AAD
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directions in residency
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Winter 2021

A deeper dive into contracts for residents

By Daniel F. Shay, Esq.

A physician's first job after training is their first step into a larger world. Becoming an attending physician places new responsibilities on the physician and grants them new authority. One's lifestyle will likely change, thanks to the higher salary of the new job. It is understandable that many physicians just finishing their training would rather sign on the dotted line than worry about what is in the contract. In a previous article (*Directions*, Summer 2019) I wrote about several common clauses and issues that appear in most employment agreements. In this article, I will highlight several others to illustrate why it is a good idea to have your contract reviewed by a professional before signing.

Considering compensation

One of the first provisions that physicians will review is their compensation. Almost no physician will have had prior experience with how compensation frequently functions in medical practices. As a resident or fellow, most will have been paid a flat salary at a fraction of the rate they can reasonably expect following training. The first employment agreement may therefore come as somewhat of a shock to them.

Many physician employment agreements guarantee a certain salary in the physician's first year or two. However, after that point, many employers transition the physician to one of two potential models. The first involves where the physician is paid a lower "base salary" with a possibility to earn additional money as bonuses. Some bonuses are tied to pure productivity, which is usually measured in "work relative value units" or "wRVUs," a measure applied to medical service that determines how much insurers pay for them. In essence, these are the "widgets" of health care; if you make more widgets/wRVUs, that means you are being more productive and performing more services, higher-value services, or both. Other bonuses may be separate from wRVUs and be tied to specific targets such as achieving quality metrics, or specific targets for services that may not be covered by insurance (e.g., cosmetic fillers or other similar products). Regardless, the base salary is often otherwise left alone, even if it is lowered from the salary first offered when the physician joins the employer.

Other models

Another approach is to place a portion of the physician's salary "at risk," meaning that they will receive a certain amount of money only if they meet specific productivity targets; otherwise, their compensation will be lower. "At risk" salary models, however, often also offer bonuses to offset the risk. Thus, a physician may receive a downward salary adjustment during the year if they fall below a given threshold, may maintain their current salary if they stay within a set range, and may earn bonuses if they perform above that range.

see **CONTRACTS** on p. 3

Daniel F. Shay, Esq., is a health care attorney at Alice Gosfield and Associates, P.C. and a frequent contributor to *DermWorld*.

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CONTRACT from p. 1

These models are becoming increasingly common as employers face declining reimbursement rates by insurers, as well as administrative burdens of their own. While flat, guaranteed salaries were once the norm, now they increasingly tie physician compensation to productivity to remain profitable. These arrangements are also often not flexible, with no option to simply remain at a flat salary forever. Depending on a physician's contract when it's presented, the physician may want to ask what — if anything — happens to compensation at the point when the contract ends. Would the agreement simply renew as written, or would a new arrangement be established?

In either case, whether for calculating only bonuses, or for determining compensation in an "at risk" arrangement, it is reasonable for the physician to want to see the employer's math in determining the physician's compensation. Toward that end, if the contract does not already include it, we often ask that it be revised to permit the physician to review the employer's records justifying the calculations on which compensation is based, and to offer the physician the opportunity to dispute those calculations if possible.

What to know about malpractice

Most employers offer malpractice insurance to physician employees, although the precise details of this may vary from employer to employer. Malpractice insurance generally comes in one of two forms: "claims made" coverage and "occurrence based" coverage. "Claims made" coverage refers to insurance that pays for claims that are made while coverage is paid for. In practice, what this means is that the insurer will pay the claim when the employer is currently paying for the coverage. By contrast, "occurrence based" coverage will cover a physician after the physician has left an employer, if a claim is made for services provided while the physician was employed. This is not the case with "claims made" coverage unless additional coverage (called "extended reporting" or "tail" coverage) is also purchased. "Occurrence based" coverage is more expensive than "claims made" coverage plus "tail" coverage and is offered far less frequently and then usually only by larger employers.

At a baseline, employers ought to provide malpractice coverage for their physician employees. The employer is the proverbial "deep pockets" anyway, so ensuring that the physician is covered is in the employer's interest. Nevertheless, some employers who offer "claims made" coverage will only offer "tail" coverage under certain circumstances. For example, the employer may require the physician to buy "tail" coverage themselves if the physician terminates the agreement without cause during the first year of employment. In the second year, that may shift to a 50/50 split on the costs of "tail" coverage, with the employer paying the full amount of "tail" coverage in year three and beyond. Other employers will refuse to provide "tail" coverage if the employer terminates for cause, or the employee terminates without cause at any time during the agreement. The ideal situation is where an employer will simply pay for "tail" coverage regardless of the reason for termination.

Employers who shift all or part of the cost of "tail" coverage often also require that the physician provide proof of coverage to the employer within a certain amount of time following termination, thereby imposing a time crunch on a physician who has left work. As a result, we try to negotiate for our clients to receive tail coverage under any circumstances. At the very least, we try to get the employer to provide it if the employer terminates without cause, or the physician terminates for the employer's breach.

Summing up…

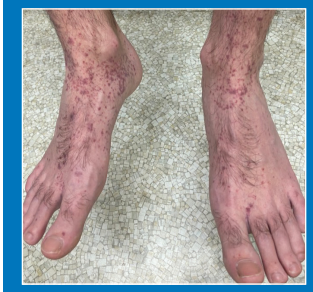
The compensation and malpractice clauses both represent aspects of the contract where a physician may not have as much leverage to ask for revisions. In the case of an employer that shifts to a productivity-based model, the employer's own interests in only paying for productive employees may outweigh whatever arguments a physician might bring to bear, especially one just coming out of training. Still, understanding the contours of their compensation is critical for any physician. Likewise, an employer may not dramatically alter how they handle the provision of malpractice insurance, but the physician can at least know what to expect when they sign. Legal counsel can help with all these issues. DR

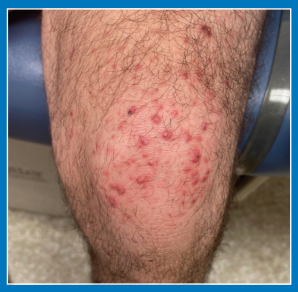
Rahul Nanda, MD, is a PGY-3 assistant chief resident at McGill University, Montreal.

Zeinah AlHalees, MD, is a PGY-5 dermatology resident at McGill University, Montreal.

Race for the Case

By Rahul Nanda, MD, and Zeinah AlHalees, MD





An otherwise healthy 25-year-old male presented to the dermatology clinic with a two-week history of purpuric skin lesions following symptoms of sore throat, rhinorrhea, and malaise. He was not taking any medications and was not known for any allergies. His review of systems was notable for abdominal pain and arthralgias of the ankles and knees. On physical exam, palpable purpura extending from the feet to the mid-thighs were noted bilaterally. Additional workup revealed microscopic hematuria and mild proteinuria. The remainder of his workup was normal. A biopsy of a purpuric papule showed findings characteristic of the diagnosis on H&E, and direct immunofluorescence demonstrated perivascular IgA and C3 positivity.

1. **What is the diagnosis and how should the biopsy ideally be performed?**
2. **What are the characteristic findings seen on H&E?**
3. **What are the extracutaneous manifestations that may be seen in association with this diagnosis?**
4. **What are a few conditions that are associated with this diagnosis?**
5. **How would you manage a patient with this diagnosis?**

Respond with the correct answers at **www.aad.org/RaceForTheCase** for the opportunity to win a $25 Starbucks gift card!

Race for the Case winner (Fall 2021)

Congrats go out to our first two-time winner, Heather Kornmehl, MD, PGY-4, of Eastern Virginia Medical School (EVMS) Department of Dermatology. She provided the most complete, correct answers to our recent nail case in the shortest amount of time. The rest of you better hurry up if you want to nail it! There's a Starbucks gift card in Dr. Kornmehl's future and there could be one in yours!

Merkel cell carcinoma

By Abdulhadi Jfri, MD, MSc, FRCPC, FAAD, and Catherine Pisano, MD, FAAD

Merkel cell	Causes	Location
Receptor of light touch in the basal layer	• Merkel cell polyomavirus 80% • UV signature mutations 20%	• Head and neck (most common) • Extremities • Buttock

Clinical features

Rapidly growing painless *pink-red* to *violaceous* dome shaped nodule.

- **A**symptomatic
- **E**xpanding
- **I**mmunosuppression
- **O**lder than 50
- **U**V exposed site

Metastatic Merkel of unknown primary **4%**

Merkel metastasis at time of diagnosis **40%**

Risk factors:

- Age
- Cumulative sun exposure
- Immunosuppression (10%)

Histologic features

Diffuse uniform small round blue cells primarily seen in the dermis with possible epidermal and/or subcutaneous involvement.

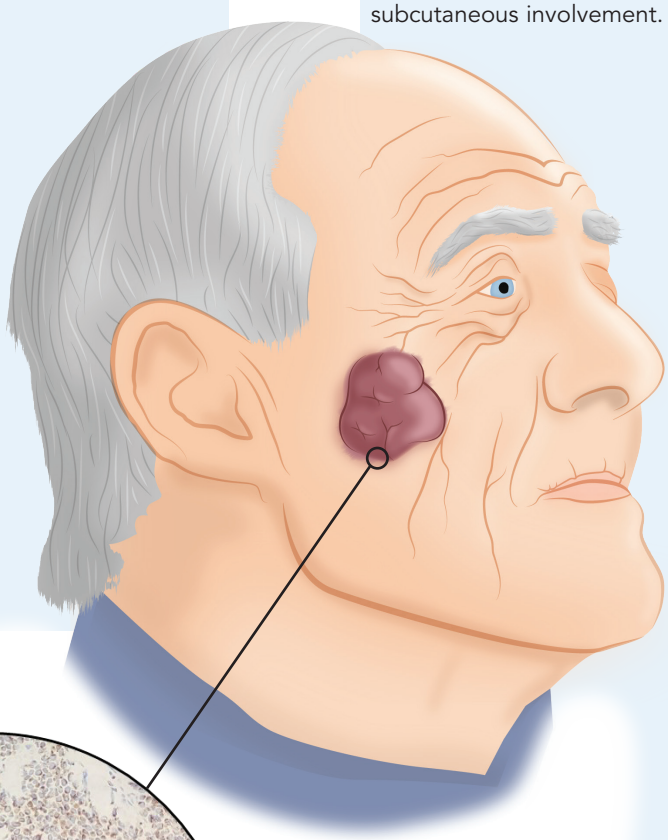
+ Stains:

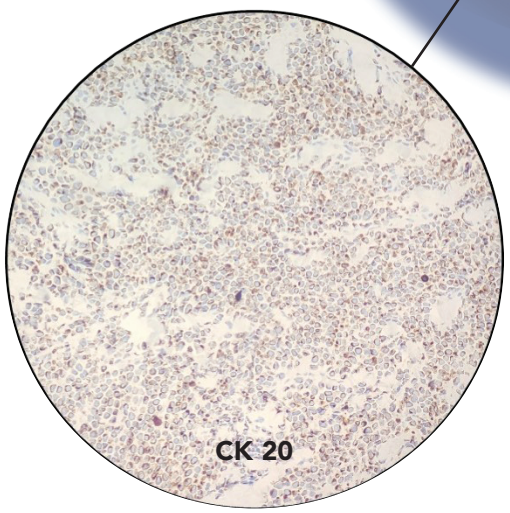
- **CK20 (perinuclear dot)**
- **CK 5/6**
- **CK7**
- **CD56**
- Neuroendocrine: synaptophysin, chromogranin, somatostatin, calcitonin, vasoactive intestinal peptide (VIP)

– Stains:

- **S100** (+ve in melanoma)
- **TTF1** (+ve in small cell lung ca)
- **CD20, CD45, CD3** (+ve in lymphoma)

Path patterns:
Small blue round cells, sheet like, nested and trabecular





ddx is for small blue round cells on path

- **L**ymphoma
- **E**wing sarcoma
- **M**erkel cell carcinoma/melanoma
- **O**lfactory/other (rhabdomyosarcoma)
- **N**euroblastoma
- **S**mall cell (oat cell) lung cancer

Clinical ddx

Basal cell carcinoma, squamous cell carcinoma, amelanotic melanoma, cutaneous lymphoma, cutaneous metastasis, angiosarcoma, dermatofibrosarcoma protuberans, keratoacanthoma, neuroblastoma, adnexal tumors, and neural tumors (neuroma, schwannoma).

Abdulhadi Jfri, MD, MSc, FRCPC, FAAD, is a Complex Medical Dermatology Fellow at Brigham and Women's Hospital Dana-Farber Cancer Institute, Harvard Medical School.

Catherine Pisano, MD, FAAD, is a Cutaneous Oncology Fellow at Brigham and Women's Hospital, Dana-Farber Cancer Institute, Harvard Medical School.

Merkel cell carcinoma

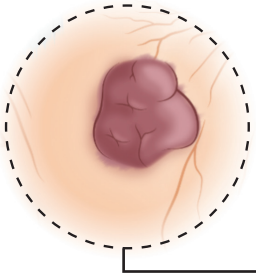
By Abdulhadi Jfri, MD, MSc, FRCPC, FAAD, and Catherine Pisano, MD, FAAD

AJCC 8th T staging	
Tis:	In situ
T1	≤ 2 cm
T2	> 2 cm ≤ 5 cm
T3	> 5 cm
T4	Muscle, fascia, cartilage, or bone

AJCC 8th clinical (cTNM)			
St.	T	N	M
0	Tis	cN0	M0
I	T1	cN0	M0
IIA	T2-T3	cN0	M0
IIB	T4	cN0	M0
III	T0-T4	cN1-3	M0
IV	T0-T4	Any N	M1

AJCC 8th pathological (pTNM)			
St.	T	N	M
0	Tis	pN0	M0
I	T1	pN0	M0
IIA	T2-T3	pN0	M0
IIB	T4	pN0	M0
IIIA	T1-T4 T0	N1a(sn) N1b	M0
IIIB	T1-T4	N1b-3	M0
IV	T0-T4	Any N	M1

Management



- Surgical excision with 1-2 cm margin
- Sentinel lymph node biopsy
- Radiation of the Merkel site and draining node basin if needed
- PET CT scan or CT chest/abdomen/pelvis to search for distant metastasis

Patient not a surgical candidate?
Radiation alone
(Merkel is very radiosensitive)

Patient has metastatic Merkel?
Immunotherapies (pembrolizumab, nivolumab, or avelumab)

Markers to follow-up response to treatment

- MCPyV oncoprotein antibodies (AMERK) at baseline, if positive, serial titers may be drawn to monitor response to treatment and help to predict recurrent disease/increased tumor burden
- Circulating tumor DNA (ctDNA) (FDA approved for monitoring colon cancer post-surgery, under investigation in MCC)

Prognosis: 5-year overall survival (OS):

Local: 51%

Nodal 35%

Distant 14%

Poor prognostic factors:

Clinical

Size: > 2 cm
Location: head & neck
Male
Immunosuppression

Path

Increased P63
Sheet like pattern
Negative CK20
Negative Merkel polyomavirus

Special thanks to **Manisha Thakuria, MD, FAAD,** director of the Merkel Cell Carcinoma Clinic Center of Excellence at Dana-Farber Cancer Institute, for reviewing this Boards Fodder chart.

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4. *NCCN Clinical Practice Guidelines in Oncology*. Merkel cell carcinoma. Version 1. 2021-Feb 18, 2021.

Boards bonus!

In addition to this issue's Boards Fodder, download two new online Boards Fodder charts. **Paisley tie differential diagnoses**, by Sujitha Yadlapati, MD, and Thomas Davis, MD, FAAD; and **Graft-versus-host disease (GVHD)**, by Abdulhadi Jfri, MD, MSc, FRCPC, FAAD, and Rachel Meltzer, MD, MPH, FAAD. Check out the archives at **www.aad.org/boardsfodder**.

Got Boards?

AAD welcomes new Boards Fodder chart ideas. View the Boards Fodder guidelines for submission at **www.aad.org/member/publications/more/dir**. Contact *DW Directions* Editor Dean Monti at dmonti@aad.org.

Maria Hordinsky, MD, FAAD, is professor and head of the department of dermatology at University of Minnesota. She is co-editor of *Hair and Scalp Disorders: Medical, Surgical, and Cosmetic Treatments, Second Edition* with Amy J. McMichael, MD, FAAD. Dr. Hordinsky is a member of the Board of Directors for the American Academy of Dermatology, and the Cicatricial Alopecia Research Foundation. She is also past chair of the clinical research advisory council for the National Alopecia Areata Foundation, and immediate past president of the American Hair Research Society.

Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with top tips from experts about what they should know about specific, key subject areas by the time they complete their residency.

Alopecia areata

Maria Hordinsky, MD, FAAD

1. Alopecia areata (AA) is a chronic or episodic, immune-mediated disorder which affects all ages, ethnicities, and genders. With an estimated prevalence of approximately one in 1,000 people and a lifetime risk of approximately 2%, AA is associated with loss of hair follicle immune privilege and a T-cell-mediated immune attack on cells within the hair bulb. This loss of immune privilege is believed to lead to activation of natural killer cells, secretion of interferon (IFN)-gamma that stimulates the expression of major histocompatibility complex class I polypeptide-related sequence and interleukin (IL)-15. IL-15 influences regulatory T-cells and promotes proliferation of both T- and natural killer cells.

2. There is currently no treatment approved by the Food and Drug Administration for managing AA but there are still treatment options to choose from. Prior to prescribing a treatment, the clinic visit should include a thorough medical history, review of hair/scalp care habits, and patient/family goals and expectations. The examination should focus on documenting any changes in all hair-bearing areas as well as any nail involvement. Disease activity can be ascertained with light hair pull tests. Treatment selection is based on patient age, hair loss location, disease extent, activity and presence or absence of any comorbidities. Stable patchy AA is commonly treated with topical or intralesional (3-10 mg/cc) corticosteroids, 2% or 5% topical minoxidil when fine vellus or indeterminate hair growth is present, topical immunotherapy or combinations such as a topical steroid with topical minoxidil. For those with extensive or recalcitrant disease, oral immunosuppressive agents may be prescribed and in patients with acute hair loss, systemic corticosteroids may be indicated.

3. Patients and family members frequently ask if AA is inherited. The risks for parents, siblings, and children of patients has been estimated to be 7.8%, 7.1%, and 5.7%, respectively. Familial and twin studies further support a genetic predisposition to AA, and genome-wide association studies have confirmed associations of AA with HLA genes and susceptibility loci associated with other autoimmune diseases.

4. Adults and children with AA should receive psychosocial well-being evaluations. It is best to proactively manage parental anxiety, frustration, and guilt as well as any patient anxiety or depression. The National Alopecia Areata Foundation is a useful resource for patients.

5. Alopecia areata patients are aware of evolving research with Janus kinase (JAK) inhibitors. Therefore, a conversation about evolving therapies in clinical trials and off-label use of oral and topical JAK inhibitors such as tofacitinib and ruxolitinib may be expected.

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1. Strazzulla LC, Wang EHC, Avila L, Lo Sicco K, Brinster N, Christiano AM, Shapiro J. Alopecia areata: Disease characteristics, clinical evaluation, and new perspectives on pathogenesis. *J Am Acad Dermatol.* 2018 Jan; 78(1):1-12.
2. Hordinsky M, Donati A. Alopecia areata: an evidence-based treatment update. *Am J Clin Dermatol.* 2014; 15:231-245.
3. Agre K, McCarthy Veach P, Bemmels H, Wiens K, LeRoy BS, Hordinsky M. Familial implications of autoimmune disease: Recurrence risks of alopecia areata and associated conditions in first-degree relatives. *J Genet Couns.* 2020 Feb; 29(1):35-43.
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5. Mackay-Wiggan j, Jabbari A, Nguyen n, et al. Oral ruxolitinib induces hair growth in patients with moderate to severe alopecia areata. *JCI Insight.* 2016; 1: e-89790. DR

NEW! Clinical Pearls online

The AAD has recently compiled its Clinical Pearls archives from the pages of *Directions in Residency*. The popular feature provides residents with useful tips from experts in dermatology.

Learn more by visiting the archives at
www.aad.org/member/publications/more/dir/clinical-pearls.

Promoting DEI in residency workshop

By Robert Dazé, DO

Robert Dazé, DO, along with his co-resident colleagues at Largo Medical Center in Florida, hosted their dermatology program's first Skin of Color Kodachromes and Suture workshop in collaboration with their hospital's Diversity, Equity, and Inclusion Committee.

"When I was a first-year resident, I was selected by the AAD to the attend their inaugural Diversity Champion Workshop, where I was inspired to promote inclusive consciousnesses across our profession," Dr. Dazé said. "As an underrepresented minority, I completed the AAD's Diversity Champion Workshop with a steadfast desire to make a difference so that others like myself could pursue dermatology."

Dr. Dazé, now a PGY-4 chief resident, said what started off as a mere concept at Largo Dermatology has blossomed into an interactive workshop for medical students and residents alike. "Our lecture and workshop even drew medical students from Texas, Michigan, and Arizona to attend," he said. DR

Largo Medical Center in Florida hosted their dermatology program's first Skin of Color Kodachromes and Suture Workshop. The Florida workshop drew medical students from across the nation.

Dr. Dazé, third from right, with fellow co-residents of Largo Medical Center in Florida. Largo's DEI workshop was part of an ongoing commitment to a culture of diversity, equity, and inclusion.

Robert Dazé, DO, is a dermatology chief resident, PGY-4, at HCA Healthcare/USF Morsani College of Medicine GME, Largo Medical Center in Florida.

Was it all worth it?

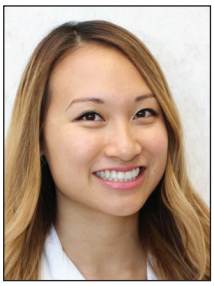
By Gloria Lin, MD, MS

Finally, the email had arrived — we were officially board-certified dermatologists! In some ways, it felt anti-climactic, as many of us had already been working as attendings, started fellowship, or pursued other career paths after residency. However, it offered a rare moment of reflection for everything that we had accomplished and sacrificed to get to this moment.

Some of it feels like a lifetime ago: trying to get into medical school, the never-ending standardized testing, and praying to match into dermatology. As bright-eyed interns, we were faced with the reality of caring for at least double the amount of patients we did as medical students and being the one that the families looked to for answers.

When we emerged from intern year, we thought we had finally made it since we were now dermatology residents at UConn; however, a global pandemic swept the nation. Residents across the country were pulled to help staff the inpatient wards. Remote video meetings became the new norm of interacting with each other. Even the AAD offered remote learning that was helpful to make sure we kept getting our CME. We were also the first class to take the new Core and Applied Exams, unsure of what to expect. But — we made it!

Looking back, I realize it truly is a process. I am grateful for all the lessons I learned along the way, as I was surrounded by wonderful colleagues and mentors. Life as a new attending feels like a dream, and even now it can be easy to forget the trials and tribulations I encountered along the way. If I could give any advice to the current residents, it would be that you are capable of anything, even when things feel insurmountable. Remember to enjoy the journey because it will be over before you know it, and you will miss the laughs and good times you had as a resident. During this last phase of training, reflect on everything that you have accomplished and know that the sleepless nights, missed holidays, and years of training will be worth it! DR

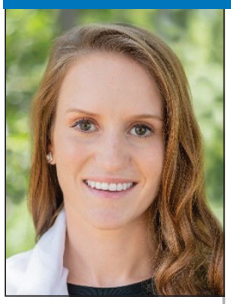


Gloria Lin, MD, MS, FAAD, recently graduated from UConn where she served as chief resident. She is currently working in private practice at Metropolitan Dermatology in New Jersey and also serves as a volunteer attending at Northwell Health and UConn.

In our next issue:

Resident Life goes to UVA!

Inside this Issue



Taylor Gray, DO, is a PGY-4 dermatology resident at Largo Medical Center in Florida.

As the journey to becoming an attending physician comes to an end, it is an exciting and surreal time! There is much to consider and many decisions to make. The obvious, where you want to work, is the first thing on the minds of many residents. This decision in and of itself can be difficult and my most trusted mentors encouraged me to start thinking about this earlier than the last year of residency. Not only do you need to decide what practice model best suits you and what region of the country will support the lifestyle you desire, but there are many contract-related questions to consider. While many of us have long awaited the day we obtain a more robust salary, there are many factors that should be carefully weighed. For example, if you have ties to a particular region, the non-compete clause in your contract will be very important as many young physicians do not stay at their initial choice of employment for more than a few years.

Other things to evaluate include the electronic medical record utilized, if you will be supervising resident physicians or mid-level providers and how this will be compensated, administrative or research expectations, and how many patients you will be expected to see. Remember, many factors outside of your skills as a physician impact your ability to see a certain volume of patients. The number of available rooms and nurses, as well as support staff such as biopsy coordinators, biologic coordinators, and individuals to assist with prior authorizations could greatly impact your efficiency. A dermatology-specific medical contract lawyer is invaluable when negotiating terms. They can help you ask meaningful questions and adeptly locate nuances in contract verbiage that may make tangible differences to the quality of your life as a new attending physician.

Finally, remember that you have spent years cultivating a skill that offers incredible benefit to your future patients! Be patient in finding a job that will best support you while you utilize this skill. Offers may come with a time limit in which they would like you to accept the position; this should not discourage you from discussing options with family, trusted mentors, and your contract lawyer. Additional considerations for life after residency include the rate at which you can repay your loans, obtaining specialty-specific disability insurance, transferring your residency 401k/403b into a personal IRA, budgeting for board preparation resources and moving costs, obtaining licensure in the state in which you will practice, and obtaining health insurance for time between residency and the start of your employment.

While the list may seem long and overwhelming at first, the burden can be eased by starting early and relying on experienced mentors and expert counsel like Daniel Shay, Esq. Most importantly, do not forget to take a moment to reflect on the journey you have been on and acknowledge the incredible accomplishment you will soon achieve! DR

Free coding modules!

The Resident's Online Coding Education (ROCE) is now available at aad.org. This free course will help you understand the fundamentals of coding. It features 12 brief, narrated modules that tackle clinical concepts and key elements needed to adequately code and document the physician-patient encounter.

Go to **digital-catalog.aad.org** and search "**coding**."

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