with feedback or Informal Counseling. In those situations, one of the actions listed below (Warning(s), Probation, Summary Suspension, Dismissal or Non-renewal) is taken, depending on the nature and/or severity of the deficiency, actions, or conduct. In determining which level of intervention is appropriate, the Program Director will take into account the house officer's overall performance, including previous evaluations, Informal Counseling, Warnings, and Probationary Periods.

a. Warning
A warning is used if concerns arise or continue regarding the performance or conduct of a house officer which are too serious to be dealt with by Informal Counseling but which do not impact the health or safety of patients or others. A Warning will be given to the house officer explaining why the conduct or performance is unacceptable. Examples of such unacceptable conduct/performance include, but are not limited to, failure to respond to Informal Counseling, unprofessional conduct, and poor in-service scores. Examples for Dermatology include: An overall score <20% on the American Board of Dermatology In Training Examination. A resident who is on academic warning will have a review done of specific academic weaknesses, and a study program initiated by the Program Director, faculty, and the resident. The resident is expected to correct the weaknesses. Clinical warning may occur if clinical performance including professional conduct is deficient as judged by the biannual resident evaluations, but have not endangered patients. A Warning may be given verbally or in writing, but will be documented in the house officer’s departmental file, with a copy to the Associate Dean for Graduate Medical Education. The house officer will be advised by the Program Director or designee about expectations for improvement of the deficiency or conduct and be given a time frame in which to meet these expectations. During or at the end of the Warning Period the house officer will meet with the Program Director or designee to advise the house officer whether the deficiency or conduct has been corrected or whether further corrective action will be
taken. If the house officer does not correct or improve the conduct or deficiency within the Warning Period, or if the same or additional conduct or deficiency occurs within that period, then the Program Director may immediately place the house officer on Probation, recommend non-renewal, or recommend immediate dismissal. At any time, whether before or after the Warning Period has passed, the Program Director may recommend further action.

b. Probation

If a house officer’s academic performance, performance of duties, attitude, deportment, or interpersonal or communication skills falls below acceptable standards or other deficiencies exist which are not corrected by Informal Counseling or a Warning, or are of a serious nature such that Informal Counseling or a Warning are not appropriate, the house officer is placed on Probation by the Departmental Chairman, Program Director, or Associate Dean of GME. The house officer will be informed in writing by the Departmental Chairman, Program Director, or Associate Dean for Graduate Medical Education (GME) that he/she is being placed on Probation. The notification should include an explanation of the deficiencies, performance or conduct giving rise to Probation, and the time period of the Probation. The Departmental Chair and/or Program Director determine the length and conditions of the Probationary Period after consultation with the Associate Dean for GME. A copy of the written notification of Probation will be sent to the Associate Dean for GME and the house officer. The effective date of the Probationary Period will be the date of the written notification. The Departmental Chair and/or Program Director convey expectations for improvement of the house officer’s performance, deficiency or conduct to the house officer, together with a copy of these guidelines. During the Probationary Period, efforts are made to advise and assist the house officer to address the performance issues and/or correct deficiencies or conduct with the goal of the house officer successfully completing the program. If at any time during the Probationary Period additional performance or conduct issues arise, or if the issues which resulted in the Probation continue, the Program Director may extend the Probation, recommend Nonrenewal, or move to Summary Suspension or Immediate Dismissal.

At the end of the Probationary Period, the Departmental Chair or Program Director determines which of the following actions will be taken and notifies the house officer:
1. Remove the house officer from probationary status.
2. Extend the probationary period.
3. Notify the house officer of non-renewal of his/her appointment.
4. Notify the house officer of his/her immediate dismissal.
The Associate Dean of GME is notified of the actions in 1 through 4 above.

c. Summary Suspension

If at any time a house officer’s conduct requires that immediate action be taken to protect the health or safety of patients or others, or to reduce the substantial likelihood of immediate injury or damage to the health or safety of patients or other persons, any member of the Medical Staff, the Hospital Administrator on Call, or the Associate Dean for GME shall have the authority to summarily suspend the house officer. If a house officer exhibits performance or conduct that is too serious to warrant a Warning or Probation, the house officer may also be summarily suspended by the Department Chair, Program Director, or Associate Dean for GME. The Summary Suspension will be reported immediately in writing to the Associate Dean for GME and the resident’s Program Director and Chair, with a copy to the house officer. The house officer will remain in paid status while on Summary Suspension. The Associate Dean for GME, after review of the circumstances giving rise to the Summary Suspension and after consultation with the Chairman and Program Director, determines a course of action which includes one or more of the following:
1. Lifting, modifying or extending the Summary Suspension;
2. Probation;
3. Notification of non-renewal of his/her appointment;
4. Immediate Dismissal.

The resident is notified in writing, with copies to the resident’s Program Director and Chair, of the action taken, and that he/she may not be present in the clinical areas or otherwise participate in on-campus GME activities unless specifically instructed. In the event of Summary Suspension or Immediate Dismissal, if the resident wishes a review, he/she should notify the Associate Dean for GME in writing (C/O GME Office during the business hours 8 a.m. – 4:30 p.m.) within 5 business days of the time written notification of the action was provided to the resident or sent to the resident’s home address.

d. Dismissal
Performance issues or conduct not resolved by a Warning or Probation, or other serious actions or behavior may result in Immediate Dismissal. If at any time, including during or at the end of a probationary period, the Department Chair or Program Director determines that Immediate Dismissal is warranted, he/she, notifies both the house officer and the Associate Dean for GME. The house officer is relieved of all clinical duties upon notification that the dismissal is warranted. The Department Chair or Program Director will consult with the Associate Dean for GME to determine the effective date of termination. The resident will be notified in writing of the action taken, and that he/she may not be present in the clinical areas or otherwise participate in on-campus Graduate Medical Education. Any medical center equipment including, but not limited to, pagers, ID badges, keys, PDAs, parking cards, laptops, email privileges, is revoked upon dismissal. In addition, all access to VU computers is terminated.

e. Response of House Officer
The house officer has 5 business days from the time written notification of the dismissal recommendation is provided to the house officer or sent to the house officer’s home address to choose one of two alternatives:
1. Accept the Dismissal without requesting a review.
2. Request a review of the Dismissal.
The response of the house officer must be submitted in writing to the Associate Dean for GME and received in the GME Office by 4:30 p.m. on the fifth business day after notification of dismissal. Failure to notify the Associate Dean’s office within this time frame is considered acceptance of the Dismissal.

f. Review Procedure for Summary Suspension or Dismissal Residents can request a review of a Summary Suspension or Dismissal.
In the event that the house officer submits a written request for review after Summary Suspension or Dismissal, the Associate Dean/Director of GME or his/her designee asks the Chair of the Graduate Medical Education Committee (GMEC) to convene the Review Committee of the GMEC (“Review Committee”) 14 calendar days from the date of the house officer’s request for review, unless the Chair of the GMEC determines there are valid reasons to extend this time frame. The review should be completed within 30 calendar days of the request for review. The Review Committee will review the circumstances leading to this action. The Review Committee consists of no fewer than six members of the current GMEC, except for the following: the Dean of the Medical School, the Associate Dean for Graduate Medical Education, and the Dean’s Chief of Staff. The Review Committee must contain at least three house staff and three faculty members, none of which may be from the appealing resident’s department.
The Review Committee may review this request only when a quorum of the Review Committee is present. A quorum shall consist of at least two of the house staff members and at least two of the faculty members of the Review Committee. Any member of the Review Committee (faculty or house staff) who has a conflict or potential conflict of interest involving the appealing house officer should recuse himself or herself from the committee and the Chair of the GMEC will appoint a new member of the Review Committee. However, to the extent the recused member has knowledge of or was involved in the events leading up to the corrective action, he/she may still be a witness. Likewise, if there is a conflict or potential conflict of interest between the chair of the GMEC and the appealing house officer, the Review Committee will elect an alternate chair for the purposes of the review. Otherwise, the Chair of the GMEC will chair the Review Committee. If there is failure to reach a quorum, due to multiple recusals or other reasons, the Associate Dean for Graduate Medical Education, or Chair of the Review Committee of the GMEC, shall appoint (a) new member(s) to the Review Committee. All relevant academic records and other documentation, as well as names of potential witnesses will be provided to the Review Committee as a part of the review process. The house officer will be given access to records as defined in Sections IV.A.4 and IV.A.5, and to other nonprivileged documents provided to the Review Committee. The house officer may, if he/she so desires, appear before the Review Committee and be given an opportunity to make a statement. The house officer may also identify witnesses to be called or documents to be considered by the review committee and is responsible for the timely provision of such documents and arranging for the appearance of their witnesses. Witnesses are limited to those who were directly involved with the circumstances giving rise to the action or who are knowledgeable of the circumstances. Retaliation against witnesses who participate in this process in good faith is not tolerated. The GMEC can request additional witnesses or documents. Witnesses are limited to those who were directly involved with the circumstances giving rise to the action or who are knowledgeable of the circumstances. The review is conducted without the presence of attorneys for either party. However, either party may consult with its own counsel prior to such review or during a break in the proceedings.

The Chair of the Review Committee appoints a recording secretary to be present during the review. After completion of the review, the Review Committee submits a written summary of the proceedings and recommendations to the Dean, who makes the final decision. The Chair of the Review Committee maintains in the GME Office and a copy of the summary. The Dean notifies in writing the house officer, the Program Director, the Departmental Chair/Clinical Service Chief, the Associate Dean for GME, and other appropriate persons for whom notification of the Review Committee’s actions is deemed necessary. Retaliation against a resident for requesting a review of the dismissal is not tolerated and will result in appropriate disciplinary action.

g. Non-renewal or non-promotion
Non-renewal of a house officer’s contract or non-promotion of a house officer to the next level of training may be appropriate for a number of reasons, including but not limited to, insufficient medical knowledge, incompetence in patient care, lack of professionalism, inability to effectively use resources, poor interpersonal and communication skills, and inability to participate in practice-based learning. Ordinarily, written notice of non-renewal of a house officer’s contract or non-promotion of a house officer to the next level of training shall be given no later than four months prior to the end of the house officer’s current contract. In the event that notice cannot be given within four months, it shall be given as soon as possible. If a house officer receives notice of non-renewal or non-promotion and chooses to initiate a review, he/she must notify the Associate Dean of Graduate Medical Education within fourteen days and request the initiation of the House Staff Complaint/Grievance Procedure in the House Staff Manual. If, in the event that within the fourteen day period, the Departmental Chairman/Clinical Service Chief and the house
officer have resolved the matter to their mutual satisfaction (and the Departmental Chairman/Clinical Service Chief notifies the Dean in writing), a Review Committee of the GMEC need not be convened and the request for review will be considered withdrawn. In either case, the Program Director and the Associate Dean for GME are advised of the outcome.
APPENDIX XII: BROWN RECLUSE SPIDER BITES

I. General Information
The Brown Recluse spider is also known as Loxosceles reclusa. They are medium-sized spiders 8-15mm in length and brown in color. There is a violin or fiddle shaped figure on the dorsal aspect of the body which gives rise to the common name of "fiddle back" spider. They are found in the Mississippi-Ohio-Missouri river basin as well as the southwestern U.S. They prefer hot, dry and abandoned environments. They are most frequently found in closets, attics etc. Bites occur most frequently on the thigh as a result of putting on an article of clothing.

II. Clinical Presentation
A cutaneous reaction is the most common presentation. The initial bite is often painless or may be a sharp, stinging pain. A more intense, local pain, often with pruritus occurs 6-8 hours later. At this time, the lesion is usually edematous with a mottled center and erythematous halo. As the lesion progresses, a bleb or blister may arise in the center. Over the next 24-48 hours, the mottled, violaceous center becomes darker eventually forming a blackish eschar. The eschar sloughs at 2-5 weeks leaving an ulcer. A systemic or viscero-cutaneous reaction occurs rarely, more commonly in children. Fever to 40 C, nausea, vomiting, chills, rash, arthralgias, weakness, malaise, leukocytosis, hemolytic anemia, renal failure, thrombocytopenia and DIC may be seen.

III. Management
Instruct the patient to rest, apply ice to the affected area for 20 minutes at a time every 2-3 hours, and elevate the affected area. Erythromycin, dicloxacillin, or cephalexin 250-500mg q6h should be given to prevent bacterial infection. An aspirin should be given on a daily basis if not contraindicated. Judicious use of antihistamines and analgesics for pruritus and pain respectively is recommended. Administer tetanus toxoid if not up to date. For severe envenomation some authorities consider using dapsone 50 mg qd for 48 hours then 100mg qd. Prior to dapsone administration, check a CBC and G6PD. This is controversial and the most recent literature and your attending should be consulted. The above therapy is continued until bite activity clears, usually 3-4 weeks. Patients on Dapsone should be followed periodically to watch for development of anemia or transaminitis. Surgical procedures, debridement or manipulation of the site is absolutely contraindicated and may actually worsen the situation.