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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. The urge to simply sign an employment contract and get to work may be strong. Physicians may not believe they can negotiate terms, 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 as well as practical tips to consider.

Term and termination

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.

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 notifying the other of its wish to terminate before the contract renews. The length of notice needed for termination also matters and must usually 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 may also 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 language surrounding "confidentiality," an anti-solicitation clause, or an anti-competition clause. Typical confidentiality provisions require the physician to maintain confidentiality of things like managed care

see **CONTRACTS** on p. 3

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CONTRACTS from p. 1

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

Not all states permit anti-competition clauses in employment contracts (e.g., California). Also, where permitted, they must usually be reasonable and limited in scope and duration. The 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 become tricky to determine applicable restricted areas. 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 apply only if you terminate without cause or if the employer terminates for 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. 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, you can ask for changes. At worst, the employer will reject the request and is unlikely to rescind the job offer. If contract clauses are unclear, most employers will explain what they intend by the language and may agree to clarify it to avoid disputes in the future.

Clear understanding is key

It's paramount to read through an employment contract first. This document will govern your life; a clear understanding of what it requires is essential. Experienced health care legal counsel can help. DR

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Race for the Case

By Frank Z. Jing, MD, and Nessa Aghazadeh Mohandesi, MD, FAAD

A 75-year-old man with a history of gastroesophageal reflux and deep vein thrombosis presented with a six-month history of unintentional 20-pound weight loss and decreased appetite. He also reported a persistent full-body eruption for the past month, which will periodically improve without treatment but then re-intensify. The individual lesions were mildly tender to palpation. Additionally, he noted increased redness involving the ears, affecting one or both sides intermittently. He was unsure if this was related to sun exposure. He denied fevers, chills, abdominal pain, or joint pains. A recent bone marrow biopsy revealed variably cellular bone marrow with erythroid hypoplasia and no increase in blasts. His hemoglobin was 7.1 g/dL, mean corpuscular volume (MCV) 97.5 fL, platelet count 225 x 10(9)/L, leukocytes 3.0 x 10(9)/L, and erythrocyte sedimentation rate (ESR) 132 mm/h.

1. **Based on the symptoms, clinical photos, and laboratory evaluation, what syndrome should you be suspicious of?**
2. **How could you confirm your suspicion in question one and what are you looking for specifically?**
3. **What abnormalities would you expect to see on a complete blood count?**
4. **What finding(s) would you expect to see on histopathology?**
5. **What is the first-line treatment for this disease?**

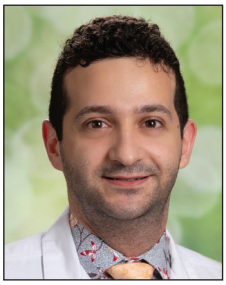
Respond with the correct answers at **www.aad.org/RaceForTheCase** for the opportunity to win a Amazon gift card!

Race for the Case winner (Spring 2025)

The winner of the spring 2025 Race for the Case is Marc Schlessel, MD, a PGY-4 dermatology resident at Penn State. Dr. Schlessel correctly identified lymphomatoid papulosis in our latest Race for the Case and provided the most accurate responses in the quickest time. Congrats to Dr. Schlessel! You can read more about this case online at **www.aad.org/race-case-answers**. If you can solve the case above, there may be a $100 Amazon gift card in your future, and you will be invited to contribute your very own Race for the Case. Visit **www.aad.org/RaceForTheCase**.

Overview of skin substitutes for secondary intention healing in dermatologic surgery

By Mohammad Fardos, DO, Vixey Silva, DO, and Anna Bar, MD, FAAD



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There is no universally accepted classification system for categorizing all commercially available skin substitutes.

Skin substitutes are indicated for temporary or permanent coverage of wounds requiring delayed reconstruction, large or secondary intention defects, cosmetically or functionally sensitive areas, poorly vascularized sites, impaired healing due to comorbidities, burns, or as adjuvants to skin grafting to optimize healing and outcomes.

Terminology

Acellular substitutes: Serve as dermal scaffolds without living cells to promote granulation tissue formation and revascularization.
Cellular substitutes: Composed of cells secreting extracellular matrix proteins and growth factors.
Allograft: Refers to tissue grafts (e.g., skin) taken from another human, typically a cadaver, used to cover wounds or burns temporarily or assist in healing.
Autograft: Refers to skin grafts harvested from the patient's own body, often from a donor site like the thigh or buttocks, for wound coverage or repair.
Xenograft: Refers to a tissue graft (e.g., collagen and extracellular proteins) obtained from an animal species, commonly pigs (porcine), cows (bovine), or fish.

Tissue type	Composition	Preparation	Advantages	Disadvantages
Amnion	Acellular substitute composed of human amniotic/chorionic membrane, composed of single-layer epithelial cells, basement membrane, and avascular connective tissue matrix.	Derived from placenta of screened donors. Can be applied directly to wound beds. For dry wound beds, the graft requires moistening (i.e., with saline) prior to application.	Non-immunogenic Long shelf life (up to 5 years) and some can be stored at room temperature Analgesic effect (reduces pain in the wound)	Typically requires multiple reapplications until wound is healed
Cultured epithelial autografts/ epidermal substitutes	Cohesive sheets of autologous keratinocytes, 2-8 cell layers thick.	Created by taking a small skin biopsy from the patient, isolating keratinocytes, expanding cells *in vitro*, and culturing them into sheets of epidermis (after 3-4 weeks). Sheets are then applied to wounds to promote skin regeneration.	Can be used on large area wounds Reduces need for harvesting multiple skin grafts as it can be regrown and reapplied as needed No need for reapplication	Fragile Does not contain dermal components Graft contraction Time-intensive process to create Costly
Acellular/ dermal allografts	Acellular substitute composed of dermal extracellular matrix proteins (collagen, elastin, glycosaminoglycans, hyaluronic acid).	Derived from cadaveric human dermis. Through a sequential decellularization process, the epidermis and all cells are removed, leaving behind a collagen-rich dermal scaffold. Scaffold integrates into the wound bed to regenerate normal skin. Must be rehydrated in a warm sterile solution prior to application. Apply within 4 hours with the dermal side facing down and basement membrane side facing up.	Ready to use Long shelf life (up to 5 years for some products) When used on superficial partial-thickness wounds, it can reduce pain. Pliability No need for reapplication	Time-intensive process to create

Overview of skin substitutes for secondary intention healing in dermatologic surgery

By Mohammad Fardos, DO, Vixey Silva, DO, and Anna Bar, MD, FAAD

Tissue type	Composition	Preparation	Advantages	Disadvantages
Cellular allografts	Cellular substitute composed of keratinocytes, fibroblasts, growth factors, and collagen.	Derived from cadaveric skin or human fetal foreskin. Can cause redness which is normal (not considered infection).	Promotes biological activity and tissue regeneration Supports reepithelialization	More costly than acellular grafts Requires proper storage (often cryopreserved or refrigerated) to maintain cell viability Higher risk of immunogenicity Reapplications often necessary
Xenografts	Collagen and extracellular matrix proteins derived from animal tissue (e.g., porcine, bovine, fish, frog)	Are sterilized to remove potential infectious agents. Applied directly to the wound bed in most cases. Used for deep wound beds with exposed bone, tendon, or cartilage. For dry wound beds, some xenografts (e.g., Kerecis) require moistening.	Readily available Low antigenicity Biodegradable Long shelf life Analgesic effect (reduces pain in the wound)	Defects healed by bovine xenografts may result in thinner skin that is vulnerable to traumatic injury Possible religious concerns for some patients
Bilayered living cellular construct/ composites epidermal and dermal	Two components: Epidermal: cultured human keratinocytes, often allogeneic (e.g., from neonatal foreskin) Dermal: Bovine type I collagen with human neonatal foreskin fibroblasts	Resemble the structure of human skin and serve as a scaffold for neovascularization and cellular infiltration. Should be handled aseptically and applied directly to a clean, debrided wound bed with adequate hemostasis. Do not require thawing or soaking. Secure in place using sutures, staples, or dressings as needed to ensure proper adherence	Ready to use Good for full-thickness defects (melanoma defect) Less vascular scars Low antigenicity Mimics natural skin structure; promotes neovascularization and cellular infiltration	Fragile Costly Requires proper handling and storage Short shelf-life
Synthetics	Hyaluronic acid-derived substitutes/ silicone	A synthetic, bi-layered, bioresorbable dermal substitute made from a hyaluronic acid derivative. The outer membrane features a transparent, semipermeable silicone layer that provides a protective barrier against fluid loss and external contaminants.	Bioresorbable Immunologically inert Ready to use Supports angiogenesis and fibroblast colonization	Characteristic smell (foul-odor) Requires proper handling and wound preparation for optimal results

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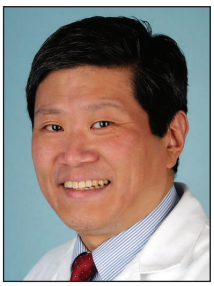
More study charts online!

There are a lot more Boards Fodder charts online! In addition to the skin substitute chart in this issue, you can view our new **Extramammary Paget's Disease** chart by Valeria González-Molina, MD, Thomas Davis, MD, FAAD, and Rick Lin, DO, MPH, FAOCD, as well as the **Genoderms with skin cancer associations** chart by Suchita Sampath, DO, and Kelly Kimball, MD.

These and many more charts can be found at **www.aad.org/boardsfodder**.



Michael E. Ming, MD, MSCE, FAAD, is associate professor of dermatology at the University of Pennsylvania.

Clinical Pearls

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

Melanoma

By Michael E. Ming, MD, MSCE, FAAD

Pearl #1: Melanoma incidence rates are decreasing in younger patients. Melanoma incidence rates are still increasing in the United States for older populations, but the incidence rate for patients younger than 40 years of age has been trending downward since 2006. Similar decreases in melanoma incidence have been replicated in independent U.S., European, and Australian databases, suggesting that this is a real change as opposed to a statistical or database quirk. It is possible that our public health messaging over the past few decades about the dangers of sun exposure may have had an effect. I see a lot more people in long-sleeved shirts and under tents at the beach now than in the past. Counseling patients about sun protection takes time during the visit, but it may have a major impact.

Pearl #2: For a large, clinically obvious melanoma, biopsying the entire lesion may not be crucial. As a dermatology resident and a dermatopathology fellow, I was taught that a melanocytic lesion is ideally biopsied in its entirety so the dermatopathologist can evaluate the whole lesion. However, removing a several-centimeter lesion can be challenging in the middle of a busy clinic. These large lesions are also often obvious melanomas clinically. In many cases, these lesions are also quite atypical microscopically, and diagnosing a melanoma is straightforward for the dermatopathologist even if the entire lesion is not submitted. For large lesions, I often take two or three 6- to 8-mm punch biopsies of the portions that are likely to have the greatest Breslow thickness to assist in formulating the management plan. If necessary, the rest of the lesion can be removed in its entirety for diagnostic purposes later.

Pearl #3: Patients on immunotherapy for metastatic melanoma who are doing well should continue to have skin exams for new primary lesions. Many patients with metastatic melanoma are on immune checkpoint inhibitor (ICI) therapy that affects the immune system globally as opposed to receiving a therapy targeted toward the specific properties of their original melanoma. The question has therefore arisen whether such immunotherapy would reduce the risk of developing new primary melanomas enough that these patients can forego routine skin exams. However, Dr. Michael Marchetti's team at Memorial Sloan Kettering Cancer Center report in *JAMA Dermatology* that patients on ICI therapy for metastatic melanoma still develop new primary melanomas at a rate of 1.1% per patient-year. That rate is high enough that I continue standard skin examination schedules for patients on systemic therapy who are otherwise doing well.

Pearl #4: For patients with concerns about the potential harm of sunscreens, I often recommend zinc oxide lotion or cream. There have been several articles in the lay press about potential dangers from chemical sunscreens, both to the marine environment after they wash off the patient's skin into the ocean and, theoretically, for the user, as sunscreen ingredients can get absorbed through the skin. In addition, concerns have been raised about inhaled titanium dioxide as a possible carcinogen. For patients with concerns, I suggest that they use zinc oxide lotion or cream, which has no associated potential health risks of which I am aware.

Pearl #5: Consider scheduling the patients with the most complex mole patterns as the last patient of the day. Although some skin examinations are very straightforward, some patients have hundreds of pigmented lesions. It can be challenging to have such patients clustered on the schedule, both in terms of staying on time and maintaining focus. Scheduling these patients as the very last appointment of the day avoids both those issues. DR

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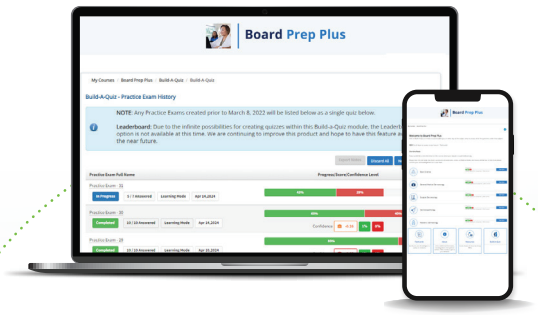

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Inside this Issue

Chirag Vasavda, MD, PhD, is a PGY-2 at Harvard Combined Dermatology Residency.

Starts and strides

As the new academic year begins, I'm honored to welcome you to this issue of *DermWorld Directions in Residency.* This time of year always brings earnest excitement: fresh starts, new friends, and the quiet thrill of updating our email signatures. Whether you're stepping into your first clinic of residency or preparing to lead one as a senior, this issue of *Directions* is dedicated to the dynamic role that dermatology plays across medicine and in our patients' lives.

For our first-year co-residents, Sampath et al. present a primer on some of the syndromes and tumors that shape specialized dermatologic care, with conditions ranging from dyskeratosis congenita to Gorlin syndrome to epidermolysis bullosa. González-Molina et al. provide an update on our current understanding and management of extramammary Paget disease. These complex diseases span multiple subspecialties of medicine, and their discussion highlights our role as dermatologists in bridging care across an increasingly interdisciplinary medical landscape.

For our junior and senior co-residents, we hope that this issue serves as a resource to learn something new while cementing the old. Test your growth with this month's Race for the Case from Jing et al. We suspect you'll find several new pearls along the way, reinforcing your knowledge and board preparation alike. Don't miss Fardos et al.'s practical guide to skin substitutes, integrating key concepts from both medical and surgical dermatology that help us provide better surgical care.

As some of us begin to consider life after residency, Daniel Shay, Esq., also offers timely reflections and guidance on employment contracts. He highlights key clauses that can have an outsized impact on our professional and personal lives. Knowing the right questions to ask can help demystify the transition and empower us to start our careers with confidence.

As we start the new year together, I also want to celebrate how far we've come and look forward to the discoveries, growth, and impact still possible ahead. Dermatology has had several momentous contributions to clinical medicine in recent years. Equipped with dupilumab for those with disfiguring eczema, anifrolumab for adults with severe lupus, and now nemolizumab for patients with debilitating itch, we can finally provide life-changing care for conditions with significant physical, emotional, and social burdens. Because of decades of investment in science and medicine by individuals before us, we can provide treatments that transform lives today. Reflecting on this progress inspires me to consider the possibilities that lie ahead. No matter the challenges ahead, the knowledge and resilience we learn in residency empower us to drive meaningful change as long as we remain curious, committed, and engaged. DR

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