DERMATOLOGY WORLD

DIRECTIONS *in* RESIDENCY

A Publication of the American Academy of Dermatology Association

Fall 2017

All things considered — a primer on contracts for residents

By James D. Kelso, JD, LLM

Contracts define and regulate the relationship between you and your employer. Both parties are managing risk by defining the "universe" in which you will work. It's all about "the consideration" — that is, consideration must be bargained for and exchanged between each party in order for the contract to be binding. Contracts are also used to manage the end of relationships. (Contracts manage the divorce not the marriage.) If you accept a position you are not crazy about, you will want to evaluate the cost and ease of separation before you execute the agreement.

There are many factors to consider, and all should be discussed with a lawyer that you trust. Here are some things to contemplate when reviewing a contract:

Issues most often negotiated

- Compensation
- Incentive or performance bonuses
- Equity ownership
  - How will the buy-in operate? Will the shares be equal to other physician owners?
- Signing bonuses
- Relocation allowances
- Benefits
  - Health, dental, vision, short-term disability, long-term disability, and life insurance
- Restrictive covenants, non-competes, and non-solicitation clauses
- Work and call schedules
- Practice locations
- Non-competition and other restrictive covenants

Types of compensation and bonuses

- Straight production (collections less expenses)
- Flat sum salaries
  - Lump sum bonus payments based on performance achievements (i.e. $20,000 if XYZ occurs)
- WRVU compensation arrangements that focus on dollar per WRVU
- Percentage of collections
  - 40 percent of cash receipts less cost of cosmetics
  - 40 percent of any amount up to $800K and 45 percent of any amount over $800K
- Percentage of product sales
- Percentage of cosmetic procedures
- Percentage of "managed" physician assistants

Other things to consider when interviewing and reviewing offers

- Understand what's important to you
- Prepare questions and ask them during the interview
- Equity ownership (partnership) is important; ask follow-up questions
  - Partnership gives you control of your life through voting rights and gives you equity income from non-physician practice profits
  - Understand the buy-in process, buy-in amount, and whether your shares will be equal to all other physician owners
  - Look to the long-term and determine how the shareholder salaries and expenses are managed

see **CONTRACTS** on p. 3

James D. Kelso, JD, LLM, provides specialized legal services for physicians and physician practices across the country. He lectured at the AAD Annual Meeting in Orlando earlier this year.

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QUESTIONS?

Please contact Kari Webb at KWebb@aad.org.

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CONTRACTS from p. 1

- If there is a complicated bonus description, ask to see how the numbers flow through the bonus calculation
  - Reviewing a spreadsheet is worth a thousand words
- Review the agreement to make sure it contains what was promised
- Respect deadlines in offer letters
  - Offers can actually expire and be withdrawn
- If there are issues you are uneasy with, have someone with knowledge of the health care industry review the agreement
  - A family friend or an attorney who does not practice in health care may not be the right person. Would you go to a cardiologist for a skin lesion question?

And remember...

- Don't be afraid to negotiate!
- How employers handle negotiations can say a lot about the employer, even if you don't get what you want
- Hire an attorney who knows about the specialty, the market, and physician employment issues
- If you don't like the back-and-forth, have your attorney negotiate with the employer
- Use the attorney as a tool to insulate you from the negotiations **DR**

Time Saving Tip

By Laura Battle, MD

Take advantage of online resources. In addition to the resident information you'll find at **www.aad.org** aad.org, most of our standard dermatology textbooks (Bologna, Rapini, McKee, Elston, etc.) come with an online access code for an electronic version that's accessible via **expertconsult.com**. The online version is easily searchable for specific topics. Through Expert Consult, you can highlight and add notes in a similar manner that you would with a physical textbook. Reading a few paragraphs on a disease while seeing a patient with that condition in clinic is a great way to solidify your knowledge. Plus, online versions of textbooks make it easy to find the relevant information quickly.

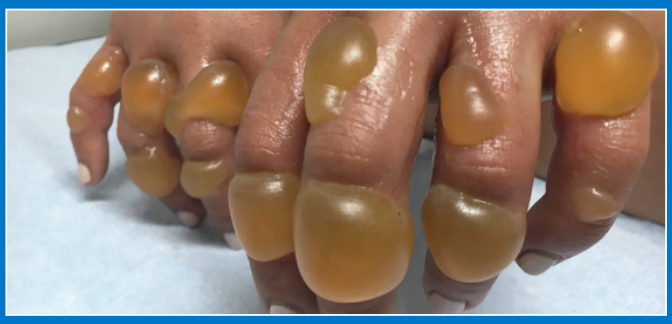
Another great e-resource is social media. Many excellent clinical dermatologists and dermatopathologists post interesting cases with high-yield learning points via Instagram, Facebook, or Twitter. I recommend following @globaldermie, @jmgarndermd, @dermpath_quiz, @derma_mnemonics, @asdpdermpath, @azdermpath, as well as @aadmember on Instagram, just to name a few. This way — without much effort on my part — I can learn about epidermodysplasia verruciformis while also scrolling through and catching up on where college roommates are traveling or what they just ate for dinner!

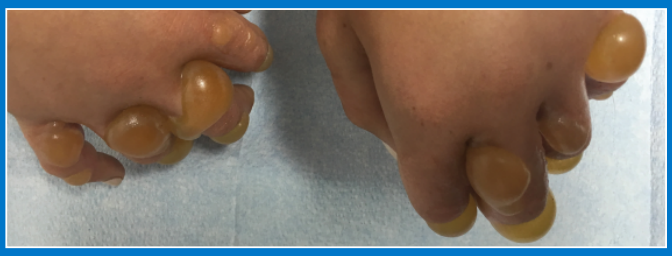
Laura Battle, MD, is a resident in the department of dermatology at the University of Arkansas for Medical Sciences.

Gina Spohn, MD, is a chief resident PGY-4 at The Ohio State University, Columbus, Ohio.

Race for the Case

Gina Spohn, MD





A 23-year-old healthy woman presented to dermatology clinic with an acute blistering rash over her hands and fingers. The rash had initially started as erythematous patches one day after the patient was squeezing limes as a part of a recipe. After squeezing the limes, she went for a run and then spent several hours relaxing in the sun. On exam, she had numerous tense bullae over the fingers with sparing of the joints and edema of the hands.

1. **What is the differential diagnosis?**
2. **Is this reaction immunologic?**
3. **What families of plants are known for causing similar reactions?**

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 (Summer 2017)

Congratulations to Megan Arthur, MD, PGY-4 for correctly answering the Race for the Case questions in the fastest amount of time! Dr. Arthur is a dermatology resident at Oregon Health and Science University.

To view the answers for the last Race for the Case, go to **www.aad.org/RaceForTheCase**.

Monitoring Systemic Dermatology Medications

By Jeffrey Collins, DO, and William Steffes, MD

Medication	Dosage	Lab Screening	Lab Monitoring	Medical history to screen for	Main toxicities to watch for with use
Methotrexate	7.5-25 mg Q weekly, folic acid 1 mg daily (except MTX day)	CBC w diff, CMP, hepatitis panel (B and C), quant gold, preg test, +/- HIV	Week 2: CBC Week 4: CBC, CMP Month 2: CBC, CMP Q3 months: CBC, CMP Consider liver bx 3.5-4.0 g cumulative dose	Liver dz, Renal dz, preg/lactation, use of bactrim is contraindicated, NSAIDs, alcoholism, obesity	Pancytopenia (risk increases with renal dz), idiosyncratic pulmonary fibrosis, hepatotoxicity, teratogen
Cyclosporine	Modified: 2-4 mg/kg a day split BID Non modified: 2-5 mg/kg/day split BID	CBC, CMP, hepatitis panel, fasting lipid panel, Mg, Uric Acid, quant Gold, UA, blood pressure, preg test	Month 1: CBC, CMP, lipid panel, UA, blood pressure, Mg Month 2: repeat month 1 Q3 months: CBC, CMP, lipid panel, Mg, Uric Acid, UA, BP	Renal dz, malignancy, infections, HTN, preg/lactation	Renal disease (decrease dose if Cr increases >30% over baseline), gingival hyperplasia, hypertrichosis ↑K, ↑Uric acid, ↓Mg hyperlipidemia, max 1 yr use
Dapsone	25-200 mg QD	G6PD, CBC with diff, CMP, UA, +/- preg test	Week 2: CBC with diff Month 1: CBC with diff, CMP, retic count Month 2: CBC with diff, CMP, +/- retic count Q3 months: CBC with diff, CMP, +/-retic count	CV dz, liver dz, anemia neuropathy, MTX or bactrim usage	Hemolytic anemia, methemoglobinemia, hypersensitivity syndrome (DRESS), agranulocytosis (weeks 2-12), motor neuropathy
Azathioprine	50-150 mg QD	TMPT, CBC, CMP, UA, preg test, quant gold	Month 1: CBC with diff, CMP Month 2: CBC with diff, CMP Q3 months: CBC with diff, CMP	Allopurinol use, malignancy (including SCC), preg/lactation	GI upset, bone marrow suppression, new onset malignancy, hypersensitivity syndrome (rare)
Mycophenolate mofetil	2-3 g a day split BID Myfortic-enteric ↑bioavailability, ↓GI side effects	CMP, CBC, Hep B, Hep C, quant gold, Preg test	Month 1: CMP, CBC with diff Month 2: CMP, CBC with diff Q3 months: CMP, CBC with diff	Preg/lactation	GI upset (dose dependent), bone marrow suppression, NO renal or hepatic toxicity
Corticosteroids	Many forms and doses; screening and monitoring only needed for long term use (>1 month); add Vit D/Ca and PPI for protection	CMP, hepatitis panel, lipid panel, quant gold, DEXA scan (for at risk patients), ophthalmologic exam	Month 1: ht and wt for children, BP, fasting BMP and lipid panel Q3 months: ht and wt for children, BP, fasting BMP and lipid panel Annual: ophthalmology exam, DEXA	Glaucoma, cataracts, mental health dz, DM, HTN, osteoporosis risk	HTN, hyperlipidemia, glaucoma and cataracts, psychiatric dz, PUD, growth retardation, DM, osteoporosis, bone and eye complications not mitigated by alternate day dosing
Hydroxy-chloroquine	200-400 mg QD Max 6.5 mg/kg	Retinal screen, CBC, CMP, +/- G6PD	Month 1: CBC, CMP (then Q3-6 months) Annual: ophthalmology exam	Retinal dz, cardiac dz	Ocular toxicity, blue-gray hyperpigmentation, cardiomyopathy, GI upset
Acitretin	25-50 mg QD	CBC, CMP, lipid panel, preg test	Month 1: CBC, CMP, lipid panel Q3 months: CBC, CMP, lipid panel, pregnancy test if applicable	Hyperlipidemia, liver dz, preg/lactation	Transaminitis, hyperostosis hyperlipidemia, ↓night vision, xerosis/cheilitis, pyogenic granulomas, pseudotumor cerebri, teratogen - avoid preg for 3 years after secondary to esterification to etretinate
Isotretinoin	0.5 - 1 mg/kg split BID; some sources up to 2 mg/kg	Pregnancy, lipid panel, LFTs Day 1-repeat neg preg test	Q month: Pregnancy Month 2: Lipid panel and LFTs Additional testing no longer indicated unless abnormalities on screening	Suicide attempts, depression, IBD, two methods of contraception	Transaminitis, hyperlipidemia, ↓night vision, depression, xerosis/cheilitis, hyperostosis, myalgias, pyogenic granulomas, pseudotumor cerebri, teratogen - avoid preg for 1 month after
Spironolactone	50-200 mg QD	+/-: K , blood pressure, preg test	+/-: K, blood pressure, preg test	Renal disease, family Hx of breast cancer, preg/lactation	Breast tenderness, menstrual irregularity, dizziness, hyperkalemia (rarely significant)

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William Steffes, MD, is an attending physician at Dermatology Residency of Orlando-ADCS

Monitoring Systemic Dermatology Medications *(continued)*

By Jeffrey Collins, DO, and William Steffes, MD

Medication	Dosage	Lab Screening	Lab Monitoring	Medical history to screen for	Main toxicities to watch for with use
Ortho Tri Cyclen Yaz	Fixed graduated dosing, start on 1st Sunday after onset of menses	Preg test	N/A	Smoking, CVA/DVT, CAD, ovarian/breast CA, migraines	Nausea, weight gain, headaches, menstrual irregularities, breast tenderness, CVA/DVT
Terbinafine	250 mg QD x 12 weeks toenail; 6 wks fingernails; 2-4 wks cutaneous	AST, ALT, +/-BMP	6 weeks: AST, ALT	Liver dz, Cr clearance <50	Liver, headache, metallic taste, drug induced SCLE, headache
Etanercept	50 mg 2x week till month 3 then 50 mg Q week	CBC, CMP, hepatitis panel, quant Gold	Q6 months: CBC, CMP Q1 yr: quant gold	CHF, IBD, MS	Infections, malignancy
Adalimumab	PSO: 80 mg x1, 40 mg day 8, then 40 mg Q2 weeks HS: 160 mg x1 80 mg week 2 then 40 mg Q week	CBC, CMP, hepatitis panel, quant Gold	Q6 months: CBC, CMP Q1 yr: quant gold	CHF, IBD, MS	Infections, malignancy
Ustekinumab	>100 kg -90 mg <100 kg -45 mg Day 1, month 1, then Q3 months	CBC, CMP, hepatitis panel, quant Gold	Q6 months: CBC, CMP Q1 yr: quant gold	IBD	Infections, malignancy
Ixekizumab	160 mg x1 80 mg Q2 weeks till week 12 then 80 mg Q month	CBC, CMP, hepatitis panel, quant Gold	Q6 months: CBC, CMP Q1 yr: quant gold	IBD	Infections, malignancy, IBD exacerbation
Secukinumab	300 mg Q week x 5 then 300mg Q month	CBC, CMP, hepatitis panel, quant Gold	Q6 months: CBC, CMP Q1 yr: quant gold	IBD	Infections, malignancy, IBD exacerbation
Apremilast	Standard fixed dosing to reach 30mg BID	No monitoring needed, +/- BMP	N/A	Depression, suicide history, renal disease	GI upset, headaches
Dupilumab	600 mg x1 then 300 mg Q2 weeks	+/- CBC with diff, hep panel, preg test, no labs required on package insert	+/- CBC with diff Q6 months	Parasitic infection	Conjunctivitis, keratitis, blepharitis, HSV

The above chart does not include antibiotics, antifungals, and antivirals that do not require labs.

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Double the Boards Fodders online!

In addition to this issue's Boards Fodder, you can download the new online Boards Fodder at **www.aad.org/Directions.**

An extended and more detailed version of Monitoring Systemic Dermatology Medications by Dr. Collins and Dr. Steffes is now available online in the Boards Fodder archive.

To view, download, or print every Boards Fodder ever published, check out the archives at **www.aad.org/boardsfodder.**

Kelly M. Cordoro, MD, is an associate professor of dermatology and pediatrics; assistant chief, division of pediatric dermatology; and fellowship director of pediatric dermatology at the University of California, San Francisco.

Job Searching

www

Check out the Academy's online job board for help with job searching: **www.aadcareercompass.org**

Career Case Study

Career Case Study is a new quarterly feature to help residents with choosing a subspecialty.

Next issue: Medical

Career case study

The pediatric dermatology career path

Kelly M. Cordoro, MD, interviewed by *Directions*.

Why did you choose to pursue a specialty in pediatric dermatology?

I never intended to pursue pediatric dermatology as a career focus. I did an internal medicine internship and then dermatology at the University of Virginia (UVA). Because we did not have a pediatric dermatologist at UVA, I did a pediatric dermatology elective during residency at the University of California, San Francisco (UCSF). It exposed me to the depth and breadth of pediatric dermatology. After residency, I joined the faculty at UVA as a general medical dermatologist. Two years later, for personal reasons, I faced a move across the country to the Bay Area. I pursued a pediatric dermatology fellowship at UCSF which resulted in a total career change. That was 10 years ago, and I've been on faculty as a pediatric dermatologist at UCSF since then.

What personality traits are most desirable and helpful in this type of work? Is it more social or solitary; do you need good "people" skills?

Patience, kindness, intuition, flexibility, and judgment. Pediatric dermatologists manage several subpopulations — neonates, infants, toddlers, early and late adolescents — and each require a different clinical, cognitive, and emotional approach. Pediatric dermatology is definitely a "social" subspecialty. Navigating direct patient care while also managing the needs of caregivers is important.

Describe a typical day. What are the various tasks? How much time are you spending with patients, office work, etc.?

As a pediatric academic dermatologist, my days and weeks vary, which is a fabulous perk of academics. It is never the same and is never boring. There is always something different to do, see, think about, learn, and get involved with. A "typical" week may include four or five clinics and inpatient rounds. My clinics vary from general pediatric dermatology clinics to multidisciplinary clinics, such as genetics/dermatology, chronic GVHD, and laser/procedures. I have one day per week dedicated to academia (writing, preparing or giving talks, reading, reviewing for journals, consulting work, meeting with colleagues, leadership work, etc.). Non-academic days involve a half day of clinic and a half day of clinical after-care (charts, patient phone calls, reading up on a patient's disease, etc.).

Does the work vary at different times of the year?

We see some fluctuations in volume based on the school year, but in general the clinical activity remains consistent. The volume and pace of the academic part of my job varies based on the time of year. I love teaching/giving lectures, so my schedule gets busy around the time leading up to major academic meetings and other educational commitments.

Is travel a factor in this profession?

For me, yes, but this is not the case for everyone. There are many academic and community pediatric dermatologists who prefer not to travel and focus their career differently.

What areas of your residency training and education are being put to use the most?

All of it. We rely on knowledge and skill from each of the major domains — medical knowledge, procedures, pathology, pharmacology, basic science, etc. I built a solid foundation of knowledge by consistently reading during residency and I continue to build on that with self-study and clinical experience.

How does a career path in pediatrics differ from other subspecialties?

Primarily just by the age of the patients. All of the domains of dermatology come in to play in our subspecialty.

In terms of need, workforce, and opportunities, how does it compare? Is it more difficult to land a pediatrics position than another subspecialty?

There is a significant workforce shortage of board-certified pediatric dermatologists! There are far more pediatric fellowship positions than applicants, so there is plenty of opportunity. We need providers in rural areas in particular.

If residents are considering a pediatrics subspecialty, what else should they be considering? Any special training or ways to increase their proficiency beyond their residency?

Interested residents (or even if you think you might be interested) should do a pediatric dermatology elective fairly early in the second year if you do not have a pediatric dermatologist on faculty. Seek advice and mentorship early in your residency.

Is there something specific to pediatrics that is personally rewarding? Why will residents feel satisfied with this choice?

Working with kids is a constant adventure — you never know how a child (of any age) is going to act and react. Kids say the most hilarious, intelligent, and insightful things. I never fail to be surprised, humbled, or educated by my patients. Working with kids offers a fresh perspective, keeps you young at heart, and brings joy. It can also bring deep sadness, as children with visible differences deal with social stigma, humiliation, and bullying. This heightens my sense of responsibility to these patients and underscores the privilege of providing health care to this vulnerable population. It is a fantastic profession that constantly offers new challenges and opportunities for discovery, growth, and gratification. **DR**

Dermatology job interview tips

By Lisa Truesdale

You're fresh out of residency and you've just scored a job interview. Now what? Since our first impressions of people are formed within seven seconds of meeting them, it's important to go into your interviews knowing how to act, what to say, and what to expect.

An interview, whether it's on the phone or face-to-face, is your chance to demonstrate why you're perfect for the job — and determine whether the job is perfect for you. But even if you decide early on that it's not the right position for you, you should still maintain an interested and professional manner throughout the interview. Although that job might not be the right one, the organization may have a more suitable position later, or the hiring manager might have important contacts in the industry (like other hiring managers).

To help you with the interview process, we've compiled a list of "do's and don'ts" for before, during, and after your next interview.

Before the interview

DO: Clear your schedule. Whether it's a phone or face-to-face interview, give yourself plenty of time in case it runs longer than you expected.

DO: Research the employer. More than 80 percent of hiring managers say it's essential for interviewees to ask a lot of questions, but you won't know what to ask unless you're familiar with the organization. Discuss it with your recruiter, if you have one, and check the website and social media channels.

DO: Prepare a list of questions about the position. Besides asking specific questions about the employer, you'll also want to ask questions about the job itself, like how many patients you will typically see in a day, the on-call schedule, specific job responsibilities, etc.

DO: Review your CV if it's been a while since you prepared it. You don't want to seem forgetful about details from your own life!

DON'T: Underestimate the value of practicing. Ask your recruiter, colleagues, friends, or family to help you prepare, or practice in front of a mirror.

The day of the interview

DO: Dress professionally.

DO: Find a quiet place to talk if it's a phone interview, and make sure you have excellent reception and plenty of battery life if you're talking on a cell phone.

DO: Silence your cell phone/pager. Sounds like a no-brainer, but hiring managers say that many people forget, and it's very disruptive if the phone rings.

DO: Watch your body language and other non-verbal clues. Never slouch, although leaning slightly forward during a conversation shows interest. Maintain good eye contact (but not too much) and don't fidget or flail your arms about when speaking, although some hand gesturing is fine.

DO: Take notes with a notepad and pen that you bring with you.

DO: Ask the interviewer when you can expect to hear from them.

DON'T: Be late. In fact, be early — but not too early. And be sure to call if you're going to be late for any reason.

DON'T: Speak negatively about a previous job or employer. And avoid using slang or peppering your answers with words like "uh..." or "um."

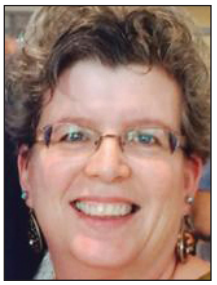
DON'T: Forget to ask all the questions you prepared.

After the interview

DO: Send a thank you note to the interviewer; a brief, handwritten note makes a good impression. Send a note even if you've decided the position isn't right for you.

DO: Follow up with a phone call or email after an appropriate length of time, but don't say anything confrontational like, "You said you would contact me within two weeks, but it's been three."

DO: Assess your performance afterwards, thinking about what you did right and what didn't go as well, so you can adjust for your next interview. DR



Lisa Truesdale, is a full-time freelance writer based in Colorado. She writes regularly for regional, national, and international publications on topics like the health care industry, healthy living, yoga and fitness, natural foods, travel, sports, and food and drink.

Inside this Issue

Mallory Shiver Abate, MD, is an attending physician at St. Louis University in St Louis, Missouri.

Two heavy weights lie on our shoulders during our last year of residency — securing our dream jobs (on that, see this issue's cover story and the piece on interviewing on pg. 7) and taking the boards. All of the traveling, interviewing, and contract negotiation will be well worth it once you sign your contract. But what about the boards? Will all of that boards studying pay off? Yesterday I took the dermatology boards and I must say the test was as unique as everyone says. See below for our takes on the test, tips for preparing, and what we would have done differently if we had to study for it all over again:

- **Take:** "Very hard but everyone thinks so."
- **Tip:** "Studying with co-residents during the last few months really kept me on track. Also looking at as many kodachromes throughout residency as possible."
- **Do over:** "Read the ASDS study book and spend less time reviewing all of the minutiae we had to know for the inservice." – *Julie Rembold, MD, University of Arkansas for Medical Sciences*

- **Take:** "Definitely challenging but not unreasonably so."
- **Tip:**"Make old-school, handwritten flashcards on those important details you can never seem to commit to memory."
- **Do over:** "Practice looking at slides in a timed, controlled setting — two-and-a-half minutes per slide goes by really fast!" – *Mallory Hurst, MD, University of Alabama at Birmingham*

- **Take:** "I thought it was a hard exam."
- **Tip:** "Reviewing glass slides on my own and with faculty. The path portion was challenging and worth your time investment to prepare."
- **Do over:** "Spend more time reviewing a few resources instead of trying to cover many different resources — that would be a better strategy." – *GiGi Tracey, MD, Tulane University*
- **Take:** "Harder than the inservice but the inservice is a good indicator of how you will do."
- **Tip:** "Board Vitals Q-bank, Alikhan and Hocker's Review of Dermatology, and Dr. Elston's dermpath and kodachrome lectures on YouTube — all amazingly helpful."
- **Do over:** "Spend more time reviewing slides — dermpath was the hardest section." – *Jessica Connett, MD, Medical University of South Carolina*

- **Take:** "Overall very difficult — glad we only have to take it once!"
- **Tip:** "Look through kodachromes in different texts (like DuVivier) — it made a big difference!"
- **Do over:** "Spend less time studying basic science and pathophysiology." – *Ashley Emerson, MD, Windham, Louisiana State University*

Overall I thought the test was challenging and random. Afterwards, everyone was unanimously perplexed by the question selection. It seems like there is a movement away from esoteric facts like we are used to reciting, so it's much different from the inservice. The most helpful thing I did was a two-day comprehensive slide review with a dermpath group and a mock slide exam with our dermpath faculty. Second most helpful thing was group studying with my co-residents. I didn't use any new sources — I reviewed my Sima Jain, Rapini, Galderma Q-bank and Quest Q-bank questions that I have used for the past three years and was prepared. If I had to do it again I would have spent more time on dermpath, surgery, and drugs/drug side effects and less time on inservice trivia. **DR**

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