DERMATOLOGY WORLD

DIRECTIONS *in* RESIDENCY

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Summer 2019

The first employment agreement: common clauses and practical tips for residents

By Daniel F. Shay, Esq.

When you are approaching the end of your residency, the first job offer is a great relief. Your income and quality of life is likely to improve considerably. The urge to simply sign an employment contract and get to work may be strong. Physicians may not believe they can negotiate terms, and need not simply accept the job. But even if the contract's terms won't significantly change, you should understand what the contract says and how it will affect your life. Let's examine several clauses common to employment contracts, and look at some practical tips when considering a contract.

Term and termination

How a contract ends is as important as one's duties during a contract. All employment contracts have clauses governing how, when, and why the contract may terminate, and language controlling the contract's length. The term of an employment contract — its length — is typically between one to five years. The term may be "fixed," meaning that it will end on a defined date, or may automatically renew.

Each approach raises different considerations. A fixed end may force parties to negotiate if they wish to continue. An automatically renewing contract requires no action and continues on its own. If one party wants out, an automatically renewing contract may require that party to notify the other — before the contract renews — of its wish to terminate. The length of notice needed for termination also matters. Notice usually must be provided in writing, ahead of time. Typical employment contracts require between 30 to 90 days, although some require as many as 180 or as few as 15 days.

Contracts also may be terminated "for cause," or "without cause." Typical grounds on which a physician may be terminated for cause may include loss of licensure or DEA registration, failure to obtain board certification, or breach of their contractual obligations. Ideally, the contract will permit the physician to terminate "for cause" as well, but not all contracts do. "Without cause" termination requires no specific reason to terminate. The terminating party need only give the required notice (which is usually longer than what is required under termination "for cause"), and the contract will terminate at the end of the notice period. In some contracts, only the employer may terminate "without cause," although ideally this provision is mutual.

Restrictive covenants

Following termination, a contract may impose a restrictive covenant on the physician. This may include

see **CONTRACT** on p. 3

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CONTRACT from p. 1

language surrounding "confidentiality," an anti-soliciation clause, or an anti-competition clause. Typical confidentiality provisions require the physician to maintain the confidentiality of things like managed care participation contracts or other contract terms, financial information, patient information, etc. There is usually no time limit on confidentiality requirements. Anti-solicitation language prohibits the physician from doing things like suggesting patients follow them to a new practice, or poaching the physician's favorite medical assistant to join them in their new job. This type of provision may have an end date (e.g., two years after termination).

Pay attention to anti-competition clauses

Anti-competition clauses can be especially complicated. First, not all states permit them. For example, California generally does not permit anti-competition clauses in employment contracts. Second, where permitted, they must usually be reasonable and limited in scope and duration. Typical duration is between one to three years after termination. They usually prohibit the physician from working in the same specialty for a competitor (as well as owning or investing in a competing business) within a specific geographic distance from where the physician used to work, or from where the employer provides services at the time of termination. In this age of consolidation and rapid health system growth, however, it can be tricky to determine the full potential restricted area. Pay close attention to how these sections are worded. If working for a large employer, the physician ideally would only be restricted from practicing within a geographic area where the physician personally performed services.

Most anti-competition clauses apply regardless of the reason for termination. But they may also be conditional, depending on why the contract was terminated. For example, we try to renegotiate anti-competition clauses to only apply if you terminate without cause, or if the employer terminates you for cause. I believe a physician's livelihood shouldn't be impaired because they had to terminate an employment agreement for their employer's breach, or if the employer terminates them without cause.

The dotted line

Prior to signing, physicians should do some research on their prospective employers, and engage in some "housekeeping" with respect to their contracts. For example how is call handled? How often must it be taken, and for how long does it last each time? How is it shared with other physicians in the practice? If the agreement states that "call shall be shared equally among similarly situated physicians," how many "similarly situated" physicians are there? If the new physician will be the only junior physician, or the only specialist of their type in a multispecialty group, they may be responsible for more call because there are no other "similarly situated" physicians.

You should also read through your contracts to have a better sense of your requirements, and what you can expect from your employer. While you may not understand every word, it is worth familiarizing yourself with the document. There may also be inconsistencies with offer letters or verbal discussions (e.g., a moving allowance was promised, but was not mentioned in the contract). You should also ensure that all pages of the agreement are present, and all attachments, schedules, addenda, or exhibits referenced in the contract have been included. If other external documents have been referenced, physicians should ask for copies of those documents to review before signing.

After reviewing the contract, it doesn't hurt to ask for changes, especially for things already promised. At worst, the employer will simply reject the request; it likely will not result in the job offer being rescinded. Likewise, if contract clauses are unclear, most employers will at the very least clarify what they intend by the language, and may agree to alter it for the sake of clarity. This helps both parties avoid disputes in the future.

Clear understanding is key

It's paramount to read through an employment contract first, even though it's tempting to sign and move on. This document will govern your life; a clear understanding of what it actually requires is essential. Towards this end, you should not "self-medicate" and try to navigate the review and negotiation process alone. Experienced health care legal counsel can help. DR

A. Edward Nadimi, MD, is a PGY-4 resident in the department of dermatology at Georgetown University Hospital.

Race for the Case

By A. Edward Nadimi, MD

A 56-year-old man was transferred from an outside hospital for a four-month history of painful and pruritic skin erosions that started on his back and progressed to involve his extremities, mouth, perianal region, and genitals. Examination revealed hypertrophic papillomatous plaques overlying friable erosions of the oral mucosa and the right side of the neck, many ill-defined pink erosions on the trunk, and a single intact pustule on the chest. He endured worsening oral pain with eating, as well as weight loss and odynophagia.

1. What would you expect to see on H&E and DIF?

2. What are the major subtypes of this condition?

3. What treatment did the FDA recently approve for treatment of this condition, and what is its mechanism of action?

4. What are at least two other entities on the differential diagnosis of hemorrhagic crusts of the vermilion lips?

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

Race for the Case: Winner (Spring 2019)

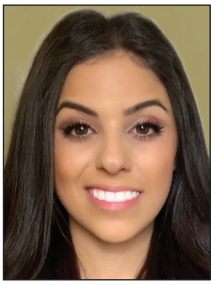
Congrats to Sophia Colantonio, MD, MPH, PGY-3, (PGY-5 in Canada), from University of Ottawa, who provided the most accurate responses in the shortest amount of time. To view the last case and apply your smarts to the the newest Race for the Case, visit: **www.aad.org/RaceForTheCase**.

Comprehensive Guide to Skin Grafts

by Atieh Jibbe, MD

Stages of graft	Duration	Description
Imbibition	0-48 hours (ischemic period)	Nutrients from plasma exudate of wound bed; fibrinous attachments to wound bed; Graft edema
Inosculation	~48 hrs – 10 days	Graft vessels anastomose with recipient bed native vessels
Neovascularization	Concurrently with inosculation; Complete by day 7	Microvascular plexus grows into graft supplementing anastomosed native vessels
Maturation/ Re-innervation	2 weeks and onward	Re-innervation around 2 weeks but lasts for months to years

Types of grafts	Description	Advantages	Disadvantages
Full thickness	Epidermis + FULL dermis	• Better cosmetic appearance • Retains adnexal structures • Less wound contraction • Lower Infection risk • Can be used for extremely deep defects after 1-3 weeks of granulation ("delayed grafting")	• Higher rate of graft failure due to increased metabolic need
Split thickness	Epidermis + partial dermis (thickness ranges from 0.13 mm – 0.78 mm)	• Ability to cover large defects especially when fenestrated with "mesher" tool • Less metabolic demand → increased likelihood of survival • Allow early visualization of tumor recurrence	• Less desirable cosmetic appearance (pale, smooth, and hairless) • Wound contraction (up to 70%) • Lacks adnexal structures
Composite	Tissue of two germ layers: Epidermis + dermis + variable tissue (ie. Cartilage)	• Restore structural integrity and restores missing cartilage in areas such as nasal ala typically grafted from helical crus/rim donor site	• Limited to 1-2 cm in size (bc dependent on lateral wound edges for nutrition) • High rate of graft failure due to HIGHEST metabolic demand especially in patients with vascular compromise or smokers
Xenograft	Tissue from different species than recipient	• Fewer wound care demands bc acts as a biologic dressing → Promotes granulation • Protect underlying structures • Post op pain	• Contraindicated with swine allergies • Must be replaced 1-2 weeks post application • Malodorous

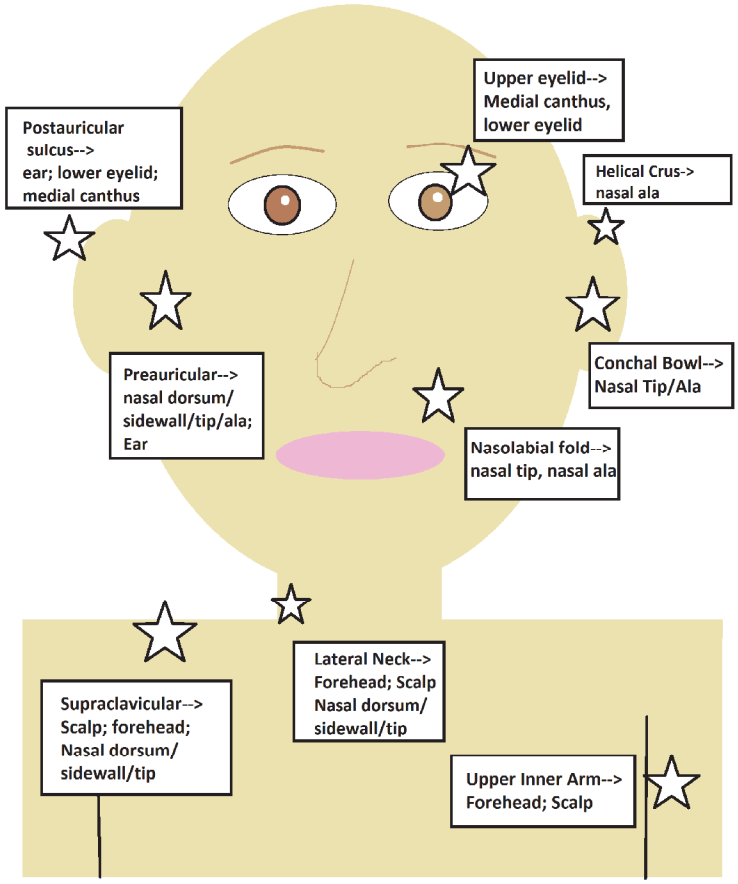


Atieh Jibbe, MD, is PGY-3 at University of Kansas department of dermatology.

Comprehensive Guide to Skin Grafts *(continued)*

by Atieh Jibbe, MD

Figure 1: Graft Site Selection (☆=donor site)



Artwork provided by Atieh Jibbe, MD

Graft Complications and Management		
Early discoloration	Dusky Blue	Normal and typically occurs at 24 hrs; indicates venous congestion
	Pink	Normal and typically seen around day 7; indicates graft survival
	Black	Indicates necrosis; do not remove graft because it will function as a biological dressing
Graft shearing	• Prevented with "bolster dressing" which immobilizes graft - Bolster dressing: bulky non-adherent gauze + layer of emollient loosely sutured in place over graft	
Graft contraction	• Maximal in first 2 months • Intralesional steroids 6-8 weeks post-op • Massaging with emollient 6-8 weeks post-op	
Poor cosmetic appearance	• Dermabrasion 4-6 weeks post-op • Prevention of hyperpigmentation via aggressive sunscreen	
Pain at donor site	• Highest in first 24 hours; manage with similar analgesics as used for dermatologic surgery	

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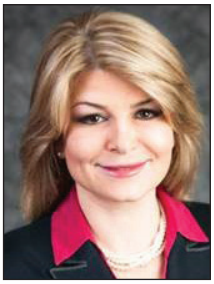

Larisa J. Geskin, MD, is associate professor of dermatology in medicine and director of the Comprehensive Cutaneous Oncology Center at Columbia University Department of Dermatology. She is also president of the International Society for Cutaneous Lymphomas.

If you have suggestions for topics or content for Clinical Pearls, contact Dean Monti at **dmonti@aad.org**

Clinical Pearls

Clinical Pearls will help prepare residents for the future by providing them with five top pearls about what they should know about a specific subject area by the time they complete their residency.

Cutaneous T- Cell Lymphoma

By Larisa Geskin, MD

Pearl #1. The pathologic and clinical features of CTCL may be non-specific and highly variable, making it difficult to distinguish from other inflammatory dermatoses including spongiotic dermatitis and psoriasiform conditions [1]. **Continue to perform multiple biopsies over a period of time to establish a diagnosis of CTCL**, and keep looking if you are suspicious. Whenever possible, send the sample to a pathologist who is a specialist in the field. The specialists may be able to discern minute details, such as subtle lymphocyte atypia, and usually are familiar with the novel biomarkers, which might be useful for the diagnosis. New markers are continually being discovered to aid in diagnosis of CTCL [2, 3].

Pearl #2: All cancer patients need to be staged to provide them with the appropriate care for disease stage. The tumor, node, metastasis, blood staging is an important prognostic factor in CTCL and will inform your approach to treatment [4]. Mycosis fungoides (MF) and Sezary syndrome (when there is significant blood involvement) are the most common types of CTCL. Remember to beware of "invisible mycosis fungoides." Because mycosis fungoides is a disease of white blood cells, the only reason that they are visible on the skin is due to a local immune response and inflammation. If there is no inflammation present, you may miss MF [5]. Rarely, what appears to be "early stage disease" may already have nodal or leukemic involvement. In addition, there are some cutaneous lymphomas that may look like MF but have an aggressive course including some cytotoxic lymphomas of the skin [6].

Pearl #3: Improvement in quality of life and long-term remission is the main goal of the therapy. MF/CTCL in general is an indolent disease with favorable long term-prognosis and protracted course. Inducing a long-term remission and improving quality of life is of utmost importance in these patients. In addition, the patients are usually immunocompromised, especially in the advanced stages of the disease, and harsh multi-agent chemotherapy is not indicated for the vast majority of these patients. Early stages of disease can be entirely managed by dermatologists using skin-directed therapies. However, dermatologists play a significant role in management of the patients through all stages, including advanced stages of the disease. Dermatologists should monitor MF patients for disease progression during early stages and contribute to the patient care in advanced stages. To achieve the best outcomes, whenever possible, input from a CTCL specialist or a specialized multidisciplinary team is advisable.

Pearl #4: Do not underestimate the importance of a good skin care routine which can significantly improve quality of life. Proper skin care plays a key role in the treatment of this disease. We recommend aggressive skin moisturization, treatment of bacterial colonization, and avoiding any tight or irritating clothing. Dilute vinegar baths also help to restore the slightly acidic pH of the skin and result in reduced bacterial load, especially on the impaired and inflamed skin. These measures help to improve pruritus, which is frequently the most important quality of life concern in these patients.

Pearl #5: Keep an eye out for new drugs and clinical trials which are available to treat CTCL in all forms and stages. Novel, better drugs are currently being tested across the country and the globe [7, 8]. Do not hesitate to send a patient to a specialist to investigate new treatment opportunities. New drugs and/or combination of therapies may improve patient outcome and possibly survival.

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Let's negotiate! Some quick and important tips

By Tara Oetken, MD

Three things to remember when negotiating your first job:

1

You are in a valuable position. A mentor of mine once told me that during those first few years out of residency, a new dermatologist is at his or her "highest value." A bank could loan you money to start up a new clinic, possibly competing in the local market. Existing groups and hospitals realize this, and actively seek to grow their practices by recruiting dermatologists like you.

2

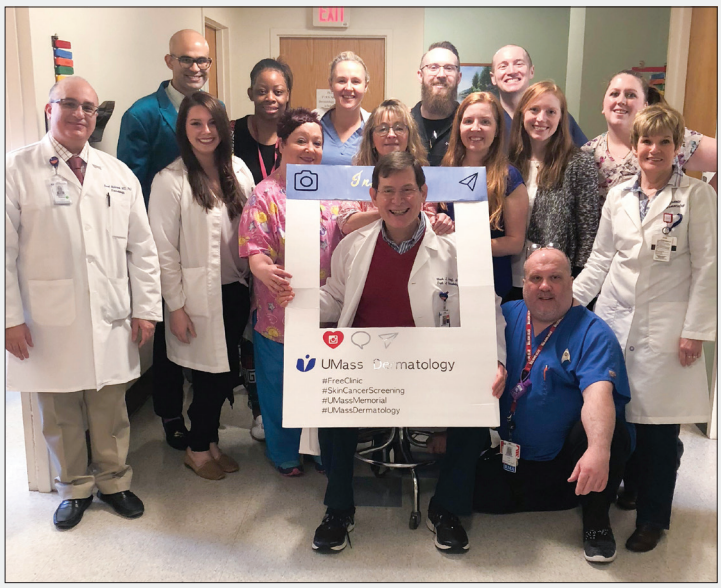
Don't be afraid to make changes to your first offer. Contract negotiations are a conversation, rather than a one-and-done deal. When you are speaking with a prospective employer or practice, keep the conversation going. Ask questions. Do not be afraid to ask for more flexibility, while in other areas changing your terms of employment. Keep in mind salaries or percentages can be negotiated, too!

3

Have a collaborative mindset. Perhaps this is a tendency of older ways of doing things, but try your best to avoid an overly competitive or zero-sum attitude. After all, you are likely negotiating a position with other people for many years. You might as well develop an attitude to better yourself and other partners/physicians.

Resident Life: UMass skin cancers screenings hit the SPOT

On May 18, 33 UMass volunteers including dermatologists, Mohs surgeons, dermatology residents, medical students, and staff helped to serve nearly 100 members of the local Central Massachusetts community with their annual free skin cancer screening. This four hour event was part of the SPOTme® Skin Cancer Screening Program sponsored by the American Academy of Dermatology. Patients not only were screened for skin cancer, but were educated about sun protection and the signs of skin cancer to aid with early detection. UMass also incorporated a life-sized social media frame that included hashtags like #SkinCancerScreening and #FreeClinic so that patients and volunteers could help spread awareness of the event through online and social media platforms. DR

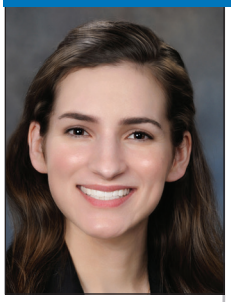


Back row: Karan Lal, DO; Maudi Buggs; Jessica St. John, MD; Max Shiver, Michael Cunningham, MD; and Krystal Bonafilla.
Middle row: Bassel Mahmoud, MD; Kaitlin Blankenship, MD; Denise Gaiewski; Tracy St. Jean; Riley McLean, MD; Amanda Auerbach, MD; and Joan Belle.
Front row: Mark Scharf, MD; and Charles Leap.

How do you manage resident life?

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

Inside this Issue



Tara Oetken, MD, is a PGY-4 dermatology resident at the University of Arkansas for Medical Sciences (UAMS), in Little Rock, Arkansas.

For nearly everyone, the final year of residency is filled with excitement. But in the midst of preparing for boards, interviewing, and hopefully landing that dream job, residents often find themselves struggling with negotiating a contract. For years, we have been in situations with little power. We try our hardest to get into medical school and residency, and sometimes it may even feel like we are just begging for someone to notice us! So it is noteworthy that the power has somewhat shifted when you pursue a career in a practice or academic institution. You are no longer subject to typical coursework like in medical school, and you will soon be board certified with no immediate supervision like in residency.

In this issue we have a feature on employee contracts that I know you'll find useful. To augment this, I've included some useful tips to keep in mind when you are in the process of negotiating your first job (see p. 7). Happy job hunting!

I'd also like to remind you about the AADA Legislative Conference, Sept. 8-10 in Washington, D.C. Residents who have attended in the past have found it a rewarding and life-changing experience. It's your opportunity to get the dermatology resident voice on the Hill. Visit **www.aad.org/meetings/legislative-conference** for more information. DR

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